# GOPB Head Start Interest Form for Supplemental Benefits
# All rates are listed per deduction (24, Semi-monthly)

***Question should be directed to your Colonial Life Representative:***
***Ginny Clark – 214.223.9158 phone – 214.206.9010 fax – gclarkatwork@yahoo.com***

***PLEASE PRINT CLEARLY***

| Employee First Name | Initial | Employee Last Name | Date of Birth | Sex |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip Code | Social Security Number |
|---|---|---|---|---|
| | | | | |

| Email Address | Date of Hire | Phone Number | Job Title |
|---|---|---|---|
| | | | |

Are you or any person applying for coverage Medicare eligible? ☐ Yes ☐ No

**ACCIDENT INSURANCE:** ☐ Add/Change ☐ Decline/Cancel

Preferred On/Off-Job Coverage. $125 initial ER/Urgent Care/Dr. Office visit per covered accident, $1,000 per covered Hospital Confinement ($2,000 for ICU), $225 Daily Hospital Confinement benefit, payouts for broken bones, surgeries, therapy and more. Includes a $25,000 accidental death policy. $50 wellness benefit.

| Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|
| ☐ $10.58 | ☐ $14.49 | ☐ $16.34 | ☐ $20.24 |

*COMPLETE DEPENDENT INFORMATION ON LAST PAGE IF ELECTING DEPENDENT COVERAGE - - COMPLETE BENEFICIARY DESIGNATION ON LAST PAGE*

**DISABILITY INSURANCE:** ☐ Add/Change ☐ Decline/Cancel

Pays out up to 60% of your monthly earnings when you can't be at work due to an illness, injury, or giving birth.

| 3 month Benefit Period | Employee Age | $800 Monthly Benefit | $1000 Monthly Benefit | $1200 Monthly Benefit | $1500 Monthly Benefit | $2000 Monthly Benefit |
|---|---|---|---|---|---|---|
| 0 day Accident/ 7 day sickness elimination | 17-49 | ☐ $12.76 | ☐ $15.95 | ☐ $19.14 | ☐ $23.93 | ☐ $31.90 |
| | 50-64 | ☐ $15.60 | ☐ $19.50 | ☐ $23.40 | ☐ $29.25 | ☐ $39.00 |
| | 65-74 | ☐ $18.88 | ☐ $23.60 | ☐ $28.32 | ☐ $35.40 | ☐ $47.20 |

**HOSPITAL CONFINEMENT GAP INSURANCE:** ☐ Add/Change ☐ Decline/Cancel

$1000 Hospital Confinement Benefit and up to $1500 Outpatient Surgical Benefit per calendar year per covered person, $100 Observation Room benefit (less than 20 hours) up to maximum of 2 visits per calendar year per person (not payable same day Confinement Benefit or Outpatient Surgical benefit), $100 Daily Hospital Confinement Benefit (up to one year), $100 Rehab Unit Benefit (up to 15 days). Includes $50 wellness benefit.

| Age | Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|---|
| 17-49 | ☐ $13.78 | ☐ $25.93 | ☐ $18.88 | ☐ $31.03 |
| 50-59 | ☐ $18.63 | ☐ $35.14 | ☐ $23.73 | ☐ $40.24 |
| 60-64 | ☐ $25.50 | ☐ $48.21 | ☐ $30.60 | ☐ $53.31 |
| 65-74 | ☐ $33.20 | ☐ $62.80 | ☐ $38.30 | ☐ $67.90 |

*We will not pay benefits for hospital confinement due to giving birth within the first 9 months after the effective date of this policy. Pre-existing conditions for which you have been treated, had medical testing, received medical advice or taken medication within the past 12 months will not be covered for 12 months.*

☐ Yes ☐ No **Do you certify that you are currently covered by health insurance that qualifies as minimum essential coverage as defined by federal law?**

☐ Yes ☐ No **Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment from a member of the medical profession for AIDS or AIDS related complex (ARC)?**

☐ Yes ☐ No If adding Spouse coverage, answer as applies to Spouse

☐ Yes ☐ No If adding Child(ren) coverage, answer as applies to Child(ren)

☐ Yes ☐ No **Within the past 12 months, other than colds, flu or normal pregnancy, has you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle?**

☐ Yes ☐ No If adding Spouse coverage, answer as applies to Spouse

☐ Yes ☐ No **Within the past 12 months, have you received medical advice/ sought treatment (including medication) for heart attack/surgery, congestive heart failure, stroke, transient ischemic attack, blood pressure reading of 160/100 +, kidney disease (except stones), insulin dependent diabetes, diabetes diagnosed prior to age 40, cancer other than skin cancer, hepatitis B or C, cirrhosis, Hodgkin's disease, leukemia?**

☐ Yes ☐ No If adding Spouse coverage, answer as applies to Spouse

☐ Yes ☐ No If adding Child(ren) coverage: Within the past 12 months, has any dependent been hospitalized for respiratory disorders including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer), or seizures?

*COMPLETE DEPENDENT INFORMATION ON LAST PAGE IF ELECTING DEPENDENT COVERAGE*

**CANCER ASSIST INSURANCE (Level 3 example):** ☐ Add/Change ☐ Decline/Cancel

Hospital Confinement - $250 per day up to 30 days, 31+ days $500 per day; Radiation/ Chemotherapy $750 per week, Experimental Treatments $300 per day, Transportation (up to $1200 round trip), Lodging benefits ($75 per day up to 70 days per calendar year), Surgery benefits, Nursing benefits and more. Includes $75 wellness benefit. *Waiting Period: Benefits will not be payable if Cancer is diagnosed within the first 30 days from the coverage effective date.*

| Employee Only | Employee + Spouse | Employee + Children | Employee + Family |
|---|---|---|---|
| ☐ $12.38 | ☐ $20.73 | ☐ $12.60 | ☐ $20.95 |

☐ Yes ☐ No **Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment from a member of the medical profession for AIDS or AIDS related complex (ARC)?**

☐ Yes ☐ No If adding Spouse coverage, answer as applies to Spouse

☐ Yes ☐ No If adding Child(ren) coverage, answer as applies to Child(ren)

☐ Yes ☐ No **Have you ever been diagnosed with, or treated for Cancer of any type or form?**

☐ Yes ☐ No If adding Spouse coverage, answer as applies to Spouse

☐ Yes ☐ No If adding Child(ren) coverage, answer as applies to Child(ren)

*COMPLETE DEPENDENT INFORMATION ON LAST PAGE IF ELECTING DEPENDENT COVERAGE - - COMPLETE BENEFICIARY DESIGNATION ON LAST PAGE*

**CRITICAL ILLNESS INSURANCE** ☐ Add/Change ☐ Decline/Cancel

$15,000 Lump-sum benefit payable upon diagnosis of Heart Attack, Stroke, Permanent Paralysis due to a Covered Accident, Coma, Major Organ Failure, End Stage Renal Failure, Occupational Infection HIV or Hepatitis B, C, or D, Blindness, and Coronary Artery Bypass Graft Surgery. May payout up to 3x. Includes $50 wellness benefit.

***Employee coverage - $15,000; Spouse coverage - $7,500; Dependent Coverage - $3,750. 12/12 Pre-existing condition exclusion applies.***

| | Employee Only | | Employee & Spouse | | Employee & Children | | Employee & Family | |
|---|---|---|---|---|---|---|---|---|
| Issue Age | Non-tobacco | Tobacco | Non-tobacco | Tobacco | Non-tobacco | Tobacco | Non-tobacco | Tobacco |
| 17-24 | ☐ $2.88 | ☐$3.63 | ☐$4.35 | ☐$5.55 | ☐$2.88 | ☐$3.63 | ☐$4.35 | ☐$5.55 |
| 25-29 | ☐ $3.48 | ☐$4.68 | ☐$5.33 | ☐$7.20 | ☐$3.48 | ☐$4.68 | ☐$5.33 | ☐$7.20 |
| 30-34 | ☐ $4.23 | ☐$6.26 | ☐$6.53 | ☐$9.68 | ☐$4.23 | ☐$6.26 | ☐$6.53 | ☐$9.68 |
| 35-39 | ☐ $6.41 | ☐$9.33 | ☐$9.83 | ☐$14.25 | ☐$6.41 | ☐$9.33 | ☐$9.83 | ☐$14.25 |
| 40-44 | ☐ $7.68 | ☐$12.18 | ☐$11.78 | ☐$18.68 | ☐$7.68 | ☐$12.18 | ☐$11.78 | ☐$18.68 |
| 45-49 | ☐$10.23 | ☐$15.93 | ☐$15.75 | ☐$24.45 | ☐$10.23 | ☐$15.93 | ☐$15.75 | ☐$24.45 |
| 50-54 | ☐$13.68 | ☐$20.81 | ☐$21.08 | ☐$31.95 | ☐$13.68 | ☐$20.81 | ☐$21.08 | ☐$31.95 |
| 55-59 | ☐$17.21 | ☐$26.88 | ☐$26.40 | ☐$41.25 | ☐$17.21 | ☐$26.88 | ☐$26.40 | ☐$41.25 |
| 60-64 | ☐$22.01 | ☐$33.18 | ☐$33.83 | ☐$50.93 | ☐$22.01 | ☐$33.18 | ☐$33.83 | ☐$50.93 |
| 65-70 | ☐$26.73 | ☐$40.61 | ☐$41.03 | ☐$62.40 | ☐$26.73 | ☐$40.61 | ☐$41.03 | ☐$62.40 |

☐ Yes ☐ No **Within the last 12 months, has the proposed insured used any tobacco products?**

☐ Yes ☐ No **Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment from a member of the medical profession for AIDS or AIDS related complex (ARC)?**

☐ Yes ☐ No If adding Spouse coverage, answer as applies to Spouse

☐ Yes ☐ No If adding Child(ren) coverage, answer as applies to Child(ren)

☐ Yes ☐ No **In the past 10 years, has the proposed insured been diagnosed with or sought medical treatment for: heart attack , heart surgery, heart disease, emphysema, organ transplant, congestive heart failure, diabetes, stroke, hepatitis B or C, blood pressure reading of 160/100 or above, kidney disease except stones, COPD, cirrhosis or liver disease, transient ischemic attack, cancer other than skin cancer, abnormal catherization?**

☐ Yes ☐ No If adding Spouse coverage, answer as applies to Spouse

☐ Yes ☐ No If adding Child(ren) coverage, answer as applies to Child(ren)

*COMPLETE DEPENDENT INFORMATION BELOW IF ELECTING DEPENDENT COVERAGE - - COMPLETE BENEFICIARY DESIGNATION BELOW*

**WHOLE LIFE INSURANCE -** ☐ **CONTACT ME FOR SPECIFIC RATES FOR ME AND/OR FAMILY AT PHONE NUMBER** _____

Provides life-long protection for you and those who depend on you. Fixed benefit amount that is paid off at 95 years of age. Guaranteed cash value that allows for policy loans. Rates remain level. Premiums are estimates within the 10 year age range – rates may vary based on actual age. Other benefit amounts available upon request.

| | $10,000 | | $15,000 | | $25,000 | | $75,000 | | $100,000 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Issue Age | Non-tobacco | Tobacco | Non-tobacco | Tobacco | Non-tobacco | Tobacco | Non-tobacco | Tobacco | Non-tobacco | Tobacco |
| 25 | $5.01 | $6.50 | $6.77 | $9.00 | $10.28 | $13.99 | $25.06 | $32.60 | $32.92 | $42.96 |
| 35 | $6.91 | $9.45 | $9.61 | $13.42 | $15.01 | $21.37 | $38.66 | $49.94 | $51.04 | $66.08 |
| 45 | $10.12 | $13.58 | $14.43 | $19.62 | $23.04 | $31.70 | $60.81 | $80.00 | $80.58 | $106.16 |
| 55 | $16.42 | $24.15 | $23.88 | $35.48 | $38.79 | $58.13 | $96.62 | $132.18 | $128.33 | $175.75 |
| 65 | $29.58 | $44.16 | $43.62 | $65.49 | $71.70 | $108.14 | $160.75 | $213.08 | $213.83 | $283.53 |

## DEPENDENT SECTION

| Spouse First, Middle Initial, Last Name<br><br>☐ Yes ☐ No Is Spouse Disabled or unable to work | Sex<br>☐ Male ☐ Female | Date of Birth<br>(mm/dd/yyyy) |
|---|---|---|
| Number of Children under age 26 to be covered _____ | | |

## BENEFICIARY DESIGNATION

| Primary Beneficiary 1 First, Middle Initial, Last Name | Relationship to Employee | Date of Birth | Percent<br>% |
|---|---|---|---|
| Primary Beneficiary 2 | | | % |
| Contingent Beneficiary | | | % |

***Unless you otherwise request, the employee named above will be the beneficiary of any spouse and child(ren) insurance applied for. If no one is named above, proceeds will be payable to the Estate of the insured.***

I verify that the information provided in this enrollment form is accurate and complete. I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that the plans are covered under the Cafeteria Plan, and I will not be able to change my election during the Plan Year except during the annual Open Enrollment period, or within 30 days of a qualifying event.

_____ _____

**Employee Signature** **Date**