## Supplemental Life Insurance

Insured by The Hartford Group Life & Accident Insurance Company

The County of Sonoma Supplemental Life Insurance Program allows eligible employees to purchase additional Life Insurance coverage based on amounts specified in their bargaining unit MOU. The maximum combined Basic Life and Supplemental Life cannot exceed $500,000. Please refer to the Employee Health and Welfare Benefits Booklet for basic life insurance coverage information. This coverage is not available for dependents.

**Who can enroll?** You are eligible for Supplemental life if you qualify for and are enrolled in Basic Life Insurance. Full-time or part-time regular employees scheduled to work 60 or more hours per pay period (.75 FTE or greater) are automatically enrolled in Basic Life Insurance. Part time DSA, SCLEA and ESC employees working less than 60 hours per pay period may purchase Basic Life Insurance.

**When can you enroll?** You can enroll in Supplemental Life insurance within 31 days of initial eligibility, during the Annual Enrollment period, or within 31 days of a qualifying life/family or work status change (see the Employee Health & Welfare Booklet for details on qualifying life/family events).

**Approval:**

1. New Hires or Newly Eligible Employees: The Hartford Group offers a Guaranteed Issue, an amount of insurance to be automatically approved without providing Evidence of Good Health. The Guaranteed Issue is the lesser of 3 times your Basic Life Amount or 3 times your Annual Base Salary (whichever one applies) or $250,000. For any supplemental insurance amounts exceeding the Guaranteed Issue amount, Evidence of Good Health is required.
2. After initial eligibility, approval for ANY supplemental life insurance amount requires Evidence of Good Health.

When Evidence of Good Health is required, The Hartford will mail the employee a Personal Health Application (PHA). An employee must complete the PHA and return the original PHA form to The Hartford.Group. Incomplete PHA forms could result in denial of your Supplemental Life Insurance application. You will be notified by The Hartford Group whether or not your application for supplemental insurance was denied. If your application is approved, The Hartford Group will notify the Human Resources Benefits Unit and deductions for your elected coverage will automatically begin.

**The Cost:** Supplemental Life insurance is employee paid. The cost is based on your desired coverage amount and your age. If you elect coverage and are approved, the cost will be deducted from your paycheck. The coverage amount is rounded to the nearest thousand dollars. The current rates for ***each $10,000 in supplemental coverage*** are:

| | Age as of December 31st of Current Year | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Under 29** | **30-34** | **35-39** | **40-44** | **45-49** | **50-54** | **55-59** | **60-64** | **65-69** | **70-74** |
| **Bi-weekly Cost** | $0.28 | $0.31 | $0.39 | $0.59 | $0.86 | $1.37 | $2.28 | $3.38 | 5.53 | 10.12 |
| **Annual Cost** | $7.20 | $8.17 | $10.20 | $15.37 | $22.44 | $35.77 | $59.40 | $88.08 | 144.35 | 264.16 |

**How to Enroll:** Complete the Supplemental Life Insurance Enrollment Form below. Keep a copy for your records. Send the original, completed form to your Payroll Clerk or the Human Resources Benefits Unit.

Submittal of the Supplemental Life Insurance Enrollment Form is not a guarantee of enrollment. Incomplete PHA forms could result in denial of your Supplemental Life Insurance application. You will be notified by The Hartford Group if your application is denied.

# SUPPLEMENTAL LIFE INSURANCE ENROLLMENT FORM

COUNTY OF SONOMA SUPPLEMENTAL LIFE INSURANCE

GROUP POLICY GL-673199

**Reason for Enrollment/Change:** ❑ Annual Enroll ❑ New Hire ❑ Newly Eligible EE ❑ Bargaining Unit Chg
❑ Beneficiary Chg ❑ Loss of Other Coverage ❑ Cancel Coverage

| ***Name:*** | ***Phone Number:*** | ***Employee Id:*** |
|---|---|---|
| ***Home Address:*** | ***Social Security Number:*** | ***DOB:*** |
| ***City, State Zip Code:*** | ***Department & Bargaining Unit:*** | ***Hire Date:*** |

**Amount you can apply for?** The chart below shows the amount of Supplemental Life you may apply for. Identify your bargaining unit and then in the Select Coverage Amount column check the box for the level of coverage you wish to apply for:

| **Bargaining Unit** | **Select Coverage Amount** |
|---|---|
| • Administrative Management (50)<br>• Board of Supervisors (49)<br>• Confidential (51)<br>• Department/Agency Heads (52)<br>• DLSEM (43)<br>• DSA (46,47)<br>• Local 39 (85)<br>• SCDPDA (60)<br>• SCLEA (30,40,41,70)<br>• SCLEMA (44)<br>• SCPA (45)<br>• SCPDIA (55)<br>• SEIU (01, 05, 10,25, 80)<br>• SEIU Supervisory (95 only)<br>• Unrepresented (00) | Select One:<br>❑ 1 times Basic Life<br>❑ 2 times Basic Life<br>❑ 3 times Basic Life<br>❑ 4 times Basic Life |
| • WCE (21) | Select One:<br>❑ 1 times Annual Salary<br>❑ 2 times Annual Salary<br>❑ 3 times Annual Salary<br>❑ 4 times Annual Salary |
| • ESC (75) | Select One:<br>❑ 1 times Annual Salary<br>❑ 2 times Annual Salary<br>❑ 3 times Annual Salary<br>❑ 4 times Annual Salary<br>❑ 5 times Annual Salary |

Beneficiary Name: _____ Relationship:_____

Address: _____ Phone No.: _____

*Upon approval I hereby authorize the County to deduct from my salary the amount necessary to provide the Supplemental Life insurance I have selected above and to forward that amount to The Hartford Group Life & Accident Insurance Company.*

***Signature*** _____ ***Date*** _____

Human Resources Benefits Unit Use Only:

Effective Date: _____ Initials: _____