



Income Protection Benefits

**Miami Dade College
Benefits Enrollment Form**

Information About You

Name:	Social Security Number / Employee ID Number:
Date of Birth:	Date of Hire:
Location/Division:	

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please enter and/or check your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer’s contract.*
- **Step 2:** Please sign, date and return this form to Human Resources.

Basic Life and AD&D Insurance

Miami Dade College provides, at no cost to you, Basic Life and AD&D Insurance in an amount equal to 1 times your annual Earnings, rounded to the next lower \$100, to a maximum of \$400,000 (\$800,000 of combined Basic and Voluntary/Supplemental Life Insurance coverage).

Supplemental Life and AD&D Insurance

You can purchase Supplemental Life and AD&D Insurance in increments of 1 times your annual Earnings up to 3 times your annual Earnings, rounded to the next lower \$100 if not an even multiple thereof, subject to a maximum of \$400,000 (\$800,000 of your combined Basic and Voluntary/Supplemental Life Insurance coverage). This coverage is offered without requiring you to provide evidence of insurability.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	\$0.05	\$0.05	\$0.05	\$0.05	\$0.07	\$0.09	\$0.13	\$0.19	\$0.29	\$0.51	\$0.71	\$1.51

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life and AD\&D Benefit Amount}}{\div \$1,000} = \text{_____} \times \text{Rate} = \$ \text{My Monthly Cost}$$

- I elect to **purchase** 1 times my annual Earnings in Life and AD&D coverage.
- I elect to **purchase** 2 times my annual Earnings in Life and AD&D coverage.
- I elect to **purchase** 3 times my annual Earnings in Life and AD&D coverage.
- I **decline** to purchase Life and AD&D coverage.

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Miami Dade College
Generic Newly Eligible
4/28/2011

Name: _____

Supplemental Dependent Life Insurance

If you purchase Supplemental Life and AD&D Insurance for yourself, you can purchase Supplemental Dependent Life Insurance in an amount equal to \$15,000 for your Spouse/Domestic Partner, not to exceed 50% of combined Basic and Voluntary/Supplemental Life Insurance coverage, and \$7,500 for each child between the ages of 2 weeks and 19 years (25 years if a full time student). Children between the ages of 2 weeks and 6 months are limited in the amount of \$500.

- I elect to **purchase** Supplemental Dependent Life coverage at a Monthly cost of \$3.50 per family unit.
- I **decline** to purchase Supplemental Dependent Life coverage.

Spouse/Domestic Partner:

First Name	Last Name	Gender	Date of Birth	Date of Marriage or Eligible Partnership

Child(ren):

First Name	Last Name	Date of Birth	Gender

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Name: _____

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your Spouse/Domestic Partner and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the Spouse/Domestic Partner and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your Spouse/Domestic Partner to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans.

This will certify that, as Spouse/Domestic Partner of the Employee named above, I hereby consent to my Spouse/Domestic Partner designating the person(s) listed above as beneficiaries of group life insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse/Domestic Partner: _____ Date: _____

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Name: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life insurance coverage described in the Benefit Highlight Sheets and offered through Miami Dade College.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____

Date _____

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