Hartford Life

MONROE 2-ORLEANS BOCES

GROUP OPTIONAL LIFE INSURANCE ENROLLMENT FORM

NAME LAST	FIRST	M.I.	BIRTH DATE M/D/Y	SEX ❑ F ❑ M
ANNUAL EARNINGS			SOCIAL SECURITY NUMBER	

Employee Optional Term Life Insurance – Employee Paid

❑ Yes ❑ No

If yes, please indicate Coverage Option you wish to elect::

The Insurance Amount Elected CANNOT exceed 3 Times Your Salary	**Rates for All Options**	
❑ $25,000	Under Age 30	$.06 per $1,000 per month
	Age 30 - 34	$.07 per $1,000 per month
❑ $50,000	Age 35 - 39	$.10 per $1,000 per month
	Age 40 - 44	$.16 per $1,000 per month
❑ $100,000	Age 45 - 49	$.26 per $1,000 per month
	Age 50 - 54	$.44 per $1,000 per month
❑ $150,000**	Age 55 - 59	$.70 per $1,000 per month
	Age 60 - 64	$.93 per $1,000 per month
❑ $250,000**	Age 65 - 69	$1.48 per $1,000 per month
	Age 70 - 74	$2.42 per $1,000 per month
	Age 75 and Over	$4.50 per $1,000 per month

****Amounts in excess of $100,000 are subject to proof of good health satisfactory to Hartford Life.**

Dependent Term Life Insurance - Employee Paid

You Must Elect one of the Employee Options above in order to elect a Dependent Life Option

❑ Yes ❑ No If yes, please indicate Coverage Option you wish to elect

PLAN 1 :

Spouse - $5,000

Children: 0 to 14 days – None
15 days to 6 Months - $100
6 months to Age 19* - $2,000
*Age 25 if Full-Time Student

❑ Spouse & Children - $2.00 per Family per month
❑ Spouse Only - Rate - $1.75 per Month
❑ Children Only – Rate - $.25 per Month

PLAN 2:

Spouse - $10,000

Children: 0 to 14 days – None
15 days to 6 Months - $100
6 Months to Age 19* - $4,000
*Age 25 if Full-Time Student

❑ Spouse & Children - $4.00 per Family per month
❑ Spouse Only - Rate - $3.50 per Month
❑ Children Only – Rate - $.50 per Month

BENIFICIARY DESIGNATION

Full Name	Address	Social Security #	Relationship	D.O.B.
PRIMARY				
CONTINGENT				

I understand that if I desire to apply at a later date for the benefits that I have declined, I will have to furnish, at my own expense, proof of good health satisfactory to Hartford Life before coverage can become effective.

❑ I hereby apply for the coverage I have indicated above and I authorize my Employer to make the appropriate deductions from my wages to pay for the cost of the insurance. I understand that the insurance available to me is in accordance with the provisions of the contract between The Hartford and my Employer.

❑ I hereby waive the coverage offered to me.

Employee’s Signature ____**Date**____________