

Life Insurance Benefit Enrollment Form

Return to: benefitforms@stlouiscountymn.gov by internal email only



Enter your information:				
Employer Name: St Louis County			NIS Group Number: 012324	
Full Name (Last name, First name, Middle Initial):			Date of Hire/Date status changed to Full-Time:	
Home Address:		City:	State:	Zip:
Employee ID #: (required)	<input type="checkbox"/> Single <input type="checkbox"/> Married	U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No*	Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation/Title:			Hours worked per week:	

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits: Elect, Decline, or indicate No Change to each Life option below	
<input type="checkbox"/> Elect <input type="checkbox"/> Decline <input type="checkbox"/> No Change	Basic Life Choose your class below. <input type="checkbox"/> St Louis County Employee <input type="checkbox"/> ARC Employee <input type="checkbox"/> CHB Employee Employer paid if full-time, prorated if part-time One times annual salary rounded to the next highest \$1,000 or \$5,000; minimum of \$15,000 to a maximum of \$50,000 or \$200,000. See your labor contract for coverage details.
<input type="checkbox"/> Elect <input type="checkbox"/> Decline <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> No Change	Supplemental Life Amount of requested coverage \$_____ (include any increase/decrease). Choose \$10,000 increments up to \$500,000 or limits below if less. <ul style="list-style-type: none"> • Amounts in excess of \$250,000 or increase over \$10,000 require completion of a medical questionnaire. • Your annual salary x 5 = maximum supplemental life coverage available to you. • Your annual salary x 7 minus basic life coverage = maximum supplemental life coverage available to you.
<input type="checkbox"/> Elect <input type="checkbox"/> Decline <input type="checkbox"/> No Change	Spouse Supplemental Life Amount \$_____ \$5,000 increments to a maximum of the lesser of 50% of the Employee Supplemental Life amount or \$250,000 Amounts in excess of \$30,000 require completion of a medical questionnaire.
<input type="checkbox"/> Elect <input type="checkbox"/> Decline <input type="checkbox"/> No Change	Child Supplemental Life (Choose one) <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000

Sign here (required whether electing or declining any coverage):	
<p>I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.</p> <p>Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.</p>	
Signature:	Date:

Full Name:	Employer Name: St Louis County	Date:
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Rate Table: Employee and Spouse Supplemental Life

Employee and Spouse Age	Rate per \$1,000
0-24	\$0.05
25-29	\$0.06
30-34	\$0.08
35-39	\$0.09
40-44	\$0.12
45-49	\$0.20
50-54	\$0.30
55-59	\$0.51
60-64	\$0.68
65-69	\$1.27
70-74	\$2.06
75-79	\$3.56
80-99	\$5.37

Calculate your Monthly Premium:

1. Write the amount of Employee Supplemental Life coverage you elected into the equation below (above the line stating Coverage Amount).
2. Take that number and divide by 1,000. Enter this into the equation below (above the 2nd line).
3. Select your rate from the table to the left based on age. Enter this into the equation (above the line stating Rate).
4. Multiply the 2nd number you entered into the equation by the Rate. This number represents your **monthly cost**.

Repeat steps 1 – 4 to determine the monthly rate for the Spouse Supplemental Life.

To calculate your Monthly Premium:

$$\frac{\text{Coverage Amount}}{\$1,000} = \text{_____} \times \text{Rate} = \text{Monthly Premium}$$

Child Supplemental Life: Option 1/ \$10,000: \$1.50 per month Option 2/ \$15,000: 2.25 per month Option 3/ \$20,000: \$3.00 per month

Please provide the following information if electing Supplemental Life coverage on your Spouse or Child(ren):

Attach additional pages if necessary.

Full Name	Date of Birth	Full-Time Student?
Spouse:		N/A
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature:	Date:
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Full Name:	Employer Name: St Louis County	Date:
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Enter your Life Insurance beneficiary information:
List the person(s) entitled to receive benefits in the event of your death.

Primary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit

Secondary Beneficiary(ies) Attach additional pages if necessary.

Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit

Spouse's Signature (Required ONLY if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than your spouse may not be honored unless your spouse signs below. Please consult with your legal advisor before making such a designation.)

Spouse's Name:	Signature:	Date:
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Sign Here

Signature:	Date:
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For Employer Use Only:

Annual Salary \$ _____ Coverage Amount \$ _____

Coverage Effective date or Eligibility Date _____

