CITY OF SPRINGFIELD, OREGON

HUMAN RESOURCES DEPARTMENT

Date of Hire: _____
Benefits Effective Date: _____
(Coverage is effective the first of the month
and premium is not prorated.)

☐ New Hire ☐ Rehire ☐ Qualifying Event: _____ Date of Qualifying Even: _____

Supplemental Life and AD&D Insurance Enrollment Form

Employee Information:	
Name:	Employee ID:
Date of Birth:	

Supplemental Life Insurance

Your cost may change when you move into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-99
Rate	$0.0335	$0.0335	$0.0335	$0.048	$0.072	$0.115	$0.187	$0.3185	$0.341	$0.581	$1.032	$3.9215

To calculate your bi-weekly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ × _____ = _____
Life Insurance Amount — Rate — Pay Period Cost

☐ I elect to purchase $_____ of supplemental life insurance.
☐ I decline to purchase supplemental life insurance.

Spouse Supplemental Life Insurance

Your cost may change when you move into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-99
Rate	$0.0335	$0.0335	$0.0335	$0.048	$0.072	$0.115	$0.187	$0.3185	$0.341	$0.581	$1.032	$3.9215

To calculate your bi-weekly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ × _____ = $_____
Life Insurance Amount — Rate — Pay Period Cost
(Not to exceed $100,000 can purchase in $5,000 increments.)

☐ I elect to purchase $_____ of supplemental life insurance for my spouse.
☐ I decline to purchase supplemental life insurance for my spouse.

Child(ren) Supplemental Life Insurance
Age 15 days up to age 26

To calculate your bi-weekly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ × __$0.048___ = _____
Life Insurance Amount — Rate — Pay Period Cost
(Not to exceed $10,000, can purchase in $2,000 increments.)

☐ I elect to purchase $_____ of supplemental life insurance.
☐ I decline to purchase supplemental life insurance.

If electing coverage for Spouse or Child(ren)	
Spouses Name:	Date of Birth:
Child's Name:	Date of Birth:
Child's Name:	Date of Birth:
Child's Name:	Date of Birth:
Child's Name:	Date of Birth:

Employee and/or Family AD&D

Coverage	Employee Only	Employee & Spouse Only	Employee & Child(ren) Only	Employee, Spouse & Child(ren)
Percent of Benefit Paid	100%	100% for Emp. Spouse - 50% of Ee. amount	100% for Emp. Child (ren) 25% of Ee. amount	100% for Emp. Spouse 60% of Ee amount Child 10% of Ee amount

Coverage Option:	**Rate:**
Employee Only	$0.024 per $1,000 of coverage
Employee & Family	$0.0335 per $1,000 of coverage

To calculate your bi-weekly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ × _____ = $_____
Elected Benefit Amount — Rate — Pay Period Cost

☐ I elect to purchase $_____ of AD&D coverage for myself only.
☐ I elect to purchase $_____ of AD&D coverage for myself and family, at the rates above.
☐ I decline to purchase AD&D coverage.

_____ _____
Employee's Signature **Date**