

Please complete this form in its entirety to designate your election(s) for the University of Hartford's optional term life insurance benefits. This form may also be used if you want to change your existing beneficiary information on record in the office of Human Resources Development. Additional primary and/or contingent beneficiaries may be added by attaching an additional form.

Employee's Information:

Print Name (First, Middle Initial, Last)	Social Security Number	Policy Number(s)
		724328

SUPPLEMENTAL LIFE INSURANCE

I would like to purchase the following level of supplemental term life insurance in accordance with the guidelines of the University's plan. I understand that evidence of insurability may be required for coverage above \$250,000* and that age reduction rules apply (see plan document for details).

One times base salary
 Two times base salary
 Three times base salary
 Four times base salary
 I do not wish to purchase this coverage at this time.

BENEFICIARY DESIGNATION
 (To list additional or contingent beneficiaries, please attach a separate sheet)

Name: _____

Address: _____

Social Security No: _____ Birthdate: _____ Relationship: _____ Percentage: _____

Name: _____

Address: _____

Social Security No: _____ Birthdate: _____ Relationship: _____ Percentage: _____

SPOUSAL LIFE INSURANCE	DEPENDENT CHILD(REN) LIFE INSURANCE
I would like to purchase the following level of spousal term life insurance, not to exceed 100% of total employee coverage amount, in accordance with the guidelines of the University's plan: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000* <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$ 100,000 <input type="checkbox"/> I do not wish to purchase this coverage at this time.	I would like to purchase the following level of dependent child(ren) term life insurance, not to exceed 100% of total employee coverage amount, in accordance with the guidelines of the University's plan: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000* <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> I do not wish to purchase this coverage at this time.

* Guaranteed issue amount

I understand that I am the primary beneficiary for the spousal and/or dependent child(ren) life insurance plan(s) that I have elected to enroll in unless I designate otherwise in writing and that I cannot have dual/cross coverage through these group life insurance plans (covered as both an employee and as spouse or dependent child[ren]). I further understand that during the University of Hartford's Open Enrollment Period or following a qualifying event as defined by IRS regulations, I can make changes to my existing optional life insurance elections; however, any new enrollment **OR** if currently enrolled, an increase in coverage of one level or beyond the guaranteed issue amount will require evidence of insurability.

My signature below indicates my agreement with the elections noted above. The right to change beneficiary(ies) without the consent of said beneficiary(ies) is reserved.

Signature of Employee: _____ Date: _____

Signature of Witness: _____ Date: _____

(Witness cannot be designated beneficiary)

Conditions

- Unless otherwise expressly provided in this Designation of Beneficiary form, if any named beneficiary predeceases the employee, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives the employee, any sum becoming payable under said Group Contract(s) by reason of the employee's death shall be payable as prescribed in said Group Contract(s).
- If this Designation of Beneficiary provides for payment to a trustee under a trust agreement, said Insurance Company shall not be obliged to inquire into the terms of the trust agreement and shall not be chargeable with knowledge of the terms thereof.
- Payment to and receipt by the trustee shall fully discharge all liability of said Insurance Company to the extent of such payment.

New Hires

- A newly hired employee at the University of Hartford will be allowed to enroll in optional life insurance upon hire, with coverage elections effective the first day of the month following date of hire. Proof of insurability will be required for coverage elections above the guaranteed issue amounts noted herein.

Instructions

- Complete **Employee Information** in full.
- **I. Supplemental Life Insurance** - The University offers all regular full-time and regular part-time faculty and staff the option to purchase supplemental life insurance equal to one, two, three or four times base salary. The maximum benefit payable is \$500,000. The employee will pay 100% of the premium for this coverage, which is currently **\$0.293** per \$1,000 worth of coverage per month. Please elect the amount of coverage you wish to purchase and designate your beneficiary(s). If you are not interested in purchasing supplemental life insurance, please indicate your intent on the form. Per plan guidelines, the value of this benefit is reduced by 50% at age 70.
- **II. Spousal Life Insurance** - The University offers all regular full-time and regular part-time faculty and staff the option to purchase spousal life insurance in \$10,000 increments. The maximum benefit payable is \$100,000. The employee will pay 100% of the premium for this coverage, which is currently **\$0.27** per \$1,000 worth of coverage per month. The amount of life insurance for a spouse may not exceed 100% of the employee coverage amount. Please elect the amount of coverage you wish to purchase. You will be the beneficiary for this policy. If you are not interested in purchasing spousal life insurance, please indicate your intent on the form. You may not cover your spouse as a dependent if your spouse is enrolled in coverage as an employee.
- **III. Dependent Life Insurance** - The University offers all regular full-time and regular part-time faculty and staff the option to purchase dependent child(ren) life insurance in \$5,000 increments. The maximum benefit payable is \$25,000. The amount of life insurance for a dependent may not exceed 100% of the employee coverage amount. The employee will pay 100% of the premium for this coverage, which is currently **\$0.156** per \$1,000 worth of coverage per month. This rate remains the same regardless of the number of dependent children of the employee. You will be the beneficiary for this policy. If you are not interested in purchasing dependent child(ren) life insurance, please indicate your intent on the form. Dependent child(ren) may not be covered by more than one employee. Dependent child(ren) cannot be covered as both an employee and a dependent.
- **Signature of Employee** – Please sign and date the form. This form must also be signed and dated by a witness (who is not your designated beneficiary).

Note: All optional life insurance policies are term insurance and are discontinued upon separation of employment.

All rates are subject to change. This form is designed to summarize the University of Hartford's Optional Life Insurance benefits, it is not intended to be all inclusive. Where there are differences between the provisions of this form and more specific statements contained in the University files (such as plan documents), those statements shall control.