

Springpoint Senior Living Services, Inc.

Supplemental Life Insurance Enrollment Form-Newly Eligible Employees

You, the employee, may elect Supplemental Life insurance coverage in **increments of 1,2, or 3 times Your basic annual salary to a maximum of \$300,000**. If you enroll within 31 days of being eligible you can purchase insurance **up to \$80,000 for Yourself, guaranteed without evidence of insurability**. This is a **"one time" offer as a newly eligible employee**. Amounts above these limits, and all future elections, will be subject to evidence of insurability.

You must be actively at work on the effective date of your coverage for this benefit to begin.

This coverage may be continued by applying for **Portability of Coverage** or **Life Insurance Conversion** if you are no longer eligible for this benefit at **Springpoint Senior Living Services, Inc.**

A. Supplemental Employee Life

Employee Rates

These rates are per \$1,000 of coverage on a Bi-Weekly/Payroll Period basis

Age Category	Bi-Weekly Rate	Age Category	Bi-Weekly Rate	Age Category	Bi-Weekly Rate
Under age 30	\$.018	45 to 49	\$.115	65 to 69	\$.697
30 to 34	\$.028	50 to 54	\$.194	70 to 74	\$1.186
35 to 39	\$.042	55 to 59	\$.309	75 & Over	\$2.174
40 to 44	\$.065	60 to 64	\$.448		

Please note: Supplemental Life rates for both employees and their spouse change as their age increases as illustrated in the table above.

	Calculation for Employee	Sample	Actual
	Age	34	
1	Benefit Elected (1,2,3 times salary)	2 times salary	
2	Salary (ex: = \$36,744)	\$36,744	
3	Benefit: multiply #1 by #2 then round to the next higher multiple of \$1,000	\$74,000	
4	Units (divide #3 by \$1,000)	74	
5	Bi-weekly rate per \$1,000	\$.028	
6	Payroll deduction-Multiply #4 times #5	\$2.07	

Check Election	Benefit level	Benefit Amount
	1 times Base Annual Earnings	
	2 times Base Annual Earnings	
	3 times Base Annual Earnings	

Primary Beneficiary:

(1) Beneficiary Name _____
Beneficiary Address _____
Relationship to Employee _____
Percentage of Benefit _____

(2) Beneficiary Name _____
Beneficiary Address _____
Relationship to Employee _____
Percentage of Benefit _____

Contingent Beneficiary:

(1) Beneficiary Name _____
Beneficiary Address _____
Relationship to Employee _____
Percentage of Benefit _____

(2) Beneficiary Name _____
Beneficiary Address _____
Relationship to Employee _____
Percentage of Benefit _____

I understand that by signing this form, I am authorizing the necessary premium deductions from my salary or wages for the coverage I have selected.

X _____
Signature Today's Date SS #

Employee Name: _____ Date of Birth: _____ Date of Hire: _____
Please Print

Employee Address _____ Phone # _____

This is a New Jersey Hospital Association Sponsored Program

Underwritten by: Met Life

The above benefits are a summary description only. Please refer to employee booklet for a full legal description

The Employee must enroll in the Supplemental Life Program in order to elect Supplemental Spouse and/or Dependent Coverage

The employee is the beneficiary for both the spouse and child(ren) coverages.

B. Supplemental Spouse Life:

Your spouse may elect 50% of Your elected amount to a maximum of \$150,000 For this enrollment insurance amounts up to \$25,000 are guaranteed without evidence of insurability. This is a “one time” offer as a newly eligible employee. All future elections will be subject to evidence of insurability.

You, the employee, must be actively at work on the effective date of your coverage for this benefit to begin. **Your spouse** must be able to perform the normal activities of a person of the same age and gender (a spouse who is disabled is NOT eligible). **A spouse does not include anyone who is personally eligible as an employee under this Policy.**

Spouse Rates

These rates are per \$10,000 of coverage on a Bi-Weekly/Payroll Period basis

Age Category	Bi-Weekly Rate	Age Category	Bi-Weekly Rate
Under age 30	\$0.18	50 to 54	\$1.94
30 to 34	\$0.28	55 to 59	\$3.09
35 to 39	\$0.42	60 to 64	\$4.48
40 to 44	\$0.65	65 to 69	\$6.97
45 to 49	\$1.15	70 to 74	\$11.86
		75 & Over	\$21.74

Please note: Supplemental Life rates for both employees and their spouse change as their age Increases as illustrated in the table above.

	Calculation for Spouse	Sample	Actual
	Age	34	
1	Benefit elected for Employee	\$74,000	
2	Benefit for Spouse (50% of the employee elected amount)	\$37,000	
3	Units (divide #2 by \$1,000)	37	
4	Bi-weekly rate per \$1,000	\$.028	
5	Payroll deduction-Multiply #3 times #4	\$1.04	

Spouse Election Amount: _____ **Spouse SS#** _____

Spouse Name: _____ **Spouse DOB:** _____

C. Supplemental Dependent Life:

Your dependent children may be covered as well:

Child(ren) 14 days to 6 months - **\$100**

Child(ren) 6 months to age 19 or age 25 if a FT student- **Increments of \$2,500 to a maximum of \$10,000**

Child(ren) Coverage (one rate covers all of your children)

These rates are on a Bi-Weekly/Payroll Period basis.

Check Election	Benefit	Bi-Weekly Cost
	\$2,500	\$.23
	\$5,000	\$.46
	\$7,500	\$.69
	\$10,000	\$.92
	I do not wish to enroll for Supplemental Dependent Life coverage	

Return completed form to:

**NJHA Corporate Services
PO Box 8738
Princeton, NJ 08543-8738
609-275-4186**