BENEFITS & EMPLOYEE WELLNESS

Life, Accidental Death & Dismemberment, and Disability Benefits Enrollment Form *(through The Hartford)*

★ **Submit completed PAGES 1 – 3 of this FORM to Benefits & Employee Wellness via Secure Document Upload *at https://hr.unm.edu/secure-upload* or Fax to 505-277-2278 within 60 calendar days of the date of your newly benefits-eligible position or your Qualifying Change in Status Event.**

★ **Proof of Enrollment - Save your Upload Successful page or your successful Fax transmission confirmation page.**

Incomplete Form or late enrollments/changes will NOT be accepted.

EMPLOYEE INFORMATION

Name (FIRST MI LAST)	**UNM Banner ID (**Employee ID- 9 digits)	**Date of Birth**

Date of Hire	**Phone**	**Preferred Email**

Group Policy Number 681589	**Employee Coverage Classifications:**	**Class 1** -School of Medicine Faculty **Class 2** -President, Executive Vice President, Executive Staff, Executive Faculty **Class 3** -All Other Active Faculty and Staff Employees

DEPENDENT INFORMATION *(Additional children may be listed on separate paper and attached to/submitted with this form)*

Spouse/Domestic Partner Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Date Married/Partnered**

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**

VOLUNTARY SHORT TERM DISABILITY (STD) INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Elect or Continue Coverage**	**Decline or Cancel Coverage**
Employee STD	60% of earnings, up to $850 each week	☐	☐

VOLUNTARY LONG TERM DISABILITY (LTD) INSURANCE

Coverage for Employee Only	**Benefit Amount** *(Max will apply based on the Class category in which your employment falls)*	**Elect or Continue Coverage**	**Decline/Cancel Coverage**
Employee LTD	Class 1 - 60% of earnings, up to $15,000 each month Class 2 - 60% of earnings, up to $15,000 each month Class 3 - 60% of earnings, up to $5,000 each month	☐	☐

BASIC TERM LIFE INSURANCE			
Coverage for Employee Only	**Benefit Amount** *(Max will apply based on the Class category in which your employment falls)*	**Elect or Continue Coverage**	**Decline or Cancel Coverage**
Employee Basic Term Life	Class 1 - 1 x annual salary, up to $230,000 Class 2 - 1 x annual salary, up to $150,000 Class 3 - 1 x annual salary, up to $150,000	☐	☐

SUPPLEMENTAL TERM LIFE INSURANCE *(Select One Option for Employee, Spouse/Domestic Partner and Child Life)*

You must enroll in Basic Term Life Coverage in order for you and your dependents to be eligible for this coverage.

Coverage for Employee Only	Benefit Amount	*Elect Coverage:*
Employee Supplemental Life *Elect in increments of 1x Annual Salary up to a max of the lesser of 5x annual salary or $1,850,000* **As a Newly Benefits Eligible Employee - Guaranteed Issue (GI) offered up to 3x annual salary. (with a GI cap of $1,000,000)*	**Elect Coverage in increments of 1x, 2x, 3x, 4x or 5x annual salary**, up to a max of $1,850,000 *Amounts above Guaranteed Issue will require Evidence of Insurability (EOI) and you will be contacted by The Hartford directly via email or letter with instructions to complete EOI for medical underwriting review and approval.	*Write in 1x, 2x, 3x, 4x or 5x:* _____**X Annual Salary**
	Decline Employee Supplemental Life Coverage	☐ Decline or Cancel
Spouse/ Domestic Partner Life *As a Newly Benefits Eligible Employee - Guaranteed Issue offered up to $50,000 (Cap is $100,000)*	**Elect Coverage Level in units of $10,000 up to $100,000** *Amounts above Guaranteed Issue will require Evidence of Insurability (EOI) and you will be contacted by The Hartford directly via email or letter with instructions to complete EOI for medical underwriting review and approval.	*Write in Coverage Level electing here (Example, $50,000):* $_____
	Decline Spouse/Partner Life Coverage	☐ Decline or Cancel
Child Life Must be 6 months of age or older and less than age 26. One monthly rate applies regardless of number of children covered	**$10,000 of coverage per eligible child** No EOI Required.	☐ **$0.15 per Month** *(Divide by 2 for Biweekly)*
	Decline Child(ren) Life Coverage	☐ Decline or Cancel

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Coverage for Employee & Dependent(s)	Benefit Amount	Elect Coverage Option and Amount
AD&D *As a Newly Benefits Eligible Employee or during Open Enrollment only- Guaranteed Issue offered*	**Elect Coverage Level in units of $10,000 increments up to $600,000** Must elect option of Employee or Family Coverage and Coverage Level amount No EOI is required	☐ Employee or ☐ Family
		Write in coverage amount *(Example: $300,000)* $_____
	Decline Accidental Death & Dismemberment Coverage	☐ Decline or Cancel

Employee Certification

By signing below:

- **I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.**
- **I understand and agree that: 1) If I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) Only the insurance policy(ies) issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy; 6) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 7) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.**
- **I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.**
- **If you knowingly make a false statement on your Enrollment Application, or file a false claim, such application or claim may be retroactively rescinded to the date of the application or claim. Any premiums collected from the Participant for coverage that is later revoked due to a fraudulent application may be refunded to the Participant by the Plan. If a claim is paid by the Plan and it is later determined that the claim should not have been paid due to a fraudulent application or claim, the Participant may be responsible for full reimbursement of the claim amount to UNM.**
- **I understand that my signature authorizes the University of New Mexico to make any necessary deductions from my pay through payroll deduction. I understand and accept that if I fail to pay my account the University may refer my delinquent account to a collection agency. I further understand that I am responsible for paying the collection agency fee which may be based on percentage, at a maximum of 40% of my delinquent account, together with all costs and expenses, including reasonable attorney's fees, necessary of the collection of my delinquent account. Finally, I understand that my delinquent account may be reported to one or more of the national credit reporting bureaus.**

*** IF UPLOADING ELECTRONICALLY TO HR'S SECURE DOCUMENT UPLOAD SITE, MY TYPED-IN NAME BELOW SERVES AS MY SIGNATURE.**
*** SIGNATURE IS REQUIRED IF PROVIDING PAPER FORM VIA FAX or MAIL.**

***Signature**_____ **Date:** _____ **UNM Banner ID** _____

It is your responsibility to review your **Benefits Statement in LoboWeb** and your benefit deductions. Report any issues or discrepancies to hrbenefits@unm.edu.

BENEFITS OFFICE USE ONLY

BCAT: _____ Benefits Rep Initials _____

Uploaded/Received on_____ Deduction starts: _____

UNM Life, Accidental Death and Dismemberment (AD&D) and Disability Monthly Rates

Effective since July 1, 2019

Employee Basic Life:

	Monthly Rate per $1,000
Class 1	$0.0870
Class 2	$0.0870
Class 3	$0.0870

Supplemental Voluntary Life (Classes 1, 2 & 3)

Employee Life : Age	Monthly Rate per $1,000	Spouse/ Domestic Partner Life: Age	Monthly Rate per $1,000
< 25	$0.036	< 25	$0.0251
25-29	$0.036	25-29	$0.0251
30-34	$0.046	30-34	$0.0330
35-39	$0.046	35-39	$0.0495
40-44	$0.079	40-44	$0.0746
45-49	$0.117	45-49	$0.1154
50-54	$0.181	50-54	$0.1978
55-59	$0.287	55-59	$0.3548
60-64	$0.439	60-64	$0.5691
65-69	$0.715	65-69	$0.8823
70-74	$1.297	70-74	$0.8823
75+	$1.297	75+	$0.8823

Child Life:

Age	Monthly Rate per $10,000
All eligible dependent children between ages 6 months and 25:	.15

Supplemental AD&D:

Classes 1, 2 & 3	Monthly Rate per $1,000
Employee:	$0.012
Employee + Family:	$0.020

Short Term Disability:

	Monthly Rate per $100
Classes 1, 2 & 3	$0.1650

Long Term Disability:

	Monthly Rate per $100
Class 1	$0.3000
Class 2	$0.3000
Class 3	$0.1500

Calculate Your Estimated Premiums

(See Rates on Page 4)

Do not submit this Calculation Sheet to the Benefits Office - it is for your use only

VOLUNTARY SHORT-TERM DISABILITY (STD) INSURANCE

(100% Employee Paid)

Estimated Monthly Premium $_____ / 100 = $_____ x $ .165 = $_____ *(Divide by 2 for Biweekly)*
Monthly Salary Premium

Additional Information: Your benefit amount is based on your salary, therefore your benefit and premium amount will change as your salary changes.

VOLUNTARY LONG-TERM DISABILITY (LTD) INSURANCE

(UNM pays a portion of this premium– Premium calculation below does not reflect UNM contribution towards Premium)

Class 1 & 2 Estimated Monthly Premium $_____ / 100 = $_____ x $0.30 = $_____ *(Divide by 2 for Biweekly)*
Monthly Salary Premium

Class 3 Estimated Monthly Premium $_____ / 100 = $_____ x $0.15 = $_____ *(Divide by 2 for Biweekly)*
Monthly Salary Premium

Additional Information: Your benefit amount is based on your salary, therefore your benefit and premium amount will change as your salary changes.

BASIC TERM LIFE INSURANCE

(UNM pays a portion of this premium– Premium calculation below does not reflect UNM contribution towards Premium)

Term Life Insurance (100% of annual salary rounded up to nearest $1,000; minimum of $25,000)

Estimated Monthly Basic Life: $_____ / $1,000 = $_____ x $.087 = $_____ *(Divide by 2 for Biweekly)*
Annual Salary Premium

Additional Information: The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 70.

EMPLOYEE SUPPLEMENTAL TERM LIFE INSURANCE

(100% Employee Paid)

Employee Life Insurance *(100% of annual salary rounded up to nearest $1,000)*

Estimated Monthly Employee Supplemental Life:
$_____ x 1, 2, 3, 4 or 5 = $_____ / $1,000 = $_____ x $_____ = $_____ *(Divide by 2 for Biweekly)*
Annual Salary Coverage Amount Rate Premium

Additional Information: The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 70. The premium amount(s) for you are based on your (employee) age; therefore, the premium amount(s) will change as you grow older.

Spouse/ Domestic Partner Life

(100% Employee Paid)

Estimated Monthly Spouse/Domestic Partner Life: *(Elect in units of $10,000, maximum of $100,000; minimum of $10,000)*

$_____ / 1000 = $_____ x $_____ = $_____ *(Divide by 2 for Biweekly)*
Spouse//DP Coverage Rate Premium

Additional Information: The premium amount(s) for your spouse/partner are based on age; therefore, the premium amount(s) will change as your spouse/domestic partner ages. The benefit amount available to your spouse/domestic partner under this plan is subject to reduction at spouse/domestic partner age 65, and cancellation at age 70.

Child Life

(100% Employee Paid)

Monthly Child Life Premium: $ 0.15 *(Divide by 2 for Biweekly)*

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

(100% Employee Paid)

Estimated Monthly Accidental Death & Dismemberment: (Elect in units of $10,000, maximum of $600,000; minimum of $10,000)

$_____ / 1000 = $_____ x _____ = $_____ *(Divide by 2 for Biweekly)*
Coverage Amount Rate Premium

(Use Employee or Employee + Family Rate)

Additional Information: The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 70.