



# Income Protection Benefits

## Oklahoma City Firefighters Benefits Enrollment Form

### Information About You

Name:	Social Security Number / Employee ID Number:
Date of Birth:	Date of Hire:

### Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please enter or check your coverage elections and details. You may only elect – and will be covered for – levels of coverage included in your employer’s contract.
- **Step 2:** Please sign, date and return.

### Supplemental Life Insurance - Employee

You have the opportunity to enroll in Oklahoma City Firefighters’ Supplemental Life Insurance plan. Your election may be made in increments of \$10,000, not to exceed the maximum of \$100,000. If you are enrolling in Supplemental Life coverage for the first time, you may enroll for up to \$20,000 without providing evidence of insurability. If you are currently participating in the Supplemental Life coverage you may increase your current coverage by 2 increments or \$20,000, without evidence of insurability up to the guaranteed issue amount of \$50,000. Additional coverage amounts will require evidence of insurability that is satisfactory to The Hartford before the excess can become effective. **You must complete the Beneficiary Designation section below.** Use the calculation line below to determine your Semi-Monthly (24) cost for this coverage.\*

Please choose rate:

Benefit Amount	Rate
\$10,000	\$0.13
Over \$10,000	\$0.18

I elect to **enroll** in the Supplemental Life plan at the Semi-Monthly (24) cost below.\*

$$\frac{\text{Elected Benefit Amount}}{\$1,000} = \text{Rate Above} \times \text{Rate Above} = \$ \text{Your Semi-Monthly (24) Cost*}$$

I elect to **decline** the Supplemental Life plan.

\*Note: Benefit reductions begin at age 65. Please see your benefits administrator for further information.

### Supplemental AD&D Insurance - Employee

You have the opportunity to elect Supplemental AD&D insurance in increments of 1 or 2 times your Supplemental Life amount to a maximum of \$100,000. Use the calculation line below to determine your Semi-Monthly (24) cost for this coverage.

You may elect Supplemental Life coverage without electing Supplemental AD&D coverage, **but you cannot elect Supplemental AD&D coverage without Supplemental Life.**

I elect to **enroll** in the Supplemental AD&D plan at the Semi-Monthly (24) cost below.

$$\frac{\text{Amount Elected}}{\$1,000} = \text{AD\&D Rate} \times \$0.02 = \$ \text{Your Semi-Monthly (24) Cost}$$

I elect to **decline** the Supplemental AD&D plan.

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Oklahoma City Firefighters  
Generic EP  
11/6/08

Name: \_\_\_\_\_

### Supplemental Life Insurance – Spouse & Child

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Spouse in the amount of \$15,000 and \$5,000 for each child. You may elect Supplemental Life coverage for your Dependent Child(ren) between the ages of 2 weeks and 19 years (25 years if a full time student). Children between 2 weeks and 6 months of age are limited to coverage in the amount of \$1,000.

- I elect to **enroll** my Dependent(s) in the Supplemental Life plan at a Semi-Monthly cost of **\$3.00** per dependent unit.
- I elect to **decline** the Supplemental Life plan for my Dependent(s).

**SPOUSE:**

First Name	Last Name	Gender	Date of Marriage	Date of Birth

**CHILD:**

First Name	Last Name	Gender	Date of Birth

### Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
<b>Primary Beneficiary</b>						
<b>Contingent Beneficiary</b>						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

### Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life insurance coverage described in the Benefit Highlight Sheets and offered through Oklahoma City Firefighters.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the

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**Name:** \_\_\_\_\_

provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed \_\_\_\_\_

Date \_\_\_\_\_

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