Benefits Election Form
July 1, 2013 – June 30, 2014

**Employee:** ________________________________________________  
(Please print)

- **I** choose to continue with my current benefit coverage as is. I acknowledge and approve any deduction change for the benefit year beginning July 1, 2013 through June 30, 2014.

- I understand that I must complete a separate enrollment form if I wish to participate in the University’s Medical or Dependent Flexible Spending Program for July 1, 2013 – June 30, 2014.

**Signature:** ________________________________  
**Date:** ___ / ___ / ___

**Note: If you are making any changes to your benefits, you must complete an enrollment form.**

1. **Health Insurance**
   - **I wish to CONTINUE this benefit** (No changes made)  
   - **ELECT** Harvard Pilgrim HealthCare Insurance
      - Individual  
      - 2- Person  
      - Family  
      - Domestic Partner Benefit (Must choose Plan type above)

2. **Dental Insurance**
   - **I wish to CONTINUE this benefit** (No changes made)  
   - **ELECT** Delta Dental
      - Individual  
      - 2- Person  
      - Family  
      - Domestic Partner Benefit (Must choose Plan type above)

3. **Flexible Spending Accounts**
   - **ELECT** **Completed Form attached**
      - Medical Flexible Spending Account  
      - Dependent Care Account

4. **Long Term Disability Tax Option**
   - **I wish to CONTINUE this benefit** (No changes made)
      - **ELECT** Pre-tax
        You are deferring the tax liability to the future. Should you receive monies from the LTD Policy, you would have to pay taxes on the full benefit amount.
      - **ELECT** After-Tax
        You are paying taxes on the premiums paid by the University now. In the event that you need the benefit, you would not owe any taxes on the monies received from the Long Term Disability Benefit.

**Signature:** ________________________________  
**Date:** ___ / ___ / ___
Voluntary Benefits Election Form
July 1, 2013 – June 30, 2014

Note: If you are making any changes to your benefits, you must complete an enrollment form.

1. VSP Vision Plan- (After Tax)   ☐ No Thank You
   ☐ I ELECT   ☐ Employee   ☐ Employee + 1 ☐ Employee + Children ☐ Employee + Family
   ☐ I wish to CONTINUE this benefit
   ☐ Please CANCEL this benefit

2. Voluntary Life Insurance Plan-(After Tax)
   ☐ I ELECT   ☐ No Thank You
   ☐ I wish to CONTINUE this benefit
   ☐ Please CANCEL this benefit

Signature: ___________________________ Date: ___ / ___ / ___
Employee Guarantee Issue Maximum: $150,000

Employee and Spouse Coverage: $10,000 Increments

Employee Maximum Coverage: The lesser of $500,000 or 5x Salary

Spouse Guarantee Issue Maximum: $30,000

Spouse Coverage: The lesser of 100% of Employee Life amount or $500,000

Child Coverage: Increments of $2,500 to a maximum benefit of $10,000

Coverage      Rate  Monthly Cost  # of Pay periods  Pay Period Cost

Employee Life (In 10,000 increments)  Coverage X ___ / 10,000 = ___ X 12 ÷ ___ = ___

Spouse Life (In 10,000 increments)  Coverage X ___ / 10,000 = ___ X 12 ÷ ___ = ___

Child Life (In 2,500 increments)  Coverage X 0.400 / 2,500 = ___ X 12 ÷ ___ = ___

Employee & Spouse Rates:

<table>
<thead>
<tr>
<th>AGE</th>
<th>RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-24</td>
<td>0.500</td>
</tr>
<tr>
<td>25-29</td>
<td>0.460</td>
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<tr>
<td>30-34</td>
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</tr>
<tr>
<td>35-39</td>
<td>0.700</td>
</tr>
<tr>
<td>40-44</td>
<td>1.160</td>
</tr>
<tr>
<td>45-49</td>
<td>1.960</td>
</tr>
<tr>
<td>50-54</td>
<td>3.280</td>
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<tr>
<td>55-59</td>
<td>5.780</td>
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<tr>
<td>60-64</td>
<td>7.340</td>
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<tr>
<td>65-69</td>
<td>11.200</td>
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<tr>
<td>70-74</td>
<td>21.860</td>
</tr>
<tr>
<td>75+</td>
<td>21.860</td>
</tr>
</tbody>
</table>

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. Any coverage amounts left blank will result in a coverage amount of $0.

AMOUNT LIFE OF COVERAGE SELECTED FOR:

You: $  
Your Spouse: $  
Your Child(ren): $  

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage.

□ I decline all Voluntary Life Benefits at this time. I understand that if I wish to elect any amount of coverage in the future, all amounts will be subject to Evidence of Insurability.

Beneficiary Information

NAME (last name, first, middle initial):  RELATION TO YOU:  BENEFIT %:

IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:  RELATION TO YOU:  BENEFIT %:

I understand that any coverage I am requesting is subject to all the terms of the policy including any exclusions, any provisions requiring the submission of Evidence of Insurability and approval by Unum, and any provisions specifying a Delayed Effective Date in the event that I am absent from work or an eligible dependent is totally disabled on the date coverage would otherwise begin. I also understand that if I submit Evidence of Insurability for additional coverage, the Effective Date for the additional coverage will be the first of the month coincident with or next following the date Unum approves my submission.

I certify that all statements are true to the best of my knowledge and belief and I understand a copy of this form will be made available 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.

________________________________________  __________________________  __________________________
Employee Signature  Date  Work Phone  Home Phone
Limitations and Exclusions

Delayed Effective Date:

Employee: Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents: Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. "Totally disabled" means that, as a result of injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

Exclusion for Suicide:

Where the cause of death is suicide:
1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

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RETAINT A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER