# *Voluntary Term Life Insurance*

*Developed for the Employees of*

***Macomb Community College***

## Who Needs Life Insurance?

You do. Single or married. Buying your first home or preparing for retirement. Raising children or sending them off to college. No matter where you are in life, insurance should be part of your financial plan.

By purchasing this insurance product through your employer, you benefit from:

- Affordable group rates
- Convenient payroll deduction
- Access to knowledgeable service representatives.

## Who Is Eligible For Coverage?

***You*** — If you are an active, full-time employee regularly working a minimum of 30 hours per week for your employer.

## How Much Coverage Can You Buy?

***You*** — You can select life insurance coverage in units of $10,000. The maximum for any employee is $200,000. The guaranteed coverage amount for you is $50,000.

## Guaranteed Coverage

If you are eligible and you apply during the initial enrollment period, or within 31 days after you are eligible to elect coverage, you are entitled to choose any of the offered amounts of coverage up to the guaranteed coverage amount, as shown on your application, without having to provide evidence of good health.

If you apply for an amount of coverage greater than the guaranteed coverage amount, coverage in *excess* of the guaranteed coverage amount will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement.

If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the guaranteed coverage amounts will not apply. Coverage will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement.

## How Much Your Coverage Will Cost

The monthly cost of insurance will depend on your age and the amount of insurance you wish to purchase for yourself. As shown in the following chart, the cost of insurance increases with the age of the insured. Note that at age 65 your benefits are reduced.

To calculate your monthly cost:

1. Find your age group in the following table;
2. Multiply the rate by the number of coverage units you want to get your total monthly cost.

3.

**Example:**

| | | | | |
|---|---|---|---|---|
| Employee *(age 32)* | 20 units ($200,000) | x | $.64 per unit | = $12.80 |
| | | | **Total Monthly Cost** | **$12.80** |

**To calculate your cost, complete this chart:**

| | | | | |
|---|---|---|---|---|
| Employee | ____ units | x | $__.__ per unit | = $__.__ |
| | | | **Total Monthly Cost** | $__.__ |

| Employee Age | Employee Monthly Cost per $10,000 Unit |
|---|---|
| Under 30 | $ 0.63 |
| 30 to 34 | 0.64 |
| 35 to 39 | 0.85 |
| 40 to 44 | 1.19 |
| 45 to 49 | 1.80 |
| 50 to 54 | 2.74 |
| 55 to 59 | 4.42 |
| 60 to 64 | 5.87 |
| 65 to 69 | 9.98 |
| 70 to 74 | 17.73 |
| 75 & over | 67.25 |

*Costs are subject to change.*

### When You Reach Age 65

By the time you reach age 65, chances are that your children will be grown and your mortgage paid. At age 65, providing you are still employed, your coverage will decrease to 67% of the benefit amount. It will decrease to 45% at age 70, to 30% at age 75, and to 20% at age 80.

# How Much Life Insurance Do You Need?

We have provided this worksheet to help you calculate how much life insurance you may need for a surviving spouse and dependents. When calculating annual amounts, be sure to multiply the annual income or cost by the number of years you expect to receive that income, or incur that cost.

## 1. Living Costs

Day-to-day Living Expenses *(Use 75% of current net income)*
$ _____annually x _____ years = $ _____

Child Care Expenses
$ _____annually x _____ years = + _____

Education Funding
$ _____annually x _____ years = + _____

Major Purchases *(cars, home repair)*
$ _____annually x _____ years = + _____

Estate and Funeral Expenses = + _____

TOTAL LIVING COSTS (A) = $ _____

## 2. Available Resources

Cash and Savings = $ _____

Retirement Savings *(IRA, 401(k), etc.)* = + _____

Stocks and Bonds *(at current market value)* = + _____

Spouse Income *(multiply by 60%)**
$ _____annually x _____ years = + _____

Other Assets = + _____

TOTAL AVAILABLE RESOURCES (B) = $ _____

## 3. Life Insurance Need

TOTAL LIVING COSTS (A) = $ _____(A)

LESS TOTAL AVAILABLE RESOURCES (B) – $ _____(B)

EQUALS LIFE INSURANCE NEED = $ _____

*Naturally a worksheet like the above is only an aid to determining life insurance needs. It cannot predict all of your expenses, economic conditions, inflation, investment performance or other factors which may alter your needs. For a more accurate plan, you should consider consulting an investment advisor.*

** Estimate likely spouse income as sole provider. Include your estimate of Social Security benefits to surviving spouse and dependents. The 60% factor above is used to account for taxation so that a net income figure can be derived. Vary this factor if you feel combined federal, state and local taxes, and FICA will be different for your situation.*

# Other Benefit Features

### *Annual Enrollment Period*

Each year, during your enrollment period, you have the opportunity to enroll in the plan or increase your voluntary coverage. We do require evidence of good health for all new coverage selections.

### *Continuation for Disability for Employees Age 60 or over*

If your active service ends due to disability, this plan provides a continuation of coverage feature. If you are disabled at age 60 or over, your coverage will continue while you are disabled. This benefit will remain in force until the earliest of the following dates: the date you are no longer disabled, the date the policy terminates, the date you are disabled for 9 consecutive months, or the day after the last period for which premiums are paid.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

### *Extended Death Benefit with Waiver of Premium*

#### *Extended Death Benefit*

*If you become Disabled* — The extended death benefit ensures that if you become disabled prior to age 60, and die before you qualify for Waiver of Premium, we will pay the life insurance benefit if you remain disabled during that period. If you qualify for this benefit and have insured your spouse or children, their coverage is also extended.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

#### *Waiver of Premium*

*If you become totally disabled* — To make sure you can keep the life insurance protection you need during a difficult period of your life, this plan provides a *waiver of premium* feature. If you are totally disabled prior to age 60 and can't work for at least 6 months, you won't need to pay premiums for your coverage while you are disabled, provided the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until age 70, subject to proof of continuing disability each year. If you qualify for this benefit and have insured your spouse or children, the premium for their coverage is also waived.

## What Is Not Covered

The plan will not pay benefits if loss of life is the result of suicide that occurs within the first two years of coverage.

## When Your Coverage Begins and Ends

The date your coverage begins is called its "effective date." Your employer will let you know the effective date of your coverage. If you are not actively at work on the effective date of coverage, your coverage will not begin until you return to work.

Your coverage cannot be terminated as long as you remain eligible, the premium is paid and the group policy remains in force.

### Converting Your Coverage to Permanent Life Insurance

If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can convert to an individual policy. No medical certification is needed. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Family members may convert their coverage as well. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed. Premiums may change at this time.

## Apply Today

In order to apply for coverage, you must complete an application form. Be sure to answer all questions accurately, and indicate how much coverage you wish to have.

### Payroll Deduction

You pay your premiums through payroll deduction. The total depends on how much coverage you select and your age.

### Designating Your Beneficiary

Your term life benefit will automatically be paid to the first beneficiary listed below who is living at the time of your death if you do not designate a specific beneficiary:

1) Your Spouse 2) Your Child(ren) 3) Your Parents
4) Your Siblings 5) Your Estate

If you wish to designate different beneficiaries, or to indicate percentages, you may do so on your application. If the listed beneficiary is a trustee or a trust, you will need to indicate the trustee's name, the name of the trust and the date of the trust agreement. The trust document must be presented in order for the claim to be processed.

### How Your Claims Are Paid

Your employer has all the forms your beneficiary will need and can provide assistance in completing them.

## Questions?

CIGNA Group Insurance has courteous, knowledgeable customer service representatives who can assist you with the completion of your enrollment form by calling 1-800-732-1603 toll-free anytime from Monday through Friday, 8 a.m. to 6 p.m. Eastern time. CIGNA does not have your coverage election information on file. For specific benefit/account inquiries on what is available under your plan, please contact your Human Resource department.

*This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of coverage are set forth in Group Policy No. FLX-964726, on Policy Form TL-004700, issued in Delaware to the Trustee of the Group Insurance Trust for Employers in the Services Industry. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.*

*Coverage is underwritten by*
*Life Insurance Company of North America*
*1601 Chestnut Street*
*Philadelphia, PA 19192*

CIGNA®

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All classes

# VOLUNTARY TERM LIFE INSURANCE APPLICATION

**Life Insurance Company of North America (LINA)**
**a Cigna Company (herein called the Insurance Company)**
*For info and customer service call 1-800-732-1603.*
- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

CIGNA

***Important:*** *Please enter all dates in mm/dd/yyyy format.*

**EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must complete this information.**

**EMPLOYER** Macomb Community College

**CLASS** _____ **LOCATION/PAYCODE#** _____ **DATE OF HIRE** _____ **ANNUAL SALARY** _____ **VERIFIED BY** _____

**REASON FOR REQUEST:** ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **OPEN ENROLLMENT EVENT** ❑ **LATE ENTRANT**

| | VOLUNTARY EMPLOYEE |
|---|---|
| NEW COVERAGE (TOTAL) | |
| CURRENT COVERAGE | |
| GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE | |
| AMOUNT SUBJECT TO MEDICAL EVIDENCE | |

*Please print (preferably in black ink).*

## EMPLOYEE SECTION

☐ Mr. ☐ Mrs. ☐ Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Sex: ☐ M ☐ F

***Important:*** You must complete the medical questions in this application if you apply for life insurance: (1) as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying more than 31 days after you are eligible to elect benefits; (2) you were eligible under the prior plan and enroll or increase your insurance amount(s) above the Guaranteed Coverage Amount.

## VOLUNTARY TERM LIFE INSURANCE — POLICY NO. FLX-964726

| | ***Applicant*** | ***Decline*** | ***Requested Amount*** | ***Guaranteed Coverage Amount**** |
|---|---|---|---|---|
| Voluntary Employee-Paid Coverage | Employee | ☐ | ☐ Number of $10,000 units _____ | $50,000 |

**Guaranteed Coverage Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.*

## BENEFICIARY

To ***specify a beneficiary***, complete the section below. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

| *Insured* | *Beneficiary* | *Percentage* | *Social Security #* | *Date of Birth* | *Relationship* |
|---|---|---|---|---|---|
| Employee *(Life)* | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## ACCEPTANCE/DECLINATION

I accept the insurance coverage elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

Signature _____ Date _____

**Please Sign Here**

***Important:*** **You must also sign and date the Agreements and Authorization section.**

***Return application to your employer. Be sure to make a copy for your own records.***

**Applicant's Name** _____ **Social Security #** _____

**IMPORTANT**
**Please complete each section that follows if it is needed.**
**Read the Agreements and Authorization. Sign and date the form in the space provided.**

Complete the employee information in this section if you (i.e., the Employee) are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

## Height and Weight Information

| **Employee** |
|---|
| Height _____ ft _____in |
| Weight _____ lbs |

## PHYSICIAN SECTION

**Employee Physician**

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

**Please indicate your answers for each question by checking the Yes or No box for the question.**

**SECTION A**

**Within the last 5 years has the proposed insured been:**

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

| | | Employee Yes | Employee No |
|---|---|---|---|
| A. | High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system? | ❑ | ❑ |
| B. | Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas? | ❑ | ❑ |
| C. | Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract? | ❑ | ❑ |
| D. | Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system? | ❑ | ❑ |
| E. | HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes? | ❑ | ❑ |
| F. | Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system? | ❑ | ❑ |
| G. | Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb? | ❑ | ❑ |
| H. | Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition? | ❑ | ❑ |
| I. | Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole? | ❑ | ❑ |
| J. | Alcohol or drug abuse or dependency? | ❑ | ❑ |

**SECTION B**

**Within the last 5 years has the proposed insured:**

| | | | |
|---|---|---|---|
| A. | Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction? | ❑ | ❑ |
| B. | Smoked cigarettes: | ❑ | ❑ |
| | 1. For how many years has the proposed insured smoked? | _____ | |
| | 2. Approximately how many cigarettes are, or were, smoked on average per day? | _____ | |
| | 3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking? | _____ | |
| C. | Used any controlled or illegal drug or other substance? | ❑ | ❑ |
| D. | Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams? | ❑ | ❑ |
| E. | Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture? | ❑ | ❑ |
| F. | Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above? | ❑ | ❑ |

*Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.*

| *Name of Employee* | *Medical Condition* | *Date Occurred* | *Duration/Treatment Received* | *Current Status* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

***Caution**: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.*

***Important:* You must also sign and date the Agreements and Authorization section.**

***Fold and staple this page to conceal health questions.***
***Return application to your employer. Be sure to make a copy for your own records.***

**Applicant's Name** _____ **Social Security #** _____

**♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦**

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

**Authorization.** I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about my health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

**Sign Here** _____ _____
*Employee's Signature* *Month/Day/Year*

***Notice:*** Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.