

Employee Supplemental Life - Current Bi-Weekly Cost by Age Band

Current Monthly Rates per \$1,000:	0.080	0.090	0.100	0.120	0.180	0.280	0.430	0.670	0.910	1.450	2.430	7.040
Coverage	Age <25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000	0.37	0.42	0.46	0.55	0.83	1.29	1.98	3.09	4.20	6.69	11.22	32.49
\$20,000	0.74	0.83	0.92	1.11	1.66	2.58	3.97	6.18	8.40	13.38	22.43	64.98
\$30,000	1.11	1.25	1.38	1.66	2.49	3.88	5.95	9.28	12.60	20.08	33.65	97.48
\$40,000	1.48	1.66	1.85	2.22	3.32	5.17	7.94	12.37	16.80	26.77	44.86	129.97
\$50,000	1.85	2.08	2.31	2.77	4.15	6.46	9.92	15.46	21.00	33.46	56.08	162.46
\$60,000	2.22	2.49	2.77	3.32	4.98	7.75	11.91	18.55	25.20	40.15	67.29	194.95
\$70,000	2.58	2.91	3.23	3.88	5.82	9.05	13.89	21.65	29.40	46.85	78.51	227.45
\$80,000	2.95	3.32	3.69	4.43	6.65	10.34	15.88	24.74	33.60	53.54	89.72	259.94
\$90,000	3.32	3.74	4.15	4.98	7.48	11.63	17.86	27.83	37.80	60.23	100.94	292.43
\$100,000	3.69	4.15	4.62	5.54	8.31	12.92	19.85	30.92	42.00	66.92	112.15	324.92
\$110,000	4.06	4.57	5.08	6.09	9.14	14.22	21.83	34.02	46.20	73.62	123.37	357.42
\$120,000	4.43	4.98	5.54	6.65	9.97	15.51	23.82	37.11	50.40	80.31	134.58	389.91
\$130,000	4.80	5.40	6.00	7.20	10.80	16.80	25.80	40.20	54.60	87.00	145.80	422.40
\$140,000	5.17	5.82	6.46	7.75	11.63	18.09	27.78	43.29	58.80	93.69	157.02	454.89
\$150,000	5.54	6.23	6.92	8.31	12.46	19.38	29.77	46.38	63.00	100.38	168.23	487.38
\$160,000	5.91	6.65	7.38	8.86	13.29	20.68	31.75	49.48	67.20	107.08	179.45	519.88
\$170,000	6.28	7.06	7.85	9.42	14.12	21.97	33.74	52.57	71.40	113.77	190.66	552.37
\$180,000	6.65	7.48	8.31	9.97	14.95	23.26	35.72	55.66	75.60	120.46	201.88	584.86
\$190,000	7.02	7.89	8.77	10.52	15.78	24.55	37.71	58.75	79.80	127.15	213.09	617.35
\$200,000	7.38	8.31	9.23	11.08	16.62	25.85	39.69	61.85	84.00	133.85	224.31	649.85
\$250,000	9.23	10.38	11.54	13.85	20.77	32.31	49.62	77.31	105.00	167.31	280.38	812.31
\$300,000	11.08	12.46	13.85	16.62	24.92	38.77	59.54	92.77	126.00	200.77	336.46	974.77
\$350,000	12.92	14.54	16.15	19.38	29.08	45.23	69.46	108.23	147.00	234.23	392.54	1,137.23
\$400,000	14.77	16.62	18.46	22.15	33.23	51.69	79.38	123.69	168.00	267.69	448.61	1,299.69
\$450,000	16.62	18.69	20.77	24.92	37.38	58.15	89.31	139.15	189.00	301.15	504.69	1,462.15
\$500,000	18.46	20.77	23.08	27.69	41.54	64.62	99.23	154.62	210.00	334.62	560.77	1,624.61

- Employee maximum is the lesser of \$500,000 or 5x Annual Earnings.

- Rates shown are current as of the effective date and are subject to change over time.
- Costs shown are estimates only. Your actual payroll deduction may slightly higher or lower from those provided here.
- **Any applicable age-related benefit reductions are not included.**
- UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company and Unimerica Insurance Company; Unimerica Life Insurance Company of New York (NYC); and in California, Unimerica Life Insurance Company.

Spouse Supplemental Life - Current Bi-Weekly Cost by Age Band

Coverage	Current Monthly Rates per \$1,000:											
	Age <25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$5,000	0.18	0.21	0.23	0.28	0.42	0.65	0.99	1.55	2.10	3.35	5.61	16.25
\$10,000	0.37	0.42	0.46	0.55	0.83	1.29	1.98	3.09	4.20	6.69	11.22	32.49
\$15,000	0.55	0.62	0.69	0.83	1.25	1.94	2.98	4.64	6.30	10.04	16.82	48.74
\$20,000	0.74	0.83	0.92	1.11	1.66	2.58	3.97	6.18	8.40	13.38	22.43	64.98
\$25,000	0.92	1.04	1.15	1.38	2.08	3.23	4.96	7.73	10.50	16.73	28.04	81.23
\$30,000	1.11	1.25	1.38	1.66	2.49	3.88	5.95	9.28	12.60	20.08	33.65	97.48
\$35,000	1.29	1.45	1.62	1.94	2.91	4.52	6.95	10.82	14.70	23.42	39.25	113.72
\$40,000	1.48	1.66	1.85	2.22	3.32	5.17	7.94	12.37	16.80	26.77	44.86	129.97
\$45,000	1.66	1.87	2.08	2.49	3.74	5.82	8.93	13.92	18.90	30.12	50.47	146.22
\$50,000	1.85	2.08	2.31	2.77	4.15	6.46	9.92	15.46	21.00	33.46	56.08	162.46
\$55,000	2.03	2.28	2.54	3.05	4.57	7.11	10.92	17.01	23.10	36.81	61.68	178.71
\$60,000	2.22	2.49	2.77	3.32	4.98	7.75	11.91	18.55	25.20	40.15	67.29	194.95
\$65,000	2.40	2.70	3.00	3.60	5.40	8.40	12.90	20.10	27.30	43.50	72.90	211.20
\$70,000	2.58	2.91	3.23	3.88	5.82	9.05	13.89	21.65	29.40	46.85	78.51	227.45
\$75,000	2.77	3.12	3.46	4.15	6.23	9.69	14.88	23.19	31.50	50.19	84.12	243.69
\$80,000	2.95	3.32	3.69	4.43	6.65	10.34	15.88	24.74	33.60	53.54	89.72	259.94
\$85,000	3.14	3.53	3.92	4.71	7.06	10.98	16.87	26.28	35.70	56.88	95.33	276.18
\$90,000	3.32	3.74	4.15	4.98	7.48	11.63	17.86	27.83	37.80	60.23	100.94	292.43
\$95,000	3.51	3.95	4.38	5.26	7.89	12.28	18.85	29.38	39.90	63.58	106.55	308.68
\$100,000	3.69	4.15	4.62	5.54	8.31	12.92	19.85	30.92	42.00	66.92	112.15	324.92
\$150,000	5.54	6.23	6.92	8.31	12.46	19.38	29.77	46.38	63.00	100.38	168.23	487.38
\$200,000	7.38	8.31	9.23	11.08	16.62	25.85	39.69	61.85	84.00	133.85	224.31	649.85
\$250,000	9.23	10.38	11.54	13.85	20.77	32.31	49.62	77.31	105.00	167.31	280.38	812.31

- Spouse maximum is the lesser of \$250,000 or 50% of the employee's Supplemental Life amount.
- Spouse rate is based on the employee's age.

Child(ren) Supplemental Life – Current Bi-Weekly Cost

\$2,000	\$4,000	\$6,000	\$8,000	\$10,000
0.11	0.22	0.33	0.44	0.55

- Rates shown are current as of the effective date and are subject to change over time.
- Costs shown are estimates only. Your actual payroll deduction may slightly higher or lower from those provided here.
- **Any applicable age-related benefit reductions are not included.**
- UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company and Unimerica Insurance Company; Unimerica Life Insurance Company of New York (NYC); and in California, Unimerica Life Insurance Company.

Enrollment/Change Form

Group Dental Insurance, Vision Care Insurance, Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance, Critical Illness Insurance, and Accident Insurance provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408



TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:	
Employer Authorization:	Date of Hire: ___/___/___	Class:	
	Plan Variation/Reporting Code:	Plan:	
Requested Effective Date of Coverage / Date of Change: ___/___/___		<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
Reason: (Check the Appropriate Boxes)	<input type="checkbox"/> New Group Plan <input type="checkbox"/> Name Change <input type="checkbox"/> Divorce <input type="checkbox"/> Adoption/Legal Custody <input type="checkbox"/> Other:	<input type="checkbox"/> New Hire <input type="checkbox"/> Employee Terminated <input type="checkbox"/> Dissolution Of Civil Union <input type="checkbox"/> Court Ordered Dependent	<input type="checkbox"/> Annual Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Death <input type="checkbox"/> Cobra/State Continuation Start Date ___/___/___ End Date ___/___/___
		<input type="checkbox"/> Address Change <input type="checkbox"/> Civil Union* <input type="checkbox"/> Birth	

EMPLOYEE INFORMATION

SS# _____ - _____ - _____	Employer Assigned ID# _____	Date of Birth: ___/___/___	
Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:	Annual Salary\$
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner * <input type="checkbox"/> Party to Civil Union*		
Employment Status: I am Actively at Work and have worked at my usual/required place of business for the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I am scheduled to work _____ hours per week and have worked those hours for the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employee Type (Check all that apply): <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Retired <input type="checkbox"/> Other			

BENEFIT ELECTIONS

Person	Dental	Vision	Basic Life	Basic AD&D	Supplemental Life	Supplemental AD&D
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Spouse (or Dom.Part*)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____	\$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Dependent Child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive	<input type="checkbox"/> Waive
	Plan code: _____				Have you used tobacco of any kind in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Person	STD	LTD	Life Insurance Beneficiary(ies)			
Employee	<input type="checkbox"/>	<input type="checkbox"/>	Full Name and Address _____ Relationship _____			
	<input type="checkbox"/> Buy-up	<input type="checkbox"/> Buy-up	1) _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	2) _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
Person	Critical Illness Insurance			Accident Insurance		
Employee	<input type="checkbox"/> \$ _____ <input type="checkbox"/> Restoration Rider (if applicable)			<input type="checkbox"/> Base Benefit <input type="checkbox"/> Base + Enhanced		
Spouse (or Dom.Part*)	<input type="checkbox"/> \$ _____			<input type="checkbox"/>		
Dependent Child(ren)	<input type="checkbox"/> \$ _____			<input type="checkbox"/>		
	In the last 24 months have you smoked a cigarette, cigar, chewed tobacco or used tobacco or nicotine in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No			Additional Benefits (if applicable) <input type="checkbox"/> Additional AD&D <input type="checkbox"/> Outpatient Medical Expense <input type="checkbox"/> Catastrophic Injury		
	<input type="checkbox"/> Waive (if applicable)			<input type="checkbox"/> Waive <input type="checkbox"/> Waive (if applicable) (if applicable)		

FAMILY INFORMATION			Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)				
Check Appropriate Box	First Name	MI	Last Name (if different)	Date of Birth	Sex	Relationship**	Incapacitated***
	Dependent Social Security Number or Assigned ID						
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner* <input type="checkbox"/> Civil Union*	Not Applicable
	SS# _____ - _____ - _____						
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
	SS# _____ - _____ - _____						
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
	SS# _____ - _____ - _____						
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
	SS# _____ - _____ - _____						

*Domestic Partner or Civil Union coverage is determined by state law or as determined by your employer. Please contact your employer for confirmation. **For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet. *** Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

AUTHORIZATION AND ACKNOWLEDGEMENT
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

FRAUD WARNING NOTICES: (Please review the notice that applies in your state.)

For residents of Colorado:

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For residents of District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For residents of Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Hawaii:

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For residents of Kansas:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of fraud as determined by a court of law.

For residents of Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime.

For residents of Louisiana:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio:

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma:

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon:

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

For residents of the state of Pennsylvania:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information may be guilty of a crime.

For residents of Virginia:

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information may have violated state law.

For residents of Washington:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents of all other states:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee/Enrollee Signature:

Date: / /
