EMI HEALTH™

emihealth.com

5101 SOUTH COMMERCE DRIVE
MURRAY, UTAH 84107
TOLL FREE 800 662 5850
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TTY 888 236 4823

Please return New York Life Voluntary Life, Accidental Life and Disability Applications to:

EMI Health
5101 S. Commerce Drive
Murray, Utah 84107
Fax: 801-269-9734
Email: mluing@emihealth.com

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employee-Paid
TERM LIFE INSURANCE

Summary of Benefits

Prepared for: Alpine School District
Class 01

Eligibility:

All active Employees of the Employer regularly working a minimum of 17.5 hours per week who are citizens or permanent resident aliens of the United States.
Employee: You will be eligible for coverage the first of the month following date of hire.
Spouse*: Up to age 75, as long as you apply for and are approved for coverage yourself.
Child(ren): Birth to age 26, as long as you apply for and are approved for coverage yourself.

*Domestic Partner is defined in the Group Policy. For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of $10,000, minimum benefit amount of $10,000	$500,000	$200,000
Spouse	Units of $10,000	$500,000 not to exceed 100% of the employees benefit	$50,000
Children	Units of $2,500	$10,000	All amounts

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Continuation of Disability – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan.
Extended Death Benefit with Waiver of Premium – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupation as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.
Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.
Accelerated Death Benefit – Terminal Illness – if two unaffiliated doctors diagnose you or your spouse as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:
Employee: 50% of your Term Life Insurance coverage amount or $250,000, whichever is less.
Spouse: 50% of your Term Life Insurance coverage amount or $250,000, whichever is less.

Portability – If your employment is terminated, you can continue your life insurance on a direct-bill basis. Coverage may also be continued for your spouse/children. Premiums will increase at this time. Coverage can be continued to age 75, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.
Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Employee's Monthly Cost of Coverage:

Age	Employee Cost Per $1,000		Spouse Cost Per $1,000		Age	Employee Cost Per $1,000		Spouse Cost Per $1,000	
	Non-Smoker	Smoker	Non-Smoker	Smoker		Non-Smoker	Smoker	Non-Smoker	Smoker
0-19	$0.063	$0.095	$0.063	$0.095	60-64	$0.660	$0.693	$0.660	$0.693
20-24	$0.063	$0.095	$0.063	$0.095	65-69	$1.270	$1.270	$1.270	$1.270
25-29	$0.063	$0.095	$0.063	$0.095	70-74	$2.060	$2.100	$2.060	$2.100
30-34	$0.080	$0.095	$0.080	$0.095	75-79	$2.060	$2.100		
35-39	$0.090	$0.126	$0.090	$0.126	80-84	$2.060	$2.100		
40-44	$0.105	$0.158	$0.105	$0.158	85-89	$2.060	$2.100		
45-49	$0.168	$0.252	$0.168	$0.252	90-94	$2.060	$2.100		
50-54	$0.231	$0.347	$0.231	$0.347	95-99	$2.060	$2.100		
55-59	$0.430	$0.588	$0.430	$0.588					

Child Cost Per $1,000 = $0.200

Actual per pay period premiums may differ slightly due to rounding. All spouse rates are based on spouse age. Rates vary by age and may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Monthly Cost:

Step 1: Use the chart above to find your **Monthly** rate based on your age as of your effective date.
Step 2: Multiply this rate by your desired coverage amount, in units. Reference the table above to find the appropriate unit amounts for employee and/or dependents.
Step 3: The result is the **Monthly** cost.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits and your spouse's benefits will reduce to 65% at age 65 and 50% at age 70. Spouse reductions are based on spouse age.
Exclusions – Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.
Limitations – The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 70 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. FLX 966724. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 51 Madison Avenue New York, NY 10010.

Created on 06/2022

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: Alpine School District

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

Have you smoked or used any form of tobacco in the last 12 months? Employee: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

❑ I am currently married and my date of marriage is: _____ or ❑ I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information Name _____ **Social Security #** _____

Birthdate _____ Gender _____

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employer-Paid (Basic) Term Life Insurance Policy # FLX 966724		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	$15,000	Guaranteed Coverage*: $15,000
Spouse	$5,000	
Children	$5,000	

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 966724		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to $500,000. Guaranteed Coverage: $200,000	❑ $10,000 ❑ $200,000* ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Units of $10,000 up to $500,000. Guaranteed Coverage: $50,000	❑ $10,000 ❑ $50,000* ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000. The amount cannot exceed 100% of the employee's coverage.* ❑ Decline Coverage
Child	Units of $2,500 up to $10,000.	❑ $2,500 ❑ $10,000** ❑ Other _____ *Amount must be a multiple of $2,500.* ❑ Decline Coverage

Please turn to other side to complete enrollment process. Be sure to make a copy for your records.

Employer-Paid (Basic) Accidental Death & Dismemberment Insurance Policy # OK 968246	
Applicant	**The coverage below is provided by your employer at no cost to you.**
Employee	$15,000
Spouse	$5,000
Children	$5,000

Employee-Paid (Voluntary) Accidental Death & Dismemberment Insurance Policy # OK 968246		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to the lesser of 5 times your salary, or $500,000.	❑ $10,000 ❑ $220,000 ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Family	Spouse and Children will receive a percentage of the Employee's selected coverage amount. Rates will be higher if you elect Employee & Family coverage.	❑ Accept Coverage ❑ Decline Coverage

Employer-Paid (Basic) Long-term Disability Insurance Policy # LK 964619	
Applicant	**The coverage below is provided by your employer at no cost to you.**
Employee	66.7% of your monthly covered earnings, to a maximum of $10,000 per month.

***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latest of 01/01/2022, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by UT: Life Insurance Company of North America.

Pre-Existing Condition Limitation: I understand that I will not receive benefits for a pre-existing condition (any injury or sickness for which medical advice, care or treatment was recommended or received during the months just prior to the coverage effective date) unless the disability begins more than 3 months after the effective date of coverage.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Please Sign Here ☛ Signature _____ Date _____

Created on 05/2022.

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: Alpine School District

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

Have you smoked or used any form of tobacco in the last 12 months? Employee: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

❑ I am currently married and my date of marriage is: _____ or ❑ I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information Name _____ **Social Security #** _____

Birthdate _____ Gender _____

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employer-Paid (Basic) Term Life Insurance Policy # FLX 966724		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	$15,000	Guaranteed Coverage*: $15,000
Spouse	$5,000	
Children	$5,000	

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 966724		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to $500,000. Guaranteed Coverage: $200,000	❑ $10,000 ❑ $200,000* ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Units of $10,000 up to $500,000. Guaranteed Coverage: $50,000	❑ $10,000 ❑ $50,000* ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000. The amount cannot exceed 100% of the employee's coverage.* ❑ Decline Coverage
Child	Units of $2,500 up to $10,000.	❑ $2,500 ❑ $10,000** ❑ Other _____ *Amount must be a multiple of $2,500.* ❑ Decline Coverage

Please turn to other side to complete enrollment process. Be sure to make a copy for your records.

GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America
New York Life Group Insurance Company of NY
Connecticut General Life Insurance Company

Beneficiary Designation Form

Employer Name: Alpine School District

Employee Name: _____ **Employee Social Security Number:** _____

Current Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Basic Life Insurance — Policy No. FLX0966724

Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Voluntary Life Insurance — Policy No. FLX0966724

☐ Check here if you want to use the same designations here that you used for Basic Life Insurance, and do not complete the rest of this section.

Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Basic Accidental Death & Dismemberment Insurance — Policy No. OK 0968246

☐ Check here if you want to use the same designations here that you used for Basic Life Insurance, and do not complete the rest of this section.

Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Note: This form is not complete without your signature. Please sign the form on the next page where indicated.

Voluntary Accidental Death & Dismemberment Insurance				Policy No. OK 0968246

☐ Check here if you want to use the same designations here that you used for Basic Accidental Death & Dismemberment Insurance, and do not complete the rest of this section.

Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse as beneficiary, payments of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse's Signature:_____ Date: _____

Owner's Signature:_____ Date: _____

Guidelines for Designation of Beneficiaries

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation(s).

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e. one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate because it is lost, contested, or superseded by a later will. Claim payment delays can result if the beneficiary designation does not provide for this situation.

Domestic Partner - If you wish to designate your domestic partner as your beneficiary, you must complete a beneficiary form. Otherwise, your death benefit will be paid according to the provisions of the policy.

Life Status Changes - We recommend that you review your beneficiary designation(s) when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation(s). A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.