INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Employer: LeadingAge Oregon

Location: Concepts in Community Living
ALL ABOUT YOU – THE EMPLOYEE

Your Name ______________________ **Social Security #**______________ **Birthdate**__________
Address ______________________ City______________ State_____ Zip__________
Work Phone ______________ Home Phone ______________ Employee ID #__________ Gender:___

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

☐ I am currently married and my date of marriage is: ________ or I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information

Name ______________________ **Social Security #** ______________

Birthdate ____________ Gender ____________

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employer-Paid (Basic) Term Life Insurance		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	$10,000	Guaranteed Coverage*: $10,000

Employee-Paid (Voluntary) Term Life Insurance		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to $500,000. Guaranteed Coverage: $200,000	☐ $10,000 ☐ $200,000 ☐ $500,000** ☐ Other ☐ Decline Coverage
Spouse	Units of $10,000 up to $500,000. Guaranteed Coverage: $30,000	☐ $10,000 ☐ $30,000* ☐ $500,000** ☐ Other ____________ ☐ Decline Coverage *Amount must be a multiple of $10,000.*
Child	☐ $2,000 ☐ $5,000 ☐ $10,000 Maximum Coverage**: $10,000	☐ Decline Coverage

Employer-Paid (Basic) Accidental Death & Dismemberment Insurance	
Applicant	**The coverage below is provided by your employer at no cost to you.**
Employee	$10,000
Spouse	$1,000
Children	$1,000

Employee-Paid (Voluntary) Accidental Death & Dismemberment Insurance

Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to $500,000.	☐ $10,000 ☐ $200,000 ☐ $500,000** ☐ Other ____________ ☐ Decline Coverage Amount must be a multiple of $10,000
Spouse	Units of $10,000 up to $500,000.	☐ $10,000 ☐ $30,000* ☐ $500,000** ☐ Other ____________ ☐ Decline Coverage *Amount must be a multiple of $10,000.*
Child	☐ $2,000 ☐ $5,000 ☐ $10,000 Maximum Coverage**: $10,000	☐ Decline Coverage

**The GI amount is only available if enrolling within the first 31 days of eligibility. For any coverage that is not Guaranteed Issue, you must complete the Evidence of Insurability Form.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latest of 01/01/2023, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Prudential's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate.

Please Sign Here ☛ Signature ________________________ Date ______________

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren). If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Basic Life Insurance				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Voluntary Life Insurance				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Basic Accidental Death & Dismemberment Insurance				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Voluntary Accidental Death & Dismemberment Insurance				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse Signature ______________________________ Date _____/_____/_______

Employee Signature ______________________________ Date _____/_____/_______

Created on 10/2022.

Be sure to make a copy for your records.