Walden School

2025-2026 BENEFITS GUIDE

Overview

Your benefits are an important part of your overall compensation. We're pleased to offer a comprehensive array of quality benefits to protect your health, your family, and your way of life. This booklet was designed to help you decide what options are right for you.

Who is eligible for benefits?

Full-time employees who work 30+ hours per week and family members, including a legally married spouse, biological children, stepchildren, and legally adopted children up to age 26. Physically or mentally disabled children are eligible past age 26, though documentation may be required.

When does coverage begin for new hires?

Coverage begins **first of the month following 60 days**

Questions to ask during open enrollment?

Which Health Plan is right for you?

Low Deductible or Traditional Plans - An individual or family that has high-cost prescription drugs, and/or maintenance conditions that result in frequent doctors visits, treatments or therapy.

High Deductible or HSA Plans - An individual or family that visits the Doctor for routine care, fills one or two generic prescriptions, and is insuring against worst-case scenarios.

Is a Dental Plan right for you?

Co-Pay Dental Plan - An individual or family that needs routine dental cleanings or basic procedures, does not need orthodontia, and is flexible on providers.

Do you need Vision Insurance?

Estimate your yearly costs, then compare the total with the cost of Vision insurance. Then, decide.

Life insurance?

Weigh the risks & protections of life insurance. Factor in the cost & choose what's right for you.

Waived Coverage:

If you choose to waive your coverage, a $600 annual bonus will be provided.

Other things to consider during open enrollment

REMINDER:

In order to enroll, change, or waive benefits, you'll need to fill out the applications contained in the booklet for any coverage you wish to obtain. **R**emember, any coverage you choose will have a participating cost to you. Due to Federal regulations, you cannot change your elections until the next annual Open Enrollment period which will be effective next **September 1** .

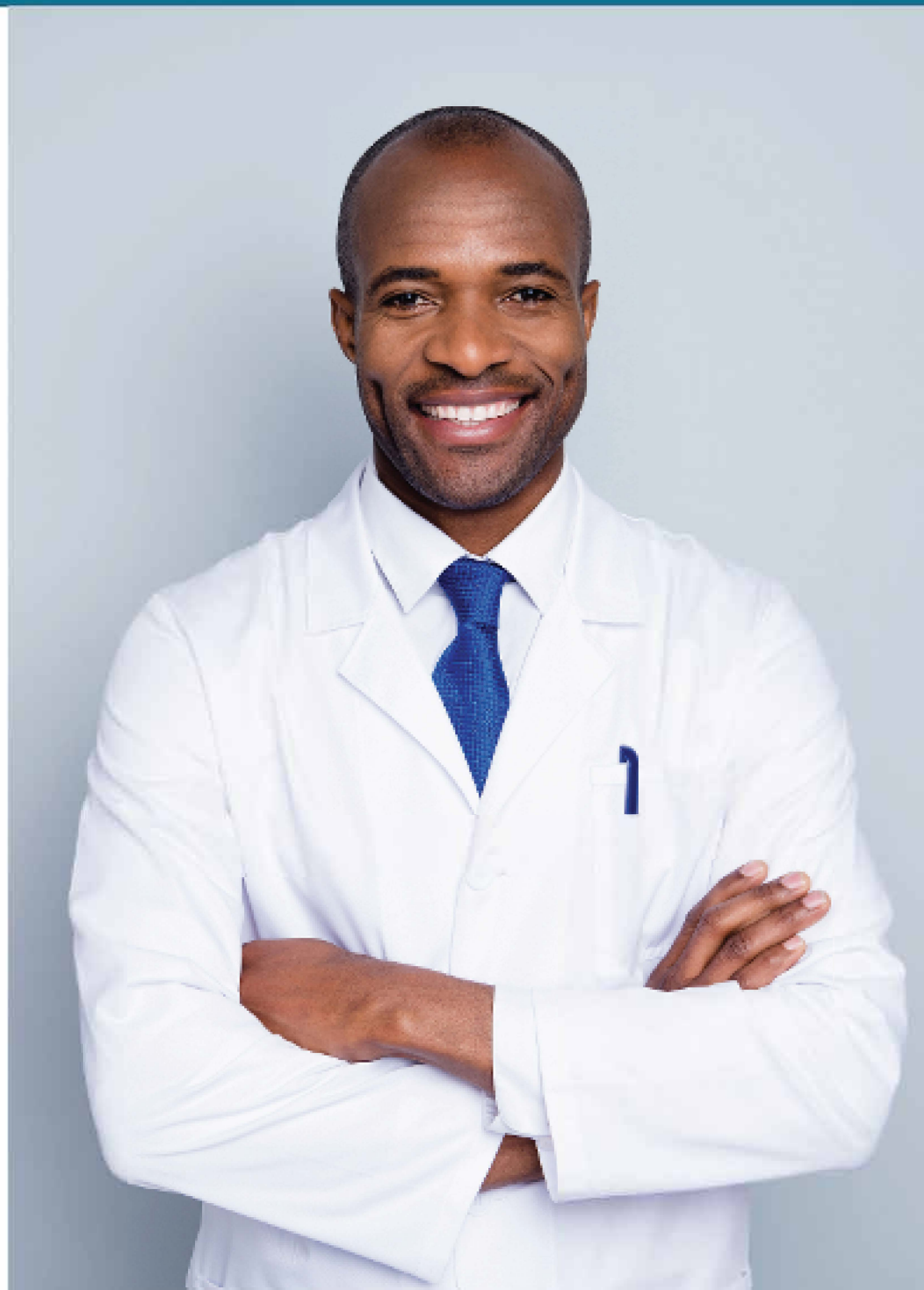
However, there are some exemptions called "qualified events" that allow you to make changes during the year. Qualified events include:

- Marriage or Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Loss of coverage under spouse or parent's plan
  You gain coverage under your spouse's plan

To make qualified life event changes you must report the change within 30 days of the qualified life event (including newborns).

Insurance carriers require evidence for a qualified event, which can include documents such as a marriage license, birth certificate, divorce decree, loss of coverage letter, or proof of coverage letter.

If changes are not submitted on time you'll have to wait until the next Open Enrollment period to make your elections changes.



Useful Contact Information

Health Insurance

Select Health

1 (800) 538-5038 selecthealth.org

Dental Insurance

Dental Select

1 (800) 999-9789 dentalselect.com

Vision Insurance

EMI Health

1 (800) 662-5850 emihealth.com

Ancillary Benefits

Allstate

1 (877)366-1607 allstate.com

Health Savings Account

Health Equity

1 (866) 346-5800 healthequity.com

Life & Disability

Unum

1 (800) 275-8686 unum.com

Need Help?

Contacting your insurance provider is a great place to go for things such as:

- ID Cards/Numbers
- Doctor/Hospital lookup
- Coverage questions


MEDICAL
SelectHealth

Medical Insurance Terms

What comes out of my pay?

Monthly Premium is the cost to purchase your health insurance. Your premium is based on the plan you choose and the number of family members you choose to cover. These costs will be taken out of your paycheck on a pre-tax basis each month.

What do I pay after I meet my deductible?

Coinsurance is the percentage or amount you are required to pay for health costs, after your annual deductible has been met. You will pay coinsurance until you meet the out-of-pocket maximum.

What am I responsible for with my health plan?

Your **Annual Deductible** is the amount of money you pay out-of-pocket for medical care before your health plan begins to pay. The only exception is preventative care, which is covered in full. For traditional plans, the annual deductible only applies to inpatient and outpatient services.

How much will I pay out of my own pocket?

The **Out-of-Pocket Maximum** is the most that you will pay for medical expenses throughout the calendar year. After you have reached this amount, your medical plan will cover the full cost of any additional care covered under your plan.

Is my Doctor in-network?

The **Provider Network** is a list of the Doctors and facilities that you can use with your health plan. Visit the medical carrier website listed on the Contact Information page and search for the doctor or facilities in question.

Is Walden School contributing?

A **Company Contribution** is the amount of money your company has generously decided to pay towards your medical insurance.

Medical Plan Options

	SELECTMED $1000	
	In-Network	**Out-of-Network**
Annual Deductible January - December	**$1,000** per individual **$2,500** per family	**$3,000** per individual **$9,000** per family
Coinsurance	You Pay **25% AD**	You Pay **50% AD**
Out-of-Pocket Maximum	**$8,950** per individual **$17,900** per family	**$20,000** per individual **$40,000** per family
Preventative Services	You pay **$0**	**Not Covered**
Office Visits		
Primary Care	You pay **$20** co-pay	You pay **50% AD** co-pay
Specialist	You pay **$40** co-pay	You pay **50% AD** co-pay
Mental Health Services		
Office Visit	You pay **$20** co-pay	You pay **50% AD** co-pay
Inpatient/Outpatient	You pay **25% AD**	You pay **50% AD**
Emergency Services		
Urgent Care	You pay **$40** co-pay	You pay **50% AD** co-pay
Emergency Room	You pay **$350 AD**	**See IN-Network Benefit**
Ambulance	You pay **25% AD**	**See IN-Network Benefit**
Inpatient & Outpatient		
Inpatient Hospital	You pay **25% AD**	You pay **50% AD**
Outpatient Surgery	You pay **25% AD**	You pay **50% AD**
Prescription Medication	**Generic / Preferred / Non-preferred / Specialty**	
Retail (30-Day Supply)	You pay **$20/ $30 / 25% /50%**	
Mail Order (90 Day Supply)	You pay **$20 /$30 / 25% /50%**	
Health Care Account	No Health Care account is available for this Traditional Plan	

MONTHLY RATE PRIOR TO ER CONTRIBUTION

Age	Monthly Rate	Age	Monthly Rate
<20	$319.00	45	$705.00
21	$403.00	46	$733.00
22	$423.00	47	$763.00
23	$449.00	48	$793.00
24	$480.00	49	$825.00
25	$523.00	50	$858.00
26	$549.00	51	$892.00
27-36	$560.00	52	$928.00
37	$566.00	53	$965.00
38	$575.00	54	$1003.00
39	$585.00	55	$104400
40	$596.00	56	$1085.00
41	$611.00	57	$1129.00
42	$630.00	58	$1174.00
43	$652.00	59+	$1209.00
44	$678.00		

*** AD = After Deductible**

Walden School Monthly Medical Contribution — **80% of Premiums of Value Plans**

Medical Plan Options

	SELECTVALUE $1000
	In-Network
Annual Deductible January - December	**$1,000** per individual **$2,500** per family
Coinsurance	You Pay **25% AD**
Out-of-Pocket Maximum	**$8,950** per individual **$17,900** per family
Preventative Services	You pay **$0**
Office Visits	
Primary Care	You pay **$20** co-pay
Specialist	You pay **$40** co-pay
Mental Health Services	
Office Visit	You pay **$20** co-pay
Inpatient/Outpatient	You pay **25% AD**
Emergency Services	
Urgent Care	You pay **$40** co-pay
Emergency Room	You pay **$350 AD**
Ambulance	You pay **25% AD**
Inpatient & Outpatient	
Inpatient Hospital	You pay **25% AD**
Outpatient Surgery	You pay **25% AD**
Prescription Medication	**Generic / Preferred / Non-preferred / Specialty**
Retail (30-Day Supply)	You pay **$20/ $30 / 25% /50%**
Mail Order (90 Day Supply)	You pay **$20 /$30 / 25% /50%**
Health Care Account	No Health Care account is available for this Traditional Plan

MONTHLY RATE PRIOR TO ER CONTRIBUTION

Age	Monthly Rate	Age	Monthly Rate
<20	$288.00	45	$636.00
21	$364.00	46	$662.00
22	$382.00	47	$689.00
23	$405.00	48	$716.00
24	$443.00	49	$745.00
25	$472.00	50	$775.00
26	$496.00	51	$805.00
27-36	$506.00	52	$838.00
37	$511.00	53	$.871.00
38	$519.00	54	$906.00
39	$528.00	55	$942.00
40	$538.00	56	$980.00
41	$552.00	57	$1019.00
42	$569.00	58	$1060.00
43	$588.00	59+	$1092.00
44	$612.00		

*** AD = After Deductible**

Walden School Monthly Medical Contribution — **80% of Premiums of Value Plans**

Medical Plan Options

	SELECTMED $3000 HSA	
	In-Network	**Out-of-Network**
Annual Deductible January - December	**$3,000** per individual **$6,000** per family	**$5,000** per individual **$10,000** per family
Coinsurance	You Pay **30% AD**	You Pay **50% AD**
Out-of-Pocket Maximum	**$7,500** per individual **$15,000** per family	**$20,000** per individual **$40,000** per family
Preventative Services	You pay **$0**	**Not Covered**
Office Visits		
Primary Care	You pay **$15 AD** co-pay	You pay **50% AD** co-pay
Specialist	You pay **$35 AD** co-pay	You pay **50% AD** co-pay
Mental Health Services		
Office Visit	You pay **$15 AD** co-pay	You pay **50% AD** co-pay
Inpatient/Outpatient	You pay **30% AD**	You pay **50% AD**
Emergency Services		
Urgent Care	You pay **$40 AD** co-pay	You pay **50% AD** co-pay
Emergency Room	You pay **$350 AD**	**See IN-Network Benefit**
Ambulance	You pay **30% AD**	**See IN-Network Benefit**
Inpatient & Outpatient		
Inpatient Hospital	You pay **30% AD**	You pay **50% AD**
Outpatient Surgery	You pay **30% AD**	You pay **50% AD**
Prescription Medication	**Generic / Preferred / Non-preferred / Specialty**	
Retail (30-Day Supply)	You pay **$20 AD/ $30 AD / 25% AD /50% AD**	
Mail Order (90 Day Supply)	You pay **$20 AD /$30 AD / 25% AD /50% AD**	
Health Care Account	Health Savings Account (HSA)	

*** AD = After Deductible**

MONTHLY RATE PRIOR TO ER CONTRIBUTION

Age	Monthly Rate	Age	Monthly Rate
<20	$261.00	45	$576.00
21	$329.00	46	$599.00
22	$346.00	47	$623.00
23	$368.00	48	$648.00
24	$393.00	49	$674.00
25	$428.00	50	$701.00
26	$449.00	51	$729.00
27-36	$458.00	52	$758.00
37	$463.00	53	$789.00
38	$470.00	54	$820.00
39	$478.00	55	$853.00
40	$488.00	56	$887.00
41	$500.00	57	$923.00
42	$515.00	58	$960.00
43	$533.00	59+	$987.00
44	$554.00		

Walden School Monthly Medical Contribution — **80% of Premiums of Value Plans**

Medical Plan Options

	SELECTVALUE $3000 HSA In-Network
Annual Deductible January - December	**$3,000** per individual **$6,000** per family
Coinsurance	You Pay **30% AD**
Out-of-Pocket Maximum	**$7,500** per individual **$15,000** per family
Preventative Services	You pay **$0**
Office Visits Primary Care Specialist	 You pay **$15 AD** co-pay You pay **$35 AD** co-pay
Mental Health Services Office Visit Inpatient/Outpatient	 You pay **$15 AD** co-pay You pay **30% AD**
Emergency Services Urgent Care Emergency Room Ambulance	 You pay **$40 AD** co-pay You pay **$350 AD** You pay **30% AD**
Inpatient & Outpatient Inpatient Hospital Outpatient Surgery	 You pay **30% AD** You pay **30% AD**
Prescription Medication Retail (30-Day Supply) Mail Order (90 Day Supply)	**Generic / Preferred / Non-preferred / Specialty** You pay **$20 AD/ $30 AD / 25% AD /50% AD** You pay **$20 AD /$30 AD / 25% AD /50% AD**
Health Care Account	Health Savings Account (HSA)

MONTHLY RATE PRIOR TO ER CONTRIBUTION

Age	Monthly Rate	Age	Monthly Rate
<20	$236.00	45	$520.00
21	$297.00	46	$541.00
22	$312.00	47	$563.00
23	$331.00	48	$585.00
24	$354.00	49	$609.00
25	$386.00	50	$633.00
26	$406.00	51	$659.00
27-36	$414.00	52	$685.00
37	$418.00	53	$712.00
38	$424.00	54	$741.00
39	$432.00	55	$771.00
40	$440.00	56	$801.00
41	$451.00	57	$833.00
42	$465.00	58	$867.00
43	$481.00	59+	$891.00
44	$500.00		

*** AD = After Deductible**

Walden School Monthly Medical Contribution — **80% of Premiums of Value Plans**

P.O. Box 30192
Salt Lake City, UT 84130-0192
844-442-6294
selecthealth.org

selecthealth

Application Supplement Form Utah Small Employer

Employer Name WALDEN SCHOOL OF LIBERAL ARTS **Employee Name** _____

DEMOGRAPHICS

Cell Phone #*: _____ Email Address: _____

Preferred (non-English) Language** ❑ Spanish ❑ Chinese ❑ Vietnamese ❑ Korean ❑ Navajo ❑ Nepali ❑ Tongan ❑ Serbo-Croatian ❑ Tagalog ❑ German ❑ Russian ❑ Arabic ❑ French ❑ Japanese ❑ Mon-Khmer, Cambodian ❑ Other _____

Race ❑ White ❑ Black or African American ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander ❑ Other

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Citizenship ❑ United States Citizen ❑ Lawful Permanent Resident ❑ Temporary Visitor ❑ Undocumented Immigrant

* By giving us your cell phone number and email address, you are giving us permission and consent to contact you using those channels
** By notifying us of your preferred language, we are not agreeing to send your materials in that language (for translation assistance, please call Member Services 800-538-5038

MEDICAL PLAN INFORMATION

☐ YES Ded: $1000/$2500 Copay: $20/$40 OOP: $8950/$17900 RX: $0 ded

☐ YES Ded: $3200/$6400 Copay: $15/$35 OOP: $7500/$15000 RX: $3200 ded

Please select from one of the following network options:

☐ Select Health Med

☐ Select Health Value

I would like to enroll in a Health Savings Account (HSA) administered by HealthEquity ☐ Yes ☐ No

☐ NO I would not like medical coverage from SelectHealth (please complete and sign the **WAIVER OF COVERAGE** in the *Utah Small Employer Application*).

P.O. Box 30192
Salt Lake City, UT 84130-0192
844-442-6294
selecthealth.org

Application Supplement Form Utah Small Employer

Employer Name WALDEN SCHOOL OF LIBERAL ARTS **Employee Name** _____

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize enrollment of myself and my listed eligible dependent(s), if applicable, for coverage with SelectHealth/SelectHealth Benefit Assurance Company (SHBAC), in connection with both this Application and any plan coverage that may be obtained. I am acting as agent and/or as natural guardian for my dependent(s). Further, in dealing with SelectHealth/SHBAC, I appoint my employer to act as an agent on behalf of myself and my dependent(s). I understand that coverage is dependent upon the satisfaction of applicable criteria and is subject to the terms and conditions of my employer's Contract with SelectHealth/SHBAC. I also understand no coverage will be in force until each person listed is approved by SelectHealth/SHBAC, that no Benefits will be provided for any service that begins before coverage is effective, and that except as expressly provided in my employer's Contract with SelectHealth/SHBAC, Benefits will not extend beyond the termination of either my coverage or my employer's Contract with SelectHealth/SHBAC. I represent that all information provided on this Application is true and complete. I understand that omissions or intentional misrepresentations regarding information provided on this Application could cause an otherwise
covered service to be denied and/or void coverage.

CONSENT AT ENROLLMENT, I understand that my employer's Contract with SelectHealth/SHBAC may limit the Providers whose services will be covered. I understand that my employer's Contract with SelectHealth/SHBAC limits or excludes certain conditions and services from coverage. I agree that to the extent I do not abide by the terms of my employer's Contract with SelectHealth/SHBAC, services I obtain may not be covered. If my employer's Contract with SelectHealth/SHBAC requires contributions be made, I authorize my employer to deduct them from my pay.

I hereby declare that to the best of my knowledge and belief, the information given on this Application is correctly recorded, true, and complete. If I subsequently become aware of information different from that provided on this Application, I agree to provide that additional information promptly to SelectHealth/SHBAC.

SIGNATURE

Employee Signature _____ **Date Signed** ____ / ____ / _____

UTAH SMALL EMPLOYER
EMPLOYEE HEALTH INSURANCE APPLICATION

OFFICE USE ONLY
Policy / Group No.
Effective Date
New Hire Waiting Period

REASON FOR ENROLLMENT (mark all that apply)

❒ New Group ❒ Newborn ❒ Loss of Coverage_____

❒ Open Enrollment ❒ Court Order ❒ Marriage_____

❒ New Hire ❒ Dependent Addition ❒ Divorce_____

☑ New Application ❒ Other:_____ ❒ Military Leave of Absence(USERRA)_____

❒ COBRA ❒ Utah mini-COBRA

Length of continuation coverage: ❒12 mos. ❒18 mos. ❒36 mos. ❒Other:

Original Qualifying Event Date:	Qualifying Event Date:	Date of Event:

❒ WAIVER OF COVERAGE Individuals waiving coverage complete Waiver of Coverage.

A. EMPLOYER INFORMATION

Employer WALDEN SCHOOL OF LIBERAL ARTS Is this a division? ❒ Yes ❒ No If "Yes," name of parent company_____

B. EMPLOYEE INFORMATION

Name (Last) _____ (First)_____ (MI) _____ Job Title _____ Hrs/Week _____

Employment status ❒ Full-time ❒Owner/business partner ❒Retired ❒Other_____ Hire Date___/___/___ Rehire Date___/___/___

Marital Status ❒ Legally Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner*

Home Address _____ Apt. _____ City _____ State _____ Zip _____

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Home/Cell Phone (____) _____Business Phone (____) _____Email Address: _____

If you are American Indian or Alaska Native, provide the state and name of your federally-recognized tribe: _____

C. ENROLLING EMPLOYEE / SPOUSE / DOMESTIC PARTNER* / DEPENDENTS

List yourself and all dependents applying for coverage. Attach a separate sheet if necessary.

	Name (Last, First, Middle)	Social Security # (for insurer use only)	Date of Birth MM/DD/YYYY	Gender	Tobacco Use:
Employee				❒ Male ❒ Female	❒ Yes ❒ No
Spouse/ Domestic Partner*				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No
Dependent				❒ Male ❒ Female	❒ Yes ❒ No

*Check with your employer to determine if domestic partner coverage is available.

D. CURRENT COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, Medicaid, or Medicare currently in effect. This will be used to determine if benefits will be coordinated. Each person applying for coverage must be listed below. If no health care coverage is in effect, indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependents' health care coverage so that the insurer can determine whose coverage is primary. Attach a separate sheet if necessary.

Name of Individual	Insurer (List policyholder name, insurer name and phone number)	Date of Coverage MM/YY Start Date	Date of Coverage MM/YY End Date	Will coverage continue?	Type of Coverage (Check all that apply)
Employee:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Spouse/Domestic Partner:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____
Dependent:				❒ Yes ❒ No	❒ Employer group ❒ Individual ❒ Medicare ❒ Governmental ❒ Other_____

E. ACKNOWLEDGMENT AND SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after the waiting period. I authorize my employer to act as my agent in all matters of administration of the group program.

I acknowledge that I have had the opportunity to waive coverage for myself and any eligible dependents.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I certify that all information completed on this form is true, correct and complete. I acknowledge that if any information provided is false, the insurer may without advance notice pursue any remedies available under state or federal law, including declaring the coverage null and void and canceling the coverage retroactive to its original effective date.

I have read the Acknowledgment of this document and agree to its terms.

Employer: WALDEN SCHOOL OF LIBERAL ARTS

Employee Name: (Last) _____ (First) _____ (MI) _____

Employee Signature _____ Date _____

WAIVER OF COVERAGE

COMPLETE WHEN WAIVING COVERAGE FOR SELF AND/OR DEPENDENTS

Employee Name: (Last) _____ (First)_____ (MI) _____

Employer: WALDEN SCHOOL OF LIBERAL ARTS

INDIVIDUALS WAIVING COVERAGE

Name of individual waiving coverage	Reason for waiving coverage	Insurer (Including policyholder name, insurer name and phone number)	Will coverage continue?
Employee:	❒ Other employer group coverage ❒ Individual coverage ❒ Governmental (Medicare, Medicaid, Tricare, etc.) ❒ Other_____		❒ Yes ❒ No
Spouse / Domestic Partner:			
Dependent:			
Dependent:			
Dependent:			

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed above. In waiving coverage, I am aware that waiving individuals (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving individual qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse/domestic partner) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage (within 60 days if the other coverage was Medicaid or CHIP). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I further certify that all information completed on this Waiver of Coverage form is true, correct and complete.

Employee Signature_____Date_____

Non-Discrimination Notice

SelectHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free aid and services to people with disabilities to help them communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, such as qualified interpreters and member materials written in other languages.

If you need these services, please call SelectHealth Member Services at **1-800-538-5038**. Any member or other person who believes he/she may have been subject to discrimination may file a complaint or grievance by calling the SelectHealth 504/Civil Rights Coordinator at **1-844-208-9012** or the Compliance Hotline at **1-800-442-4845** (TTY Users: 711). You may also call the Office for Civil Rights at **1-800-368-1019** (TTY Users: **1-800-537-7697**).

selecthealth

Language Access Services

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a SelectHealth: **1-800-538-5038**.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 SelectHealth: **1-800-538-5038**. 。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số SelectHealth: **1-800-538-5038**.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. SelectHealth: **1-800-538-5038**.

번으로 전화해 주십시오.

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęʹęʹ', t'áá jiik'eh, éí ná hóloʹ, kojį' hódíílnih SelectHealth: **1-800-538-5038**.

Nepali

ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमि्ति भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । SelectHealth: **1-800-538-5038** मा फोन गर्नुहोस्।

Tongan

FAKATOKANGA'I: Kapau 'oku ke lea fakatonga, ko e kau fakatonu lea te nau tokoni atu ta'etotongi, pea te ke lava 'o ma'u ia. Telefoni ki he SelectHealth: **1-800-538-5038**.

Serb-Croatian

ОБАВЕШТЕЊЕ: Ако говорите српски језик, услуге језичке помоћи доступне су вам бесплатно. Позовите SelectHealth: **1-800-538-5038**.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa SelectHealth: **1-800-538-5038**.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: SelectHealth: **1-800-538-5038**.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги переводчика. Позвоните SelectHealth: **1-800-538-5038**

Arabic

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بشركة SelectHealth: **1-800-538-5038**.

Mon-khmer, Cambodian

សម្គាល់៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ សូរៀបំនួយផ្នែកភាសា ដាយមិនគិតថ្លៃ គឺអាចមានសរាប់ អ្នក។ សូមទូរស័ព្ទមក SelectHealth: **1-800-538-5038** ។

French

ATTENTION : si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Contactez SelectHealth: **1-800-538-5038**.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。SelectHealth: **1-800-538-5038**. まで、お電話にてご連絡ください。

HEALTH SAVINGS ACCOUNT

Health Equity

Health Savings Account

A Health Savings Account (HSA) allows you to contribute money (pre-tax) to offset out-of-pocket medical, dental, and vision expenses such as co-pays, prescriptions, and glasses.

	Health Savings Account (HSA)
Do I need to be enrolled in a medical plan?	Yes
What plan is this available with?	**HDHP PLAN**
Is this required?	No. Participation is voluntary.
What is the maximum I can contribute?	**$4,300** Employee-only medical coverage **$8,550** Family medical coverage If you will be 55 or older, you can make an additional $1,000 catch-up contribution.
Does my company contribute?	Employee only-$500; Employee + 1-$1,000; Family-$1,750
When is my money available to use?	Your money will be available as it comes out of your paycheck each pay period. Your entire contribution is not available at the beginning of the year or when coverage starts.
How do I use my money throughout the year?	When you enroll in your HSA, you may choose to use a debit card instead of getting reimbursements. If you have not received a debit card, please contact your HSA provider. Contact information is available on Useful Contact Information at the beginning of this booklet. Keep copies of receipts in case you ever get audited.
What happens if I don't use all of my money throughout the year?	Money in your HSA will remain in your HSA each year without forfeiture. Your HSA will earn a small interest amount each year and has investment options when you meet a minimum balance threshold.
What can I use this money for?	Money in your HSA can be used to pay for current eligible medical, dental, or vision expenses. You can also save up your money to pay for future health care expenses such as a birth or a surgery.

DENTAL

Dental Select

Dental Plan Option

Our dental carrier is **Dental Select** and the provider network is **Platinum.** You can search for covered providers by going to the website on the Useful Contact Information page.

	CO-INSURANCE	
	In-Network	**Out-of-Network**
Annual Deductible January - December	**$50** per individual **$150** per family	**$50** per individual **$150** per family
Calendar Year Maximum	**$1500**	
Preventive Services Routine exams, cleanings (2 per year), topical fluoride, x-rays	Plan pays **100%** of covered services, deductible waived	Plan pays **80%** of covered services, deductible waived
Basic Services Composite fillings, extractions, oral surgery	Plan pays **80%** of covered services, deductible applies	Plan pays **70%** of covered services, deductible applies
Major Services Crowns, bridges, dentures, endodontics, periodontics, implant alternate.	Plan pays **50%** of covered services, deductible applies	Plan pays **50%** of covered services, deductible applies
Orthodontic Services Children under 19; 12 month waiting period	Plan pays **50%** of covered services, deductible applies	Plan pays **50%** of covered services, deductible applies
Orthodontic lifetime Maximum	**$1,000**	

Your Monthly Cost			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$43.96	**$100.13**	**$84.33**	**$142.25**

enrollment / change / waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Ameritas

Policy and Div. # **010-** _____

Cert. # _____

COBRA: If individual is a continuee:	Qualifying Event	Date of Event

Name and Address of Employer (Policyholder) _____

1 to enroll ☐ Dental ☐ Eye Care ☐ To terminate all coverages

Employee Information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number _____ Dept. number _____

Employee's last name, first name, MI _____

Date of birth_____ ☐ Male ☐ Female Full time date of hire_____ ☐ Rehire: Rehire date _____

Occupation _____ Hours worked each week_____ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address_____ City_____ State_____ ZIP _____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Are you covered under another **eye care** insurance plan? . . . . . **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Dependent Coverage Information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

Print full legal name (last, first. MI)	Dental add	Dental drop	Eye Care add	Eye Care drop	Relationship	Sex	Date of birth	Social Security no.	College student?
1									
2									
3									
4									
5									

Please Sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**

As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X _____ X _____

Employee Signature (do not print) **Date** **Policyholder Signature (do not print)** **Date**

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date_____

Dependent late entrant date_____

Effective Date	Class	Dep. Code

2 to change

☐ Name Change New Name _____ Old Name_____

☐ Add Dependent Coverage

☐ If due to marriage, what is the date of marriage?_____ ☐ If due to birth/adoption, what is the date of event?_____

☐ If due to loss of coverage, date and reason: _____

☐ If other, the date of event and please explain:_____

☐ Drop Dependent Coverage Number of dependents still covered: _____ Effective date of drop: _____

Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) _____

3 to waive IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER.

I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

myself (does not apply to TRUST policies) ☐ **spouse/domestic partner** ☐ **child(ren) only** ☐ **spouse/domestic partner and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Enrollment/Change/Waiver Group Insurance Form

Ameritas Life Insurance Corp. P.O. Box 81889 / Lincoln, NE 68501-1889 / 800-659-2223 / Fax: 402-467-7338

Must Be Completed in Full - Please print.		
First Name:	Last Name:	Middle Initial:
Group Number:	Group Name:	

Plan/Coverage – Confirm available options with your employer. Select all that apply.		
Requested Dental Plans: ☐ Copay ☐ R&C - Contracted/Non-Contracted ☐ MAC - Contracted/Non-Contracted ☐ High Deductible Plan	**Dual Option: (Contracted/Non-Contracted)** ☐ High ☐ Low	Network: ☐ Gold ☐ Platinum
Requested Vision Plan: EyeMed ☐ VIS 6 ☐ VIS 8 ☐ VIS 12 ☐ VIS 21 ☐ Other: _____	**Requested Vision Plan: VSP** ☐ VSP 1 ☐ VSP 2 ☐ VSP 3 ☐ VSP 4 ☐ Other: _____	
Vision Networks: ☐ Access ☐ Select ☐ Insight	**Vision Networks:** ☐ VSP Choice Network + Retailers	

I am eligible for enrollment based on a qualifying life event.		
☐ New Hire	☐ Marriage	☐ Open Enrollment
☐ Divorce/Legal Separation/Annulment	☐ PT to FT Employement	☐ Loss of Other Coverage
Date of Event:		

Note for California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For group policies issued, amended, delivered, or renewed in California, dependent coverage includes individuals who are registered domestic partners and their dependents.

No Cost Language Services. You can get an interpreter and have documents read to you in your language. For help, call us at the number listed on your ID card or 877-233-3797. For more help call the CA Dept. of Insurance at 800-927-4357.

Servicios de idiomas sin costo. Puede obtener un intérprete y que le lean los documentos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 877-233-3797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 800-927-4357.

Note for Colorado Residents: 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.

Note for Florida Residents: 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.

Note for Georgia, Kansas, Nebraska, Oregon, Vermont and Virginia Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Note for Kentucky Residents: 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 commits a fraudulent insurance act, which is a crime.

Note for Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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.

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

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

Note for 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 a crime and may be subject to civil fines and criminal penalties. **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does not satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Note for Rhode Island Residents: 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 civil fines and criminal penalties.

Note for North Carolina Residents: After 2 years from the date of issue or reinstatement of this policy, no misstatements made by the applicant in the application shall be used to void the policy or deny a claim for loss commencing after the expiration of such 2 year period.

Note for Pennsylvania Residents: 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.

Note for Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Note for Texas Residents: Any person who knowingly and with intent to defraud provides false, incomplete or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, may be guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim.

Note for Washington, D.C. Residents: 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.

Note for Washington Residents: For groups policies issued, amended, delivered, or renewed in Washington, dependent coverage includes individuals who are registered domestic partners and their dependents.

tips for filling out this form

To Enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

- **Policy Name and Group Number –** to make sure plan members are added to the correct group.
- **Department/Division Numbers –** so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.
- **Social Security Numbers –** the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.
- **Full-time Employment Date –** needed so the correct effective date is calculated for new members.
- **Class Number –** needed when the plan has more than one class of employees.

To Change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce…) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:

1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:

1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.

VISION

EMI

Vision Plan Option

Our vision carrier is **EMI** and the provider network is **Opticare of Utah.** You can search for covered providers by going to the website on the Useful Contact Information page.

	OPTICARE VISION	
	In-Network	**Out-of-Network**
Routine Vision Exams	**$10** Copay	Plan reimburses up to **$85**
Frequencies		
Exam	Once every 12 months	
Contact Lenses	Once every 12 months	
Frames	Once every 12 months	
Glasses (in lieu of contacts)		
Single Vision Lenses	**$10** Copay	Plan reimburses up to **$85**
Lined Bifocal Lenses	**$10** Copay	Plan reimburses up to **$85**
Frame Allowance	No Copay, **$150** Allowance	Plan reimburses up to **$90**
Contact Lenses (in lieu of glasses)		
Elective Lenses	No Copay, **$60** Allowance	Plan reimburses up to **$90**

Your Monthly Cost		
Employee	**Employee + Spouse**	**Employee +**
$5.90	**$10.90**	**$17.40**

☐ **ENROLLMENT APPLICATION** (Complete entire application.)
☐ **CHANGE FORM** (Complete entire application.)

Walden School of Liberal Arts

LAST NAME	FIRST	INITIAL	GENDER	SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	DATE OF EMPLOYMENT / /

ADDRESS/STREET NO.	CITY & STATE	ZIP CODE	HOME PHONE
			BUSINESS PHONE

SPECIFIC JOB TITLE	E-MAIL ADRESS

EMPLOYMENT STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED (RETIREMENT DATE / /) ☐ COBRA

BENEFIT OPTIONS

VISION

☐ Employee only
☐ Employee plus one dependent
☐ Employee plus two or more dependents

RELATIONSHIP TO EMPLOYEE **CODE KEY:**	RELATION TO EMPLOYEE	**LIST ALL FAMILY MEMBERS TO BE COVERED/DELETED** NOTIFY EMPLOYER WITHIN 31 DAYS OF ANY CHANGE (marriage, birth, divorce, etc.).	SEX	BIRTHDATE MO	DAY	YR	SOCIAL SECURITY NUMBER	SAME ADDRESS AS EMPLOYEE?
S: Spouse		1.						
B: Biological Child		2.						
SC: Step Child		3.						
A: Adopted		4.						
O: Other		5.						
		6.						
		7.						
		8.						

OTHER INSURANCE INFORMATION

Will you, your spouse, or dependents have other vision coverage in addition to this EMI Health coverage?

☐ Yes ☐ No

If so, what type of coverage? ☐

If so, what is the coverage classification? ☐ Single ☐ Couple ☐ Family

Name of Insured _____ Insured's Social Security Number OR Group/Policy Number _____

Name of Other Insurance Company _____ Insurance Company Phone Number _____

ELECTION TO PARTICIPATE - Please note: Plans may be subject to binding arbitration procedures

I hereby apply for coverage to which I may be entitled or to which I may become entitled under the terms of agreements, including binding arbitration provisions, in the policies issued by EMI Health. I accept the terms of group agreement between my employer and the plans and appoint my employer to act as agent on my behalf. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage. The proposed coverage shall not take effect until this application has been accepted by the other underwriting companies, as applicable, and shall become effective only in accordance with the provisions of such agreements or group policies. I understand that I am not entitled to change my coverage elections during the plan year, unless I experience a special enrollment situation (i.e., marriage, divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage). I also understand that if I experience such a qualifying even I may elect to terminate coverage for myself and/or my dependents by providing written notice to my employer within 31 days of the qualifying event. I authorize EMI Health to share PHI concerning me and my family, including adult dependents, with any health care provider or HSA/HRA administrator providing benefits. I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature of Applicant Application Date

EMPLOYER SIGN OFF SECTION

☐ New Enrollment ☐ Special Enrollment ☐ Name/Address Change ☐ Beneficiary Change
☐ Change of Coverage ☐ Add Family Member ☐ Cancellation ☐ Delete Family Member
☐ Other: _____

Employer Signature Effective Date

WAIVER OF GROUP COVERAGE

I choose not to participate in the following group benefits that have been offered and hereby waive such coverage. I understand that I may later apply for these benefits if I experience a special enrollment situation (i.e., marriage divorce, birth, death, adoption, placement for adoption, or loss of other insurance coverage), or during my employer's next open enrollment period.

☐ VISION

I am waiving this group coverage because I have other coverage: ☐ Yes ☐ No

Signature of Applicant for Waiver Only Date

EHP.EN.APP.1208.1901

EMI HEALTH Smart Benefits

LIFE INSURANCE

Unum

Life Insurance Terms and Benefits

TERMS

Life Insurance

Life insurance provides your named beneficiary(ies) with a benefit in the event of your death. Some options may be available at no cost to you.

Accidental Death and Dismemberment (AD&D) Insurance

Provides a benefit payout to you or your beneficiaries in the event of a covered accidental bodily injury that directly causes dismemberment, or in the event an accident causes your death. In the event of an accidental death, both the life and AD&D will be payable.

BENEFITS

Basic Life/AD&D (Company Paid)

This benefit is provided at NO COST to all active, full time employees.

Benefit Amount	**$20,000**
Spouse Benefit Amount	**$5,000**
Child Benefit Amount	**$2,000**

Walden School of Liberal Arts

Term Life with Accidental Death & Dismemberment (AD&D) Insurance

How does it work?

You keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why Choose Unum?

Your employer is contributing to the cost of this coverage.

What else is included?

A "Living" Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to $250,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Work-life balance Employee Assistance Program

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Who can get Term Life coverage?

If you are actively at work at least 29 hours per week, you can receive coverage for:

You:	You can receive a benefit amount of $20,000. You can get up to $20,000 with no medical underwriting.
Your spouse:	If eligible, (see delayed effective date), your spouse can receive the following coverage: Get $5,000 of coverage for your spouse.
Your children:	If eligible, (see delayed effective date), your children can receive the following coverage: The maximum benefit for children from live birth to 6 months is $1,000. The maximum benefit for children 6 months and older is $2,000.

One policy covers all of your children until their 19th birthday or until their 26th birthday if they are full time students.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	You can receive an AD&D benefit amount of $20,000.
Your spouse:	If eligible, (see delayed effective date), your spouse can receive the following AD&D coverage: Get $5,000 of coverage for your spouse.
Your children:	If eligible, (see delayed effective date), your children can receive the following coverage: The maximum benefit for children from live birth to 6 months is $1,000. The maximum benefit for children 6 months and older is $2,000.

No medical underwriting is required for AD&D coverage.

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.
An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.
Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.
Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths that are caused by suicide occurring within 24 months after the effective date of coverage or the date that increases to existing coverage becomes effective. This exclusion standardly applies to all medically written amounts and contributory amounts that are funded by the employee including shared funding plans.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age reduction

Coverage amounts for Life and AD&D Insurance for you and your dependents will reduce to 65% of the original amount when you reach age 70, and will reduce to 50% of the original amount when you reach age 75. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

Work-life balance Employee Assistance Program

The Work-life balance Employee Assistance Program, provided by HealthAdvocate, is available with select unum insurance offerings, Terms and availability of service are subjet to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.
Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.
Unum complies with state civil union and domestic partner laws when applicable.
Underwritten by: Unum Life Insurance Company of America, Portland, Maine

Accident Insurance Enrollment Form — Complete this form to enroll.

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

Unum Insurance Company
2211 Congress Street Portland, Maine 04122

Please complete both sides of this form to ensure a smooth enrollment. If you need assistance, please contact your employer.
Initial enrollment: To make initial elections; OR **Annual enrollment**: To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum.
Note: if you do not wish to make any changes, do not complete this form. Please contact your employer with any questions.

Walden School of Liberal Arts

Step 1: Complete your personal information

Accident: 943107

First name (please print) | M. initial | Last name

Social Security Number | Gender | Date of birth (mm-dd-yyyy)

Street address | Apartment #

City | State | ZIP code

Original hire date | Hours worked per week | Email

Did you recently become eligible for benefits? (Y/N)

Have you been rehired by your company? (Y/N)

If so, please provide a date (mm-dd-yyyy)

Spouse first name | M. initial | Last name

Date of birth (mm/dd/yyyy)

Step 2: Choose your coverage amount

Accident Insurance

Your monthly premium	Option 1
☐ You	$14.38
☐ You and your spouse	$25.73
☐ You and your children	$31.62
☐ Family	$42.97

Continued on back >

Accident Insurance Enrollment Form (continued)

Step 3: Name your beneficiaries

Your primary beneficiary is the person (or persons) who will receive the benefit payment from your insurance policy if you were to die.
The total percent of benefit must not exceed 100%.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Your secondary beneficiary would receive the benefit payment from your insurance policy if a primary beneficiary is no longer living.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Step 4: Signature

☐ **Yes**, I do want Accident insurance.
I understand that my coverage may be subject to limitations, exclusions and terminations as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ __ / __ / _____
Signature Date

☐ **No**, I do not want Accident insurance.

_____ ___ / ___ / _____
Signature Date

Return forms to: plan administrator

Note: Your email will only be used if you need to answer health questions to get this coverage. You will receive a link to answer health questions online.

Underwritten by: Unum Insurance Company, Portland, Maine

ANCILLARY BENEFITS

Allstate

Additional Voluntary Benefit Options

Company offers these voluntary benefits to help offset any additional out-of-pocket costs that you may incur.

Accident Insurance			
Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
$11.65	**$20.16**	**$35.93**	**$48.18**

Critical Illness Insurance - Per $10,000								
	Non-Tobacco				Tobacco			
	Employee	**Spouse**	**Child(ren)**	**Employee + Family**	**Employee**	**Spouse**	**Child(ren)**	**Employee + Family**
0-29	$4.84	$7.87	$4.84	$7.87	$7.15	$11.35	$7.15	$11.35
30-39	$8.26	$13.02	$8.26	$13.02	$13.11	$20.28	$13.11	$20.28
40-49	$15.10	$23.27	$15.10	$23.27	$27.29	$41.57	$27.29	$41.57
50-59	$26.12	$39.81	$26.12	$39.81	$68.67	$68.67	$45.37	$68.67
60-63	$42.13	$63.83	$42.13	$63.83	$74.44	$112.30	$74.44	$112.30
64	$54.27	$82.02	$54.27	$82.02	$97.21	$146.45	$97.21	$146.45

Walden School of Liberal Arts

Group Critical Illness Insurance

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why should I buy coverage now?

- It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive a payment for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, spina bifida, type 1 diabetes, sickle cell anemia and congenital heart disease. The diagnosis must occur after the child's coverage effective date.

Benefits may be subject to a pre-existing condition provision

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once.
  Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical Illnesses

- Heart attack
- Stroke
- Major organ failure
- End-stage kidney failure
- Sudden cardiac arrest
- Coronary artery disease
  Major (50%):
  Coronary artery bypass graft or valve replacement
  Minor (10%):
  Balloon angioplasty or stent placement

Cancer conditions

- Invasive cancer — all breast cancer is considered invasive
- Non-invasive cancer (25%)
- Skin cancer — $500

Progressive diseases

- Amyotrophic Lateral Sclerosis (ALS)
- Dementia, including Alzheimer's disease
- Multiple Sclerosis (MS)
- Parkinson's disease
- Functional loss
- Huntington's Disease
- Lupus
- Muscular Dystrophy
- Myasthenia Gravis
- Systemic Sclerosis (Scleroderma)
- Addison's Disease

Supplemental conditions

- Loss of sight, hearing or speech
- Benign brain tumor
- Coma
- Permanent Paralysis
- Occupational HIV, Hepatitis B, C or D
- Occupational PTSD

Paid at 25%

- Infectious Diseases
- Pulmonary Embolism
- Transient Ischemic Attack (TIA)
- Bone Marrow/Stem Cell

Please refer to the certificate for complete definitions of these covered conditions. Coverage may vary by state. See exclusions and limitations.

Monthly costs		
Age	Employee coverage: $10,000 Spouse coverage: $5,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$4.14	$3.04
25 - 29	$4.94	$3.44
30 - 34	$5.74	$3.84
35 - 39	$7.14	$4.54
40 - 44	$9.04	$5.49
45 - 49	$11.54	$6.74
50 - 54	$14.54	$8.24
55 - 59	$18.94	$10.44
60 - 64	$30.24	$16.09
65 - 69	$40.14	$21.04
70 - 74	$54.34	$28.14
75 - 79	$75.74	$38.84
80 - 84	$104.34	$53.14
85+	$159.84	$80.89

Monthly costs		
Age	Employee coverage: $20,000 Spouse coverage: $10,000 Be Well benefit: $75	
	Employee	Spouse
under 25	$8.28	$6.08
25 - 29	$9.88	$6.88
30 - 34	$11.48	$7.68
35 - 39	$14.28	$9.08
40 - 44	$18.08	$10.98
45 - 49	$23.08	$13.48
50 - 54	$29.08	$16.48
55 - 59	$37.88	$20.88
60 - 64	$60.48	$32.18
65 - 69	$80.28	$42.08
70 - 74	$108.68	$56.28
75 - 79	$151.48	$77.68
80 - 84	$208.68	$106.28
85+	$319.68	$161.78

Monthly costs		
Age	Employee coverage: $30,000 Spouse coverage: $15,000 Be Well benefit: $100	
	Employee	Spouse
under 25	$12.42	$9.12
25 - 29	$14.82	$10.32
30 - 34	$17.22	$11.52
35 - 39	$21.42	$13.62
40 - 44	$27.12	$16.47
45 - 49	$34.62	$20.22
50 - 54	$43.62	$24.72
55 - 59	$56.82	$31.32
60 - 64	$90.72	$48.27
65 - 69	$120.42	$63.12
70 - 74	$163.02	$84.42
75 - 79	$227.22	$116.52
80 - 84	$313.02	$159.42
85+	$479.52	$242.67

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required 29 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees may have a waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

Your paycheck deduction will include the cost of coverage and the Be Well Benefit. Actual billed amounts may vary.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

- voluntary commission of or attempt to commit a felony; voluntarily engaging in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; voluntary participation in a riot, or insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; and -voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and -being intoxicated; and a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Pre-existing conditions

We will not pay benefits for a claim when the Covered Loss occurs in the first 6 months following an Insured's Coverage Effective Date and the Covered Loss is caused by, contributed to by or occurs as the result of any of the following:

- a Pre-existing Condition; or
- complications arising from treatment or surgery for, or medications taken for, a Pre-existing Condition.

An Insured has a Pre-existing Condition if, within the 6 months just prior to their Coverage Effective Date, they have an injury or sickness, whether diagnosed or not, for which:

- medical treatment, consultation, care or services, or diagnostic measures were received or recommended to be received during that period;
- drugs or medications were taken, or prescribed to be taken during that period; or
- symptoms existed.
  The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage. Coverage Effective Date refers to the date any initial coverage or increases in coverage become effective.

Pre-existing Condition requirements are not applicable to children who are newly acquired after your Coverage Effective Date.
Covered Loss must be after the coverage effective date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.
However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.
Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.
Unum complies with applicable civil union and domestic partner laws.
THIS INSURANCE PROVIDES LIMITED BENEFITS
This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this coverage.
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Certificate Form UIC-GCIC16-2 and Policy Form UIC-GCIP16-2 or contact your Unum representative.
Underwritten by: Unum Insurance Company, Portland, Maine

A SHOPPER'S GUIDE TO CANCER INSURANCE

Should you buy Cancer Insurance?

Cancer Insurance Is Not A Substitute for Comprehensive Coverage

Caution: Limitations on Cancer Insurance

Prepared by the National Association of Insurance Commissioners

Cancer insurance provides benefits only if you get cancer. No policy will cover you for cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

CANCER INSURANCE IS NOT A SUBSTITUTE FOR COMPREHENSIVE COVERAGE...

Cancer treatment accounts for about 10% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies because they cover more, but they are generally considered a better buy.

SHOULD YOU BUY CANCER INSURANCE?... MANY PEOPLE DON'T NEED IT

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease?

If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low-income people who are Medicaid recipients don't need more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first such as a major medical policy. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a coordination of benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your regular insurance as well as the cancer policy.

Some Cancer Expenses May not be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs, and nursing home care. Cancer patients often face large nonmedical expenses which are not usually covered by cancer insurance. Examples are home care, transportation, and rehabilitation costs.

Don't be Mislead by Emotions. While three in ten Americans will get cancer over a lifetime, seven in ten will not. In any one year, only one American in 250 will get cancer. The odds are against you receiving any benefits from a cancer policy. Be sure you know what conditions must be met before the policy will start to pay your bills.

CAUTION: LIMITATIONS OF CANCER INSURANCE...

Cancer policies sold today vary widely in cost and coverage. If you decide to purchase a cancer policy, contact different companies and agents, and compare the policies before you buy. Here are some common limitations:

Some policies pay only for hospital care. Today cancer care treatment, including radiation, chemotherapy and some surgery, is often given on an out-patient basis. Because the average stay in the hospital for a cancer patient is only 13 days, a policy which pays only when you are hospitalized has limited value.

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However since the average stay in a hospital for a cancer patient is 13 days, large dollar amounts for extended benefits have very little value for most patients.

Most cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it may have fixed payments such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount such as $5,000 for $10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes, or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

FOR ADDITIONAL HELP...

If you are considering a cancer policy, the company or agent selling you the policy should answer your questions. You do not need to make a decision to purchase a policy the same day you talk to the agent. Be sure to ask how long you have to make your decision.

If you do not get the information you want, call or write your Insurance Department:

In Maine

Department of Professional and Financial Regulation
Bureau of Insurance
#34 State House Station
August, ME 04333-0034
(800) 300-5000
(207) 624-8475]

In New Hampshire

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(800) 852-3416
(603) 271-2261

In Vermont

Department of Financial Regulations
89 Main Street
Montpelier, VT 05620
(802) 828-3301

In Utah

Utah Department of Insurance
3110 State Office Building
Salt Lake City, UT 84114
(800) 439-3805
(801) 538-3800

Critical Illness Enrollment Form — Complete this form to enroll.

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

Please complete both sides of this form to ensure a smooth enrollment. If you already have Unum coverage: Please be aware that any new benefit elections on this form will replace all existing elections. If you do not wish to make changes, you do not need to complete the form. Please contact your plan administrator for assistance.

Walden School of Liberal Arts

Step 1: Complete your personal information

943108

First name (please print) | M. initial | Last name

Social Security Number | Gender | Date of birth (mm-dd-yyyy)

Have you used tobacco products (such as cigarettes, cigars, snuff, chew, or pipe) or any nicotine delivery system in the past 12 months? (Y/N)

Street address | Apartment #

City | State | ZIP code

Original hire date | Hours worked per week | Email

Did you recently become eligible for benefits? (Y/N)

Have you been rehired by your company? (Y/N)

If so, please provide a date (mm-dd-yyyy)

Spouse first name | M. initial | Last name

Date of birth (mm/dd/yyyy)

Step 2: Choose your coverage amount

Employee coverage
(Child coverage is automatically included)

- ☐ Option 1: $10,000
- ☐ Option 2: $20,000
- ☐ Option 3: $30,000

Spouse coverage

You can purchase coverage for your spouse as long as you have purchased coverage for yourself. Your spouse coverage will be 50% of your amount.

- ☐ **YES**, I want coverage for **my spouse**
- ☐ **NO**, I do not want coverage for **my spouse**

If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete a Statement of Health form. The amount of coverage over the Guarantee Issue amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Statement of Health form.

If you DO NOT APPLY FOR coverage for you or your spouse during your or their initial enrollment period, you will need to complete a Statement of Health form for all amounts of coverage. You may complete and electronically submit the Statement of Health form — please see your Plan Administrator.

Continued on back >

Step 3: Name your beneficiaries

Your primary beneficiary is the person (or persons) who will receive the benefit payment from your insurance policy if you were to die.
The total percent of benefit must not exceed 100%.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Your secondary beneficiary would receive the benefit payment from your life insurance policy if a primary beneficiary is no longer living.

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit

Step 4: Signature

☐ **Yes,** I do want **Critical Illness**.

I understand that my coverage may be subject to limitations, exclusions and terminations as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

_____ ___ / ___ / _____

Signature Date

☐ **No,** I do not want **Critical Illness**.

I understand that if I elect coverage in the future, I may need to complete a Statement of Health form relative to my health status in order for Unum to determine my eligibility for coverage.

_____ ___ / ___ / _____

Signature Date

Note: Your email will only be used if you requested a level of coverage above the guaranteed issue amount. You will receive a link to answer health questions online.

Return forms to: plan administrator

Underwritten by:
Unum Insurance Company, Portland, Maine