

# MOUNT HOLYOKE<sup>SM</sup>

## Group Life Insurance and Long Term Disability Election Form

Name:	Dept.:	Social Security No.:
Date of Hire:	Date of Birth:	Annual Salary:
Effective Date:	Payroll:	Billing Division:

If you are interested in purchasing additional voluntary life/accidental death and dismemberment insurance and/or the additional long term disability insurance, **please check the appropriate options.** **You will automatically be enrolled in the MHC Core Benefit.**

Life/Accidental Death and Dismemberment

Option A 1 X Salary (Min. \$15,000 - Max. \$25,000) Coverage Amt.: \$ \_\_\_\_\_ Cost: MHC Core Benefit

Voluntary Life/Accidental Death and Dismemberment

Option B 1 X Salary (Max. \$25,000) Coverage Amt.: \$ \_\_\_\_\_ Cost: \$ \_\_\_\_\_

Beneficiary Designation

Primary Full Name	% of Benefit	Address	Social Security #	Relationship
_____	_____	_____	____-____-____	_____
_____	_____	_____	____-____-____	_____
Contingent Full Name	% of Benefit	Address	Social Security #	Relationship
_____	_____	_____	____-____-____	_____
_____	_____	_____	____-____-____	_____



Long Term Disability

Plan 1 40% to a maximum of \$6,666/month Cost: MHC Core Benefit  
 Plan 2-Option A 50% to a maximum of \$8,333/month Cost: \$ \_\_\_\_\_  
 Plan 2-Option B 60% to a maximum of \$10,000/month Cost: \$ \_\_\_\_\_  
 Plan 2-Option C 66 2/3% to a maximum of \$12,000/month Cost: \$ \_\_\_\_\_



Delayed Effective Date: Insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective.

Any increased or additional insurance will be delayed if the employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective.

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline any of the above coverages, I cannot later change my mind during the plan year and elect these coverages, unless I experience a change in family status. There will be an opportunity to change my elections at the next annual open enrollment. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form will remain unchanged, although the cost may change.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date