SYMETRA
RETIREMENT | BENEFITS | LIFE

Saint Louis University Benefits Enrollment Form

Information About You

Name:	**Employee ID Number:**
Date of Birth:	**Date of Hire:**
Salary:	**Department:**

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** this form to the Benefits Office.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of 1, 2 or 3 times your annual earnings. The maximum amount you can purchase cannot be more than 3 times your annual Earnings or $400,000 (combined Basic & Supplemental Life Insurance). If you enroll after your new hire enrollment period, you will need to provide evidence of insurability that is satisfactory to Symetra before coverage can become effective.

Use the rate chart and calculation line below to determine your Monthly cost for this coverage.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.039	$0.039	$0.052	$0.059	$0.072	$0.124	$0.221	$0.383	$0.584	$0.974	$1.532	$2.060

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $ _____

Life Benefit Amount (1, 2 or 3 times your earnings) | Above Rate | My Monthly Cost

I elect to **purchase:**

- ☐ **1 times my earnings** of Life coverage.
- ☐ **2 times my earnings** of Life coverage.
- ☐ **3 times my earnings** of Life coverage.

☐ I **decline** to purchase Life coverage.

(please check one)

Name: _____

Dependent Supplemental Life Insurance

You can purchase Spouse Supplemental Life Insurance in the amount of $25,000.

You can purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) between the ages of live birth and 19 years (or up to 26 years if a full-time student), in the amount of $12,500.

Use the rate chart below to determine your Monthly cost for this coverage.

I Elect Dependent Supplemental Life Insurance and my Benefit Will Be:		My Monthly Cost Will Be:
☐	**$25,000 Spouse** **$12,500 Child(ren)**	**$4.35**
☐	**I decline**	

SPOUSE:

First Name	Last Name	Gender	Date of Marriage	Date of Birth

CHILD:

First Name	Last Name	Gender	Date of Birth

Voluntary Accidental Death & Dismemberment Insurance

You can purchase Voluntary Accidental Death & Dismemberment Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than the lesser of 10 times your annual Earnings or $500,000.

You can also purchase coverage for your Spouse or Child(ren) at the percentages of your election outlined in the following chart:

Family Member(s) Covered:	Employee Only	Employee & Spouse Only	Employee & Child(ren) Only	Employee, Spouse & Child(ren)
Percent of Benefit Paid:	100%	100% for Employee 50% for spouse	100% for Employee 15% for each Child	100% for Employee 40% for Spouse 10% for each Child

Coverage Options	Pay Period Rate
Myself Only	$ 0.021
Myself and My Family	$ 0.032

To calculate your Monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $ _____

Elected Benefit Amount (Employee Coverage Amount Only) | Rate | My Monthly Cost

☐ I elect to **purchase** $_____of AD&D coverage for myself only.

☐ I elect to **purchase** $_____of AD&D coverage for myself. My family will be covered at the percentages of my election listed above.

☐ I **decline to purchase** AD&D coverage.

Name: _____

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 Symetra 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
Primary Beneficiary						
Contingent Beneficiary						

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 and AD&D insurance coverage described in the Benefit Highlight Sheets and offered through Saint Louis University.

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 Symetra and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by Symetra.

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 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 and AD&D coverage with Symetra, I understand and agree that my life and AD&D insurance benefit is reduced at a specified age stated in the policy.

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 _____