County of Sonoma
Employee Supplemental Life Insurance Enrollment/Change Form

Insured by The Hartford Life & Accident Insurance Company

The County of Sonoma Supplemental Life Insurance Program allows eligible employees to purchase additional Life Insurance coverage based on amounts specified in their bargaining unit MOU. If you qualify for and enroll in Basic Life Insurance you may apply for Supplemental Life Insurance with the maximum combined Basic Life and Supplemental Life not to exceed $500,000. Please refer to the Employee Benefits Guide for basic life insurance coverage information. *This coverage is not available for dependents.*

Who can enroll? You are eligible for Supplemental life if you qualify for and are enrolled in Basic Life Insurance. Fulltime or part-time regular employees scheduled to work 60 or more hours per pay period (.75 FTE or greater) are automatically enrolled in Basic Life Insurance. Part-time DSA, SCLEA and ESC employees working less than 60 hours per pay period may purchase Basic Life Insurance.

When can you enroll? You can enroll in Supplemental Life insurance within 31 days of initial eligibility, during the Annual Enrollment period, or within 31 days of a qualifying life/family or work status change (see the Employee Benefits Guide for details on qualifying life/family events).

Approval:

1. New Hires or Newly Eligible Employees: Supplemental Life insurance is automatically approved for an amount up to $250,000, referred to as a Guaranteed Issue amount. For an amount above $250,000, Evidence of Good Health is required and Hartford will send a Personal Health Application (PHA) to be completed and returned to them for a decision.
2. After initial eligibility, approval for ANY supplemental life insurance amount requires Evidence of Good Health.

When Evidence of Good Health is required, The Hartford will mail the employee a Personal Health Application (PHA). An employee must complete the PHA and return the original PHA form to The Hartford. Incomplete PHA forms could result in denial of your Supplemental Life Insurance application. You will be notified by The Hartford Group whether or not your application for supplemental insurance was denied. If your application is approved, The Hartford will notify the Human Resources Benefits Unit and deductions for your elected coverage will begin automatically.

The Cost: Supplemental Life insurance is employee paid with the cost based on your desired coverage amount and your age. If you elect coverage and are approved, the cost will be deducted from your paycheck. The current rates for each $10,000 in supplemental coverage are:

	Age as of January 1st of current year									
	Under 29	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**
Bi-weekly Cost	$0.28	$0.31	$0.39	$0.59	$0.86	$1.37	$2.28	$3.38	$5.53	$10.12
Annual Cost	$7.20	$8.17	$10.20	$15.37	$22.44	$35.77	$59.40	$88.08	$144.35	$264.13

How to Enroll: Complete the "Request for Enrollment" form below. Keep a copy for your records. Send the original completed form to your Payroll Clerk or Human Resources (HR) Benefits Unit. Submittal of the Request for Enrollment is not a guarantee of enrollment. If The Hartford requires a Personal Health Application (PHA) it will be mailed to your home address to be completed and returned to The Hartford for an approval decision. Incomplete PHA forms could result in denial of your Supplemental Life Insurance application. You will be notified by The Hartford of the decision of your application.

HR Benefits Unit Use Only
Effective Date: _____
Initials: _____

REQUEST FOR ENROLLMENT

COUNTY OF SONOMA SUPPLEMENTAL LIFE INSURANCE
GROUP POLICY GL-673199

Reason for Enrollment/Change: ☐Annual Enrollment ☐New Hire/Newly Eligible ☐Other: _____ ☐Cancel Coverage

Name:	***Phone Number:***	***Employee Id:***	***FTE:***
Home Address:	***Social Security Number:***	***DOB:***	
City, State Zip Code:	***Department & Bargaining Unit:***	***Hire Date:***	

Amount you can apply for? The chart below shows the amount of Supplemental Life you may apply for. Identify your bargaining unit and then in the "Amount Applying for" field, check which level of coverage you wish to apply for:

The Hartford Group # GL-673199				
Bargaining Unit	**Basic Life Class**	**Basic Life and AD&D Insurance**	**Supplemental Life Employee Paid**	**Amount Applying For (Select One)**
Unrepresented (00)	4	1.5 times Base Annual Salary	Increments of $10,000 (up to a Combined Total of $500,000)	**Enter your election amount:** **$**_____
DSA (46, 47)	3	$25,000	1, 2, 3 or 4 times your Basic Life Amount	☐ **1 times Basic Life** ☐ **2 times Basic Life** ☐ **3 times Basic Life** ☐ **4 times Basic Life**
Confidential (51)	4	1.5 times Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount	☐ **1 times Basic Life** ☐ **2 times Basic Life** ☐ **3 times Basic Life** ☐ **4 times Basic Life**
Administrative Management (50) Board of Supervisors (49) Department/Agency Heads (52) DLSEM (43), SCDPDAA (60) SCLEMA (44), SCPA (45)	5	2 times Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount	☐ **1 times Basic Life** ☐ **2 times Basic Life** ☐ **3 times Basic Life** ☐ **4 times Basic Life**
Local 39 (85) SEIU (01, 05, 10, 25, 80, 95) SCLEA (30, 40, 41, 70) SCPDIA (55)	6	1 time Base Annual Salary	Increments of $10,000 (up to a Combined Total of $500,000)	**Enter your election amount:** **$**_____
WCE (21)	7	1 time Base Annual Salary	1, 2, 3 or 4 times your Base Annual Salary	☐ **1 times Annual Salary** ☐ **2 times Annual Salary** ☐ **3 times Annual Salary** ☐ **4 times Annual Salary**
ESC (75)	8	$25,000	1, 2, 3, 4 or 5 times your Base Annual Salary	☐ **1 times Annual Salary** ☐ **2 times Annual Salary** ☐ **3 times Annual Salary** ☐ **4 times Annual Salary** ☐ **5 times Annual Salary**

Upon approval I hereby authorize the County to deduct from my salary the amount necessary to provide the Supplemental Life insurance I have selected above and to forward that amount to The Hartford Life & Accident Insurance Company.

Signature_____ ***Date*** _____