LIFE INSURANCE SPECIAL ENROLLMENT FORM 2015

THE UNIVERSITY OF UTAH

Name:	Empl ID#:

The Special Enrollment period runs from September 21 through October 30, 2015.
Coverage elected will become effective on November 1, 2015.

See the back of this form or the Benefits Department's web page at www.hr.utah.edu/benefits/life-special.php for rates and specific information on this special offer.
Please designate beneficiaries on the back of this form for any coverage elected.

Employee Supplemental Term Life Insurance

During this Special Enrollment, you may enroll in up to $350,000 (minimum $20,000) without providing evidence of good health.

Premiums are based on your age and tobacco use.

Have you used tobacco in any form in the past 12 months?
[ ] Yes [ ] No

$_____

(If you are already enrolled, put the total amount you would like on the line above – this amount will not be in addition to any amount you already have.)

Domestic Partner Supplemental Term Life Insurance

During this Special Enrollment, you may enroll in up to $30,000 (minimum $20,000) without providing evidence of good health.

Premiums are based on your domestic partner's age and tobacco use.

Domestic Partner's Birthdate:_____

Has your Domestic Partner used tobacco in any form in the past 12 months? [ ] Yes [ ] No

$_____

(If you are already enrolled, put the total amount you would like on the line above – this amount will not be in addition to any amount you already have.)

I have read and understand the information provided. I hereby apply for the coverage I have indicated above and authorize the University to make the deduction of appropriate premiums from my pay.

I acknowledge that I have been given this special enrollment opportunity and that I am only eligible to enroll if I am actively at work on the effective date of coverage or your first regularly scheduled work day following the date coverage takes effect and I have not previously been denied coverage by Hartford Life.

I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I certify that my Domestic Partner and I are both over the age of 18; reside together in a permanent residence and have done so for at least six months and will remain members of the same household for the period of coverage; have a serious and committed relationship which we intend to continue indefinitely; are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of our household or one of us is chiefly dependent upon the other for financial assistance; not related in any way that would prohibit legal marriage; and not legally married to anyone else or the partner of anyone else. I acknowledge that if we fail to meet any of these conditions in the future, my Domestic Partner and his/her children will no longer be eligible for coverage under this plan.

Employee Signature: _____ Date: _____

See the back of this form for information and rates.

To apply for Employee Supplemental Term Life Insurance in an amount over $350,000 or Domestic Partner Supplemental Term Life Insurance in an amount over $30,000, you must provide evidence of good health. Applications are available on the Benefits Department's website www.hr.utah.edu/ben or by contacting the Benefits Department at (801) 581-7447.

In the event of any discrepancy between this document and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet.

Entered By: _____ QC By: _____
Date: _____

University of Utah Division of Human Resources – Benefits Department
420 Wakara Way, Suite 105 (801) 581-7447
Salt Lake City, UT 84108 Fax: (801) 585-7375

BENEFICIARY DESIGNATIONS

Employee Supplemental Term Life Insurance			
Employee Supplemental Term	Name/Address/Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Domestic Partner Supplemental Term Life Insurance			
Domestic Partner Supplemental Term	Name/Address/Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary	**Employee**		
Contingent Beneficiary(ies)			

Monthly Premium Rates Effective July 1, 2015

Age	Non-tobacco User	Tobacco User	Age	Non-tobacco User	Tobacco User
Under 30	$ 0.045	$ 0.076	62	$ 0.594	$ 1.180
30	$ 0.054	$ 0.084	63	$ 0.594	$ 1.281
31	$ 0.054	$ 0.092	64	$ 0.594	$ 1.339
32	$ 0.054	$ 0.092	65	$ 0.829	$ 1.524
33	$ 0.054	$ 0.092	66	$ 0.913	$ 1.657
34	$ 0.054	$ 0.101	67	$ 1.004	$ 1.791
35	$ 0.072	$ 0.109	68	$ 1.096	$ 1.950
36	$ 0.072	$ 0.109	69	$ 1.143	$ 2.101
37	$ 0.072	$ 0.126	70	$ 1.499	$ 2.486
38	$ 0.072	$ 0.126	71	$ 1.758	$ 2.849
39	$ 0.072	$ 0.126	72	$ 1.854	$ 3.130
40	$ 0.081	$ 0.150	73	$ 1.854	$ 3.490
41	$ 0.081	$ 0.159	74	$ 1.854	$ 3.901
42	$ 0.081	$ 0.185	75	$ 1.854	$ 4.370
43	$ 0.081	$ 0.193	76	$ 1.854	$ 4.921
44	$ 0.084	$ 0.210	77	$ 1.854	$ 5.415
45	$ 0.117	$ 0.226	78	$ 1.854	$ 5.901
46	$ 0.122	$ 0.243	79	$ 1.854	$ 6.428
47	$ 0.122	$ 0.276	80	$ 1.854	$ 7.023
48	$ 0.122	$ 0.302	81	$ 1.854	$ 7.683
49	$ 0.135	$ 0.335	82	$ 1.854	$ 8.429
50	$ 0.159	$ 0.377	83	$ 1.854	$ 9.283
51	$ 0.185	$ 0.427	84	$ 1.854	$ 10.262
52	$ 0.201	$ 0.469	85	$ 1.854	$ 11.040
53	$ 0.207	$ 0.527	86	$ 1.854	$ 11.928
54	$ 0.207	$ 0.603	87	$ 1.854	$ 12.848
55	$ 0.302	$ 0.636	88	$ 1.854	$ 13.744
56	$ 0.318	$ 0.695	89	$ 1.854	$ 14.639
57	$ 0.352	$ 0.761	90	$ 1.854	$ 15.585
58	$ 0.387	$ 0.829	91	$ 1.854	$ 16.639
59	$ 0.387	$ 0.904	92	$ 1.854	$ 17.803
60	$ 0.485	$ 0.987	93	$ 1.854	$ 19.058
61	$ 0.545	$ 1.088	94	$ 1.854	$ 20.306
			95	$ 1.854	$ 21.494

To calculate premium cost: Determine the premium rate that applies to your age and tobacco use. Divide your desired coverage amount by 1,000, then multiply that number by the premium rate. *For example, assume you are age 45, do not use tobacco, and want $150,000 of coverage. Your premium rate would be $.117 per $1,000 of desired coverage ($.117 multiplied by 150), for a total premium of $17.55 per month.*