



**CITY OF MANCHESTER  
GROUP INSURANCE ELECTION FORM  
POLICY #910591**

Name:		Social Security #:	
Date of Hire:		Annual Salary:	
Effective Date:		Date of Birth:	

**IMPORTANT! This form must be returned to your employer prior to the end of the enrollment period.**  
**New hire enrollment period:** If your form is not signed, dated and returned *within 31 days after the effective date of this form*, you will automatically be enrolled in the employer-funded plan.  
**Re-enrollment period:** If your form is not signed, dated and returned *before* the effective date of the plan year for which elections are being made, you will remain in the options you had previously, or a plan most similar, although your cost may change.

**EMPLOYER PAID LONG TERM DISABILITY INSURANCE:**  
Employer Paid Long Term Disability Insurance helps replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as an elimination period, of 180 days, and as long as you remain disabled, **the maximum time you can receive the benefit is 2 years**. The coverage provided by City of Manchester provides you with income protection to replace up to 60% of your Earnings, to a maximum monthly benefit of \$5,000 at no cost to you.

**OPTIONAL LONG TERM DISABILITY INSURANCE:**  
You have the opportunity to enhance your coverage by enrolling in Optional Long Term Disability Insurance. Optional Long Term Disability Insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 180 days, and as long as you remain disabled, **you may receive the benefit until your Social Security Normal Retirement Age**. This plan provides you with income protection to replace up to 60% of your Earnings to a maximum monthly benefit of \$5,000.

- I elect to purchase Optional Long Term Disability Coverage
- I decline to purchase Optional Long Term Disability Coverage

To calculate your Optional Long Term Disability cost, please use the following formula:

$$\frac{\text{Annual Earnings}}{\text{Maximum \$100,000}} \div 12 = \frac{\text{Monthly Earnings}}{\text{Monthly Earnings}} \div 100 = \frac{\text{Rate}}{\text{Rate}} \times .159 = \frac{\text{Monthly Cost}}{\text{Monthly Cost}} \times 12 = \frac{\text{Annual Cost}}{\text{Annual Cost}} \frac{\div 48}{\text{Pay Periods}} = \frac{\text{Pay Period Cost}}{\text{Pay Period Cost}}$$

You can calculate your/your spouse's Life cost by finding your/your spouse's age in the chart below.

**\*\*FINAL COST MAY VARY DUE TO ROUNDING\*\***

INSURANCE RATE		INSURANCE RATE	
Age	Employee/Spouse Cost Per Month For Life Coverage Per \$1,000	Age	Employee/Spouse Cost Per Month For Life Coverage Per \$1,000
< 30	.08	50 – 54	.38
30 – 34	.09	55 – 59	.65
35 – 39	.12	60 – 64	.89
40 – 44	.16	65 – 69	1.67
45 – 49	.22	70 – 74	3.79
		75+	6.99

**EMPLOYER FUNDED BASIC EMPLOYEE LIFE/AD&D COVERAGE: 1X SALARY TO A MAXIMUM OF \$50,000**

**YOU MAY PURCHASE ADDITIONAL LIFE COVERAGE INCREMENTS OF \$25,000 TO A MAXIMUM OF \$300,000**

$$\frac{\text{Life Amount Elected}}{\text{Rate from Table Above}} \times \frac{\text{Rate from Table Above}}{\$1,000} \times 12 = \frac{\text{Annual Cost}}{\text{Pay Periods}} \div \frac{48}{\text{Pay Period Cost}} = \frac{\text{Pay Period Cost}}{\text{Pay Periods}}$$

**Note: Evidence of Insurability will be required if:**

- Your volume of additional coverage exceeds \$150,000
- You increase your current coverage by any level
- You are electing additional coverage for the first time and had previously opted out of the coverage

Life coverage amounts for which you contribute or that are medically underwritten are not payable if you commit suicide within the 24 months following your effective date of coverage. Please consult your employee booklet. See your Plan Administrator or refer to your employee booklet for details about other Life coverage exclusions.

**YOU MAY ELECT SPOUSE LIFE COVERAGE IN \$500 INCREMENTS TO A MAXIMUM OF \$150,000**

$$\frac{\text{Life Amount Elected}}{\text{Rate from Table Above}} \times \frac{\text{Rate from Table Above}}{\$1,000} \times 12 = \frac{\text{Annual Cost}}{\text{Pay Periods}} \div \frac{48}{\text{Pay Period Cost}} = \frac{\text{Pay Period Cost}}{\text{Pay Periods}}$$

**Note: Evidence of Insurability will be required if:**

- Your spouse volume of additional coverage exceeds \$20,000.
- You are electing spouse coverage for the first time and had previously opted out of the coverage

**YOU MAY ELECT CHILD(REN) LIFE COVERAGE OF \$10,000 (live birth to 6 months = \$1,000; 6 months to age 23 (25 years if full-time student = full benefit) – Cost is to cover all of your children**

**I ELECT CHILD(REN) COVERAGE \_\_\_\_\_**

$$\frac{\$20.40}{\text{Annual Cost}} \div \frac{48}{\text{Pay Periods}} = \frac{\$0.43}{\text{Pay Period Cost}}$$

**Note: Evidence of Insurability will be required if:**

- You are electing child(ren) coverage for the first time and had previously opted out of the coverage

**Total Amount of Per Pay Period Deductions..... = \$ \_\_\_\_\_**

See your Plan Administrator or refer to your enrollment materials for details about pre-existing condition limitations and/or exclusions.

*"Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include such items as disability income or other amounts you receive or are entitled to receive under: workers compensation or similar occupational benefit laws; state compulsory benefit laws; automobile liability and no fault insurance; legal judgments and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability programs or insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs."*

**Dependent Information: Complete the following for those dependents covered by your elections.**

Name	SSN	Date of Birth	Relation to You	Status
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

\* Relation to You: SP = spouse; CH = child; ST = stepchild who lives with you and depends upon your financial support

\*\* Status: (complete if applicable): S = full time student age 23 - 25 (if child); H = handicapped person; D = totally disabled person (may be subject to a delayed effective date); N = not applicable

Please indicate the expected date of graduation for those dependents that are full time students age 23 and over:

Name: \_\_\_\_\_ Expected Graduation Date: \_\_\_\_\_

Name: \_\_\_\_\_ Expected Graduation Date: \_\_\_\_\_

**Beneficiary Information: Designate your beneficiary(ies) below. You will automatically be your spouse and child(ren) beneficiary.**

Name of beneficiary (last name, first, middle initial)	Relation to You	Benefit Percent
_____	_____	_____
_____	_____	_____
_____	_____	_____

If the beneficiary(ies) named above are not living, then pay:

_____	_____	_____
_____	_____	_____

Delayed Effective Date: (1) Employee - Insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective. (2) Dependents - Initial insurance coverage will be delayed if a dependent is totally disabled on the date that insurance would otherwise be effective. Any increased or additional insurance will be delayed if the employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective.

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deductions from my earnings. I understand that if I decline any of the above coverages, I cannot later change my mind during the plan year and elect these coverage, unless I experience a change in status. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form will remain unchanged, although the cost may change.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date