# Life, Accidental Death & Dismemberment, and Disability Benefits Enrollment Form for University of New Mexico *(through The Hartford)*

**Instructions: 1)** Print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Review the applicable benefit information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable Class group policy. **3)** For each coverage, check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Sign and date the form. **5) Submit your form to the UNM HR Service Center in-person at 1700 Lomas Blvd NE, Suite 1400 or fax to 505-277-2278 by the enrollment deadline for processing**.

## EMPLOYEE INFORMATION

| **Name** (FIRST MI LAST) | **UNM Banner ID (**Employee ID- 9 digits) | **Date of Birth** (MM/DD/YYYY) |
|---|---|---|
| | | |

**Date of Hire** (MM/DD/YYYY)

| **Group Policy Number** | **Employee Coverage Classifications:** | |
|---|---|---|
| 681589 | | **Class 1** -School of Medicine Faculty<br>**Class 2** -President, Executive Vice President, Executive Staff, Executive Faculty<br>**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** M F | **Date Married/Partnered** |
|---|---|---|---|
| | | | |

| **Child Name** (FIRST MI LAST) | **Date of Birth** | **Gender** | **Child Name** (FIRST MI LAST) | **Date of Birth** | **Gender** |
|---|---|---|---|---|---|
| | | M F | | | M F |
| | | M F | | | M F |

## 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 | ☐ | ☐ |

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

**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

| **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<br>Class 2 - 60% of earnings, up to $15,000 each month<br>Class 3 - 60% of earnings, up to $5,000 each month | ☐ | ☐ |

**Class 1 & 2 Estimated Monthly Premium** $_____ (Monthly Salary) / 100 = _____ (Units) x $0.30 = $_____ (Premium) *(Divide by 2 for Biweekly; Does not include UNM contribution towards premium)*

**Class 3 Estimated Monthly Premium** $_____ (Monthly Salary) / 100 = _____ (Units) x $0.15 = $_____ (Premium) *(Divide by 2 for Biweekly; Does not include UNM contribution towards 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

| 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<br>Class 2 - 1 x annual salary, up to $150,000<br>Class 3 - 1 x annual salary, up to $150,000 | ☐ | ☐ |

**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; Does not include UNM contribution towards premium)*
(Annual Salary; Units; Premium)

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

## 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**<br>*Elect in increments of 1x Annual Salary up to a max of the lesser of 5x annual salary or $1,850,000*<br>**As a Newly Benefits Eligible Employee or during 2019 Open Enrollment only- 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<br>*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:*<br>_____**X Annual Salary** |
| | **Decline Employee Supplemental Life Coverage** | ☐ Decline or Cancel |

**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; Units; 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**<br>*As a Newly Benefits Eligible Employee or during 2019 Open Enrollment only - Guaranteed Issue offered up to $50,000 (Cap is $100,000)* | **Elect Coverage Level in units of $10,000 up to $100,000**<br>*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, $50,000):*<br>$_____ |
| | **Decline Spouse/Partner Life Coverage** | ☐ Decline or Cancel |

**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; Units; 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.

| | | |
|---|---|---|
| **Child Life**<br>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**<br>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**<br>*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**<br>Must elect option of Employee or Family Coverage and Coverage Level amount<br>No EOI is required | ☐ Employee<br>or<br>☐ Family |
| | | Write in coverage amount<br>*(Example: $300,000)*<br>$_____ |
| | **Decline Accidental Death & Dismemberment Coverage** | ☐ Decline or Cancel |

**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 — Units — 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.

## 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.**

**Signature**_____ **Date:** _____

It is your responsibility to review your **Benefits Statement in LoboWeb** and your benefit deductions. Report any issues or discrepancies to 277-MyHR (6947).

| HR SERVICE CENTER USE ONLY | HR BENEFITS USE ONLY |
|---|---|
| HR Service Rep Initials: _____<br>Form Complete: ☐ Yes ☐ No<br>If no, reason: _____ | Appt %: _____ BCAT: _____<br>Annualized Salary: ☐<35 ☐ 35-50 ☐ >50<br>Deduction starts: _____ |

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

## Effective 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 |