



Basic Life and Additional Life Enrollment Form
Associated School Boards Protective Trust – GROUP #758438

The Standard®

Applicant Name: _____
Social Security Number: _____
Hours Worked/Week: _____
Date of Hire: ____/____/____ Annual Salary: \$ _____

School District: Lead-Deadwood

Date of Birth: ____/____/____

Gender: ____ Female ____ Male

Basic Life Amount: \$10,000

Below are the rates for additional coverage that is 100% employee paid.
Rates are calculated per \$1,000 – Includes AD&D

	Employee	Spouse
<25	\$0.085	\$0.090
25-29	\$0.086	\$0.090
30-34	\$0.097	\$0.090
35-39	\$0.111	\$0.103
40-44	\$0.156	\$0.130
45-49	\$0.235	\$0.180
50-54	\$0.381	\$0.289
55-59	\$0.560	\$0.469
60-64	\$0.712	\$0.691
65-69	\$1.273	\$1.031
70-74	\$2.343	\$2.072
75+	\$6.149	\$2.072

I elect \$ _____ in additional employee life coverage between \$10,000 - \$300,000 in increments of \$10,000. Maximum amount may not exceed 4 times your annual earnings.

I elect \$5,000 - \$10,000 - \$15,000 - \$20,000 - \$25,000 in spousal coverage. If electing this the employee must have equal amount or more in additional life coverage. Rate is determined by spouse age (see above chart)

Spouse name _____ Gender: ____ Female ____ Male Date of Birth ____/____/____

I elect \$5,000 or \$10,000 in child life coverage. If electing this the employee must elect additional life coverage. Rate is \$.20 per \$1,000.

Child name _____ Gender: ____ Female ____ Male Date of Birth ____/____/____

Child name _____ Gender: ____ Female ____ Male Date of Birth ____/____/____

Beneficiary Information: (Employee is deemed the beneficiary for dependents)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Contingent Beneficiary:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

____ YES – I would like to participate. I authorize my employer to deduct from my salary or wages the necessary premium for this coverage. This signature is also to verify the accuracy of information supplied on this application.

____ No – I do not wish to participate. I understand that evidence of insurability will be required, if I decide to elect this coverage in the future.

Employee Signature: _____

Date: ____/____/____