



LifeMap Assurance Company
100 SW Market Street
P.O. Box 1271, MS E8L
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

Employee Enrollment and Change Form with Beneficiary Designation

For residents of Oregon and Washington, the definition of a Spouse includes your legal husband or wife or your State Certified/Registered Domestic Partner. Please contact your employer for any additional eligibility requirements.

For residents of Alaska, Idaho, Utah, Montana and Wyoming, the definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

Please print in blue or black ink; complete all information requested.

Employer Name Jefferson County School District #251		Group Number ID039101	Occupation
<input type="checkbox"/> New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____		<input type="checkbox"/> Change of Existing Enrollment	
Employee's Name (Last, First MI)	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Do you have dependents? (Spouse or Children) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, do you wish to enroll them in Dependent Life Insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Available To Your Group)			

Check one and sign below: (If Employer pays 100% of the premium for this coverage, please skip this section.)

☐ **I HEREBY APPLY FOR ENROLLMENT** with LifeMap Assurance Company under the Group Insurance Plan of the Employer named above. I understand this will not be in force until my return to full time employment should I not be actively at work (i.e., leave of absence, sick leave) on my effective date. I authorize the Employer named above to withhold insurance premiums, if required, from my paycheck and to pay them directly to LifeMap Assurance Company.

☐ **I DO NOT WISH TO APPLY** with LifeMap Assurance Company for the Group Insurance Plan available to me. The benefits of the Plan have been thoroughly explained to me, and I decline to participate. I fully understand that I cannot enroll in the future except by providing evidence of insurability to LifeMap Assurance Company and that I am forfeiting any employer contribution for this program.

ALL PERSONS ENROLLING IN LIFE COVERAGE SHOULD COMPLETE THIS SECTION

Please See Page 2 For Instructions For Completing Your Beneficiary Designation. If you wish to name additional beneficiaries, please attach a separate piece of paper with all of the necessary information, including the date and your signature.

Primary Beneficiary (Last, First MI)	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You	Benefit %	
Primary Beneficiary (Last, First MI)	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You	Benefit %	

If Primary Beneficiary(ies) dies before you, the benefit will be paid to your Contingent Beneficiary(ies).

Contingent Beneficiary (Last, First MI)	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You	Benefit %	

Sign, date and return this form to your Benefits Administrator.

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.
I acknowledge that I have read the fraud notice on page 3 of this form.

Employee Signature _____		Date _____	
Employer: Please complete this section if using this form for benefit enrollment.			
Group No.	Effective Date	Class	Dept
Salary \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Annual		<input type="checkbox"/> Monthly <input type="checkbox"/> Other



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Instructions for Completing Your Beneficiary Designation

The Primary Beneficiary receives the Life and AD&D proceeds upon your death. You may have more than one Primary Beneficiary. If so, please provide their full names, dates of birth, Social Security numbers, addresses, and the percentage of proceeds you would like each Primary Beneficiary to receive. The Contingent Beneficiary receives proceeds only if the Primary Beneficiary(ies) dies before you. Please provide their full name, date of birth, Social Security number and address. Examples follow:

- | | | |
|----|---|---|
| A. | One Primary Beneficiary | Mary R. Jones – 100%
(list information) |
| B. | Two or more Primary Beneficiaries | 50% to John Jones and 50% to Sally Smith
(list information for both.) |
| C. | Two or more Primary Beneficiaries in Unequal Shares | 75% to John Jones and 25% to Sally Smith
(list information for both) |
| D. | One Primary and Contingent Beneficiary | 100% to Mary R. Jones, if living, otherwise to Sally Smith
(list information for both) |
| E. | Trustee | Mary R. Jones, Trustee, under trust agreement dated _____ |
| F. | Insured's Estate | My Estate |

Under items B. and C. above, if one of the Primary Beneficiaries dies before you, 100% of the proceeds will go to the living Primary Beneficiary(ies).

Do you know that if death occurs and a minor (a person not of legal age) is the beneficiary, it may be necessary to have a Guardian of the Estate of the minor, or a Conservator for the minor appointed before any death benefit can be paid? This means legal expenses for the beneficiary and delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.



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Insurance Fraud Notice

Unless specific state language is provided below, the following fraud notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Arkansas, Louisiana, New Mexico, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.



Basic Life and AD&D Insurance

For Jefferson County School District - Actives

How the Plan Works

Life is full of many twists and turns. LifeMap Basic Life and AD&D coverage protects your family's future, no matter what life may throw your way.

- **Eligibility Requirement**
If you are a full-time active employee working a minimum of 20 hours per week, you will be covered with these benefits.
- **Who pays for the coverage?**
Life and AD&D Insurance premiums are paid for by your employer. Dependent Life insurance premiums are paid for by you.
- **Dependent Eligibility Requirement**
Dependents must be a Legal Spouse, and/or child(ren) up to age 26 of the covered employee to be eligible for coverage.
- **Guarantee Issue**
With no questions asked, you will be covered for up to \$50,000 in Basic Life and AD&D Insurance.

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Benefits Summary

Plan Benefits

Employee Life Insurance	\$50,000
Employee AD&D Insurance	\$50,000
Dependent Life Insurance	Spouse \$10,000 Child(ren): \$5,000

Guarantee Issue Amount

Employee	\$50,000
Spouse	\$10,000
Dependent Child(ren)	\$5,000

Plan Features

Accelerated Benefit	A covered employee who is diagnosed as terminally ill may receive a portion of the life insurance benefit before death. Remaining benefits are reserved for the member's beneficiary.
Conversion	Option of converting to an individual life policy, without proof of insurability, within 31 days of termination.
Portability	You may elect to port your Voluntary Life insurance to continue your coverage under the group policy. If elected, portability coverage will end the earliest of when you reach age 65 or when this master policy terminates.
Waiver of Premium	Life coverage continued without payment of premium if insured becomes totally disabled (proof of disability required). Coverage may be continued up to age 65.

Reduction Schedule

If you are still working the required number of hours to be eligible for this insurance at age 65, your benefits will reduce to 65% at age 65, to 40% at age 70, and to 25% at age 75.

Accidental Death & Dismemberment

If due to an accident you die, lose a limb, sight of an eye or become paralyzed, benefits are available.

AD&D Benefits Included

- | | |
|---------------------------------|------------------------------|
| • Adaptive Home/Vehicle Benefit | • Coma |
| • Rehab Benefit | • Day Care |
| • Air Bag and Seat Belt | • Exposure and Disappearance |
| • Spouse and Child Education | • Felonious Assault |

This summary is provided for your convenience only and is not intended to be inclusive of all policy provisions. Please see your certificate for complete details. If there is any discrepancy between this summary and the master policy, master policy provisions will prevail.



Insurance for every step of life.

Additional Benefits

- **Travel Assistance**
When traveling 100 or more miles away from home, or outside of your home country, you can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world.
- **Repatriation**
If death occurs more than 100 miles from your primary residence, a benefit may be payable to prepare and ship your body to the place of burial or cremation.
- **Seat Belt**
If you die in an automobile accident and were wearing your seat belt, your beneficiary(ies) will collect an amount equal to the AD&D benefit to a maximum of \$50,000 in addition to the Basic Life and Basic AD&D benefits described above.

Limitations & Exclusions

- **Life:** No restrictions or exclusions regarding time, place or circumstances of death.
- **AD&D** benefits are not payable for death or dismemberment caused by or as result of:
 - suicide or such attempts;
 - participation in a riot;
 - war or act of war;
 - military service for any country;
 - committing or attempting to commit an assault or felony;
 - sickness, disease or pregnancy or any medical treatment for sickness, disease or pregnancy;
 - heart attack or stroke;
 - bodily infirmity or disease from bacterial or viral infections not the result of an injury; or
 - taking medications, drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed and used/consumed in accordance with the directions of the prescribing physician or administered by a licensed physician.
 - travel, flight in or descent from any aircraft, including balloons and gliders, except as a fare-paying passenger on a regularly scheduled flight;
 - the insured Employee's intoxication

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