Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

# MINNESOTA LIFE

## Supplemental Term Life Insurance and AD&D Enrollment/Cancellation Form
## San Bernardino County Policy Number 33772 & 33773

*Must print in Black or Blue ink ONLY*

| Employee ID | Last Name, First Name | Department |
|---|---|---|
| | | |
| **Date of Hire** | **Date of Birth** | **Age** |
| | | |

**Supplemental Life Insurance – Employee** ☐ Before-Tax ☐ After-Tax (if no election is made, after-tax will be applied)

You may re-enroll or enroll for the first time in the San Bernardino County's Supplemental Term Life Insurance plan and elect coverage in increments of $10,000, up to $700,000. If you elect an amount that exceeds $250,000, you will need to provide evidence of good health that is satisfactory to Minnesota Life before the excess can become effective. Refer to the current Employee Benefits Guide to determine your bi-weekly cost for this coverage. ***You must complete the Beneficiary Designation section on page 2 of this form.***

☐ I elect to **enroll** or **re-enroll** in the Supplemental Life Plan. *Total amount of supplemental life insurance requested $ _____

☐ I elect to **decline** or **cancel** the Supplemental Life Plan.

*Note: Benefit reductions begin at age 70. If you are over the age of 70, the bi-weekly costs shown are calculated based on your reduced benefit amount, not the employee life amount shown. Please see your benefits administrator for further information.

**Supplemental Life Insurance - Spouse/Domestic Partner** (offered on after-tax basis only)

You may enroll your spouse or registered domestic partner in the Supplemental Term Life Insurance plan and elect coverage in increments of $10,000, up to $250,000. Your dependent's coverage cannot exceed your total combined basic and supplemental life coverage, up to $250,000. If you elect a coverage amount that exceeds $50,000 or enroll under one of the EOI-required enrollment opportunities (e.g., mid-year qualifying life event), you will need to provide evidence of good health that is satisfactory to Minnesota Life before the excess can become effective.

***IMPORTANT NOTE: If your spouse or registered domestic partner is eligible for County's life insurance plan(s) including Basic/Supplemental Life as an employee of the County or an affiliated agency, you may <u>not</u> enroll them in the Supplemental Spouse/Domestic Partner plan.***

☐ I elect to **enroll** or **re-enroll** in the Supplemental Spouse/Domestic Partner Life Plan and **my spouse/domestic partner is <u>not</u> eligible for their own County life insurance plan(s) as an employee of the County or affiliated agency**.

**Total amount of supplemental life insurance requested $ _____

☐ I elect to **decline** or **cancel** the Supplemental Spouse/Domestic Partner Life Plan.

| Spouse/Domestic Partner Last Name, First Name | SSN | Relationship | Date of Birth |
|---|---|---|---|
| | | | |

**Note: Benefit reductions also applies on Spouse/Domestic Partner coverage.

**Supplemental Life Insurance - Child(ren)** (offered on after-tax basis only)

You may enroll your eligible child(ren) under the age of 26 in the Supplemental Term Life Insurance plan and elect coverage in increment of $5,000, up to $20,000. Your dependent's coverage cannot exceed your total combined basic and supplemental life coverage, up to $20,000. All amounts for child(ren) coverage are guaranteed and one election will cover all eligible child(ren). Refer to the current Employee Benefits Guide to determine your bi-weekly cost for this coverage.

***IMPORTANT NOTE: If your child(ren) is eligible for County's life insurance plan(s) including Basic/Supplemental Life as an employee of the County or an affiliated agency, you may <u>not</u> enroll them in the Supplemental Life Insurance Child(ren) plan. Additionally, if both you and your spouse/domestic partner are eligible for the County's Supplemental Life Insurance Child(ren) plan, your child(ren) may only be covered under one policy.***

☐ I elect to **enroll** or **re-enroll** in the Supplemental Child(ren) Life Plan and **my child(ren) is <u>not</u> eligible for their own County life insurance plan(s) as an employee of the County or affiliated agency.**

***Total amount of supplemental life insurance requested $ _____

☐ I elect to **decline** or **cancel** the Supplemental Child(ren) Life Plan.

| Child(ren) Last Name, First Name | SSN | Relationship | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

***Note: One election will cover all eligible child(ren).
Attach additional pages as necessary to provide information for all eligible child(ren)

*DISTRIBUTION:*
*New Hire- EMACS-HR (0030)*
*Mid-Year- HR-EBSD (0440)*

**Voluntary Accidental Death & Dismemberment (AD&D)** ☐ Before-Tax ☐ After-Tax (if no election is made, after-tax will be applied)

| Plan Option | Employee | Spouse or Domestic Partner | Each Child |
|---|---|---|---|
| **1** | $10,000 | $5,000 | $3,125 |
| **2** | $25,000 | $12,500 | $6,250 |
| **3** | $50,000 | $25,000 | $12,500 |
| **4** | $100,000 | $50,000 | $25,000 |
| **5** | $150,000 | $75,000 | $25,000 |
| **6** | $200,000 | $100,000 | $25,000 |
| **7** | $250,000 | $125,000 | $25,000 |

AD&D is offered to all units except Fire Fighters, Per Diem Nurses, Safety and Safety Management and certain contract positions. Refer to the current Employee Benefits Guide to determine your bi-weekly cost for this coverage.

***IMPORTANT NOTE: If your spouse/domestic partner or child(ren) is eligible for County life insurance plan(s) including Basic/Supplemental Life as an employee of the County or an affiliated agency, you may not enroll them as dependents in the Voluntary AD&D plan. Additionally, if both you and your spouse/domestic partner are eligible for the County's Voluntary AD&D plan, your child(ren) may only be covered under one policy.***

☐ I elect to **enroll or re-enroll** in the AD&D plan and **my spouse/domestic partner or child(ren) are not eligible for their own County life insurance plan(s)**.

**Select a plan option**: ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4 ☐ Option 5 ☐ Option 6 ☐ Option 7

**Select one of the following coverages:** ☐ EMPLOYEE ONLY ☐ EMPLOYEE + SPOUSE ☐ EMPLOYEE + CHILD ☐ EMPLOYEE + FAMILY

☐ I elect to **decline** or **cancel** the Voluntary AD&D plan.

## Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. Contingent beneficiaries collect only if all primary beneficiaries predecease the insured. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. ***Please Note: you are the beneficiary of spouse/domestic partner and child(ren) supplemental life benefits if you are living, otherwise benefit will be paid to your estate.***

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example, "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

| | Full Name | Address | SSN (required) | Relationship | Date of Birth | % |
|---|---|---|---|---|---|---|
| **Primary** | | | | | | |
| | | | | | | |
| | | | | | | |
| **Contingent** | | | | | | |
| | | | | | | |
| | | | | | | |

*A beneficiary for employee Life Insurance may be changed upon written request*

## Employee Confirmation

I have been given the opportunity to enroll in the San Bernardino County's Group Supplemental Term Life & AD&D Insurance plans with Minnesota Life. I understand that for any amount which exceeds the guaranteed issue amount, I will be required to provide evidence of good health that is satisfactory to Minnesota Life and understand my request for coverage may be denied. I authorize my employer to make the appropriate payroll deductions from my wages. I am not now disabled, and I am performing all the duties of my occupation on a full-time basis.

| Employee Signature | Date |
|---|---|
| | |

This document/form incorporates use of e-signature(s) in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

| FOR OFFICE USE ONLY | | |
|---|---|---|
| **EOI Required** | ☐ Employee | ☐ Spouse/Domestic Partner |

| FOR HR USE ONLY | |
|---|---|
| Processed By (Employee ID) | Date |
| | |

*DISTRIBUTION:*
*New Hire- EMACS-HR (0030)*
*Mid-Year- HR-EBSD (0440)*