**Basic Life and Additional Life Enrollment Form**

**Associated School Boards Protective Trust – GROUP #758438**

**Applicant Name:** _____ **School District: Andes Central**

**Social Security Number:**_____ **Date of Birth: ___/___/___**

**Hours Worked/Week:** _____ **Gender: ____ Female ____ Male**

**Date of Hire: ___/___/___** **Annual Salary: $** _____ **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:___/___/___

1/2020