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.

Return completed form to New York Life Group Benefit Solutions
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Phone: 1-800-732-1603
Fax: 1-800-440-0856

Offered by Life Insurance Company of North America

Employer: Sonoma County Office of Education

ALL ABOUT YOU – THE EMPLOYEE

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 OR DOMESTIC PARTNER*

❑ I am currently married and my date of marriage is: __________ or ❑ I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information

Name ____________ **Social Security #** ____________
Birthdate ____________ Gender ____________

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

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 # FLX 962928		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	$60,000	Guaranteed Coverage*: $60,000

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 962928		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to the lesser of 5 times your salary, or $300,000. Guaranteed Coverage: The lesser of 2 times your salary, or $100,000.	❑ $10,000 ❑ $100,000* ❑ $300,000** ❑ Other ____________ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Units of $5,000 up to $100,000. Guaranteed Coverage: $20,000	❑ $5,000 ❑ $20,000* ❑ $100,000** ❑ Other ____________ *Amount must be a multiple of $5,000.* ❑ Decline Coverage
Child	Units of $2,500 up to $10,000.	❑ $2,500 ❑ $10,000** ❑ Other ____________ *Amount must be a multiple of $2,500.* ❑ Decline Coverage

Employer-Paid (Basic) Accidental Death & Dismemberment Insurance Policy # OK 964593	
Applicant	**The coverage below is provided by your employer at no cost to you.**
Employee	$1,000

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Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

Employee-Paid (Voluntary) Accidental Death & Dismemberment Insurance Policy # OK 964593		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to the lesser of 5 times your salary, or $300,000.	❑ $10,000 ❑ $130,000 ❑ $300,000** ❑ Other ____________________ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Family	Spouse and Children will receive a percentage of the Employee's selected coverage amount. Rates will be higher if you elect Employee & Family coverage.	❑ Accept Coverage ❑ Decline Coverage

Employer-Paid (Basic) Long-term Disability Insurance Policy # LK 961447	
Applicant	**The coverage below is provided by your employer at no cost to you.**
Employee	67% of your monthly covered earnings, to a maximum of $7,000 per month.

***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 CA: Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to long-term disability insurance only): "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Please Sign Here Signature ______________________________ Date ____________________

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren). If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Basic Life Insurance			Policy No. FLX 962928	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Voluntary Life Insurance	Policy No. FLX 962928

Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Basic Accidental Death & Dismemberment Insurance			Policy No. OK 964593	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Voluntary Accidental Death & Dismemberment Insurance			Policy No. OK 964593	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse Signature ______________________ Date ____/____/____

Employee Signature ______________________ Date ____/____/____

Created on 02/2022.

Be sure to make a copy for your records.