LIFE, SHORT-TERM AND LONG-TERM DISABILITY

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: Town of Milford

ALL ABOUT YOU – THE EMPLOYEE

Step 1

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State ____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

Step 2

❑ I am currently married and my date of marriage is: _____

My Spouse's Information Name _____ **Social Security #** _____

Birthdate _____ Gender _____

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employer-Paid (Basic) Term Life Insurance Policy # SGM 607000		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	Option 1: 1 times your salary up to $150,000 ❑ Choose Option 1 Option 2: 2 times your salary up to $200,000 ❑ Choose Option 2	Option 1: Guaranteed Coverage: Lesser of 1 times your salary or $150,000 Option 2: Guaranteed Coverage: Lesser of 2 times your salary or $200,000
Spouse	$3,000 ❑ Elect Spouse Coverage	❑ Decline Spouse Coverage
Children	$2,000 ❑ Elect Child Coverage	❑ Decline Child Coverage

Step 3 - select 1x salary or 2x salary -employER pays

Step 4 - spouse or child coverage - employER pays

Employee-Paid (Voluntary) Term Life Insurance Policy # SGM 607000		
Applicant	Available Coverage	Accept your desired coverage amount or decline coverage below.
Employee	1 times your salary to maximum of $150,000. Guaranteed Coverage: The lesser of 1 times your salary, or $150,000.	Choose a multiple of salary below: ❑ 1 times your salary ❑ Decline Coverage

Step 5 - voluntary additional life - employEE pays

Employer-Paid (Basic) Accidental Death & Dismemberment Insurance Policy # SOK 604994		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	Option 1: 1 times your salary ❑ Choose Option 1 Option 2: 2 times your salary ❑ Choose Option 2	Option 1: Max Coverage**: $150,000 Option 2: Max Coverage**: $200,000

Step 6- select AD&D - should reflect 1 x salary or 2 x salary as in Step 3 - employER pays

Short Term Disability - employER pays

Employer-Paid (Basic) Short-term Disability Insurance Policy # SGD 607282	
Applicant	**The coverage below is provided by your employer at no cost to you.**
Employee	66.67% of your weekly covered earnings, to a maximum of $1,000 per week.

Step 7 - Long Term Disability - employEE pays

Employee-Paid (Voluntary) Long-term Disability Insurance Policy # VDT 601636		
Applicant		
	Available Coverage	Accept or decline coverage below.
Employee	60% of your monthly covered earnings, to a maximum of $5,000 per month	❑ Accept Coverage ❑ Decline Coverage

***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latest of 01/01/2022, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by NH: Life Insurance Company of North America.

Please Sign Here ☛ Signature _____ Date _____

Created on 04/2022.