- ○ New Subscriber
- ○ Open Enrollment
- ○ Optional Life Change
- ○ Dependent Life Change
- ○ Beneficiary Change

Colorado College
Life / Long-Term Disability Enrollment Form

Coverage Effective Date: _____

Name: _____ Social Security Number: _____ Date of Birth: _____

Basic Life Insurance/Accidental Death and Dismemberment Plan

You automatically receive one and one-half (1 ½) times your base annual salary rounded to the next multiple of $1,000 under this plan (life and accidental death). Maximum coverage: $500,000

Optional Life Insurance

Minimum coverage: $10,000
Maximum coverage: $500,000

Coverage that exceeds $100,000 requires evidence of insurability

☐ One times annual salary ☐ Two times annual salary ☐ Three times annual salary
☐ Four times annual salary ☐ Five times annual salary ☐ No coverage

Formula to calculate life volume and cost:
Annual Salary $ _____ x Option _____ = $ _____ = Volume $ _____
(Rounded to Next higher $1,000)

Volume $ _____ ÷ 1000 x Rate $ _____ = Your Cost $ _____ Per Month

Age	Rate	Age	Rate	Age	Rate	Age	Rate
00-29	$ .053	40-44	$ .110	55-59	$ .536	70-74	$2.580
30-34	$ .072	45-49	$ .202	60-64	$ .771	75-99	$4.640
35-39	$ .088	50-54	$ .330	65-69	$ 1.400		

Optional Dependent Life Insurance

☐ Plan I
($5,000 Spouse/$2,000 child(ren)
$1.68 per month

☐ Plan II
($10,000 Spouse/$4,000 child(ren)
$3.30 per month

☐ No coverage

Optional ACM Voluntary Travel Accident Insurance

Minimum coverage: $10,000
Maximum coverage: $750,000

Amounts in excess of $350,000 may not exceed ten (10) times your base annual salary.

☐ Employee Only
$0.012 per $1,000 of Principal Sum

☐ Employee and Family
$0.023 per $1,000 of Principal Sum

☐ No coverage

Principal Sum Elected $ _____

Long Term Disability (LTD) Insurance Effective Date of Coverage: _____

Coverage is effective on the first day of the month following one year of employment.

If you had 12 months of coverage during the preceding 12 month period, the one year waiting period is waived.
Previous Employer _____
Prior Insurance Company _____ Date Prior Coverage Terminated _____

Employee Signature: _____ Date: _____
I authorize Colorado College to deduct the appropriate premiums from each paycheck to pay for the optional plans I elected above.

OVER

Please fully complete this form and sign it to designate a beneficiary or to change your existing beneficiary designation.

Name _____Social Security Number _____

This beneficiary election is for the basic life insurance plan, and if applicable, the optional life insurance plan and ACM personal accident insurance plan.

Primary Beneficiary(ies):
I designate the person(s) named below as my primary beneficiary(ies) to receive payment under the policy(ies) in the event of my death. The share of any primary beneficiary, who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining beneficiary (ies) in equal shares.

1. _____ _____ _____ _____ _____%
   Name / Social Security Number | Date of Birth | Relationship | Address

2. _____ _____ _____ _____ _____%
   Name / Social Security Number | Date of Birth | Relationship | Address

3. _____ _____ _____ _____ _____%
   Name / Social Security Number | Date of Birth | Relationship | Address

Contingent Beneficiary(ies):
I designate the person(s) below as my contingent beneficiary(ies) who will receive payment only if all primary beneficiary(ies) predecease me or are otherwise disqualified by law.

1. _____ _____ _____ _____ _____%
   Name / Social Security Number | Date of Birth | Relationship | Address

2. _____ _____ _____ _____ _____%
   Name / Social Security Number | Date of Birth | Relationship | Address

3. _____ _____ _____ _____ _____%
   Name / Social Security Number | Date of Birth | Relationship | Address

Authorization and Signature:
By signing this document, I understand and agree to the following: This beneficiary designation revokes all prior designations. This beneficiary designation form will apply to The Standard Insurance plan established in connection with my employers' plan. If more than one primary beneficiary is named and no percentages are indicated, payment will be made in equal shares to my primary beneficiary(ies) who survive(s) me or if the percentages listed do not add up to 100%, The Standard will disburse the benefit pursuant to its discretion and/or pursuant to the policy provisions if applicable.

Signature _____ Date _____