

Open Enrollment
Acknowledgement
Packet

Calendar Year 2017

Return to Human Resources by October 6, 2016



Employee Name _____ (Print)	Date: _____ For Calendar Year 2017 (Jan. 1, 2017)
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I have been provided with enrollment paperwork, including applicable premium changes.
I understand that if I need to enroll, terminate coverage, or make any changes, the appropriate form must be submitted to Human Resources no later than October 6, 2016. <u>Changes will be effective January 1, 2017.</u>
I acknowledge that I have been provided the opportunity to enroll for the benefits listed below: <ul style="list-style-type: none"> ✓ CalPERS – Health Plans ✓ MetLife: Dental HMO, Dental PPO, and Vision ✓ Lincoln Financial: Short Term Disability and Voluntary Life Insurance
<input type="checkbox"/> I <u>DO NOT</u> wish to make any changes to my benefits for Calendar Year 2017 <i>Sign and return this packet to HR.</i>
<input type="checkbox"/> I <u>WISH</u> to make changes to my benefits (forms attached). IDENTIFY CHANGES BELOW – Complete appropriate form(s). <i>Sign and return this packet to HR.</i>

Check Box	Health	Dental	Vision	Lincoln
Add Coverage				
Change Plan				
Dependent Change				
Cancel Coverage				
American Fidelity	Flexible Spending Accounts (FSA) requires re-enrollment each year. Existing cards will be reloaded at the beginning of the new year!			

Signature: ✕ _____

Deduction Authorization:

By signing this form, I hereby authorize the City to take any applicable deductions from my salary and to pay such sums as are due to selected carriers. This authorization shall apply to any increase or decrease due to the City and is to continue in effect until termination of my employment or until terminated by written notice served to me. Coverage and payment obligation are effective through the calendar month in which such notice is served or termination of employment occurs.



Employee Name _____ (Print)	Date: _____ For Calendar Year 2017 (Jan. 1, 2017)
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Health Benefits Calculator

As in the past, you may choose your premium cap health plan and pay out-of-pocket for dental and vision, or choose a lower-premium health plan and use the "credit" to purchase all or part of your cost for dental and vision. (Any remaining credit stays with the City.)

Other Southern California Region Rates listed					
If you reside in a different region such as San Bernardino, LA County - please refer to your health plan statement in My CalPERS for your rates.					
Other Southern California Region CAPS/Allowances are used for all regions.					
Health Benefits	Plan	EE Only	EE+1	EE+2+	Selection
PERS Care	PPO	\$802.24	\$1604.48	\$2085.82	
Anthem Traditional	HMO	\$799.15	\$1598.30	\$2077.79	
Blue Shield Access+	HMO	\$778.45	\$1556.90	\$2023.97	
PERS Choice	PPO	\$714.43	\$1428.86	\$1857.52	
PORAC	PPO	\$699.00	\$1467.00	\$1876.00	
Anthem Select	HMO	\$659.03	\$1318.06	\$1713.48	
PERS Select	PPO	\$633.46	\$1266.92	\$1647.00	
Sharp	HMO	\$614.46	\$1228.92	\$1597.60	
Kaiser(CA)	HMO	\$599.54	\$1199.08	\$1558.80	
United Healthcare	HMO	\$549.76	\$1099.52	\$1429.38	
Health Net SmartCare	HMO	\$537.20	\$1074.40	\$1396.72	
Health Net Salud y Mas	HMO	\$473.46	\$946.92	\$1231.00	
MetLife VSP Vision	PPO	\$8.45	\$18.86	\$18.86	
MetLife Dental	HMO	\$16.59	\$30.98	\$49.13	
MetLife Dental	PPO	\$39.89	\$76.44	\$127.65	
Health Dental Vision Cost					\$
Short Term Disability (Log into paychex for contribution amount)					\$
Total					\$
Deduct Allowance					\$
Mo. Difference – <i>if credit no out of pocket</i>					\$
Mo. Difference X 12 / 26 =					\$ <i>per pay period</i>

Deduction Authorization:

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Member Account Management Division
 P.O. Box 942715
 Sacramento, CA 94229-2715
(888) CalPERS (or 888-225-7377)
 TTY (877) 249-7442
 FAX (800) 959-6545

Declaration of Health Coverage: HBD-12A

(INSTRUCTIONS ON REVERSE)

EMPLOYEE INFORMATION	NAME (FIRST)	(MIDDLE)	(LAST)
SOCIAL SECURITY NUMBER	_____	_____	_____

<p>PART A</p> <p><input type="checkbox"/> I elect to enroll myself and all eligible dependents.</p>	
<p>PART B-1</p> <p><input type="checkbox"/> I elect to enroll myself. My eligible dependents have other health insurance coverage.</p>	<p>If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage.</p>
<p>PART B-2</p> <p><input type="checkbox"/> I elect to enroll myself and all eligible dependents. I also have eligible dependents who have other health insurance coverage.</p>	
<p>PART C-1 * <i>Proof of insurance is required</i></p> <p><input type="checkbox"/> I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.</p>	
<p>PART C-2</p> <p><input type="checkbox"/> I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.</p>	<p>You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.</p>

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependents, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Member's Signature	Date Signed	Health Benefits Officer's Signature
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California Public Employees' Retirement System
 P.O. Box 942715
 Sacramento, CA 94229-2715

**HEALTH BENEFIT PLAN
 ENROLLMENT FORM DO NOT SEND MEDICAL
 PERS-HBD-12 (Rev. 6/13) CLAIMS TO THIS ADDRESS**

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One)		2. SOCIAL SECURITY NUMBER		AC C O D E	LIST ALL PERSONS (including self) TO BE ENROLLED IN:			DATE OF BIRTH			Family Relationship		G E N D E R		C O D E
<input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage		3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER			17. BASIC PLAN			Mo. Day Yr.			SELF		M F		
4A. Name		SSN		(FIRST) (MI) (LAST)											
Mailing Address		(FIRST) (MI) (LAST)		(FIRST) (MI) (LAST)											
City, State, ZIP		Daytime Phone Evening Phone		SSN											
4B. RESIDENCE ZIP CODE (if different from 4A)		(FIRST) (MI) (LAST)		(FIRST) (MI) (LAST)											
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)		6. GENDER		7. MARRIED		SSN									
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No		(FIRST) (MI) (LAST)									
8. PLAN CODE		9. NAME OF HEALTH PLAN		SSN											
10. GROSS PREMIUM \$		11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP													
12. PRIOR PLAN CODE		13. PRIOR HEALTH PLAN		AC C O D E	18. SUPPLEMENTAL PLAN			DATE OF BIRTH			Relation-ship		C O D E		
					(FIRST) (MI) (LAST)			Mo. Day Yr.							
14. Reason Code		15. Permitting Event Date		16. EFFECTIVE DATE											
		Mo. Day Yr.		Mo. Day Yr.											

19. CHECK ONE

I DO NOT elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.

I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I elect to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy)

21. DATE SIGNED

Mo. Day Year

TELEPHONE NUMBER ()

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of action (Check One)	1. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input type="checkbox"/> Change	24. PAY PERIOD	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
			Month Year			

28. AGENCY NAME (or Retirement System)
City of Cathedral City

29. PAYROLL OFFICE CODE

30. AGENCY CODE

31. UNIT CODE

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act.

SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office

Mo. Day Year

34. PHONE NUMBER

35. REMARKS

_____ of _____ Forms

WHITE - HB PINK - Agency BLUE - Employee

DENTAL | VISION ENROLLMENT FORM

EMPLOYEE INFORMATION			
Last Name:		First Name:	Middle Initial:
Gender: Male _____ Female _____	Birthdate:	SSN:	
Home Address		City	State Zip
Contact Information Phone:	E-mail		Effective Date:

ELECTION		REQUIRED DOCUMENTS WHEN ADDING DEPENDENTS
DENTAL PLAN	VISION PLAN	<ul style="list-style-type: none"> Copy of Social Security Card(s) Copy of Birth Certificate(s) <i>(Children Only)</i> Marriage Certificate <div style="text-align: right; margin-top: 10px;"> <p style="font-size: small; color: #ff0000; margin: 0;">Don't forget!</p> </div>
<input type="checkbox"/> PPO <input type="checkbox"/> HMO Facility ID: _____ <input type="checkbox"/> EE Only <input type="checkbox"/> EE + 1 Dependent <input type="checkbox"/> EE + Family <input type="checkbox"/> Decline Dental coverage	<input type="checkbox"/> EE Only <input type="checkbox"/> EE + 1 Dependent <input type="checkbox"/> EE + Family <input type="checkbox"/> Decline Vision coverage	

LIST ONLY AFFECTED FAMILY MEMBERS Name (Last, First, MI)	Relation -Spouse -Son -Daughter -Step Child	Social Security No.	Date of Birth	ADD		DELETE	
				Den	Vis	Den	Vis

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Employee Signature

Date

HR USE ONLY - QUALIFYING EVENT | ELIGIBLE – The First day of the month following month of hire or change:

	New Enrollment Effective Date
	Add/Delete Dependent Effective Date
	COBRA Effective Date

Required Documents Received
-Copy of Social Security Card(s)
-Copy of Birth Certificate(s)
-Marriage Certificate

Health Benefits Officer's Signature

Date



Employee Name _____ (Print)	Date: _____ For Calendar Year 2017 (Jan. 1, 2017)
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Lincoln Open Enrollment Calculator

COMPLETE ONLY IF YOU ARE MAKING CHANGES TO YOUR LIFE INSURANCE...

Currently enrolled or eligible employees may elect to enroll or increase insurance coverage up to two (2) benefit levels on a guaranteed acceptance basis during open enrollment, provided that you or your spouse/domestic partner have not been previously declined for coverage.

Employee:	An Additional Two Increments Not To Exceed \$20,000
Spouse:	An Additional Two Increments Not To Exceed \$10,000
Children:	\$10,000 If Not Already Enrolled For Child Coverage

You will be required to complete Evidence of Insurability if:

- ✓ Your elected coverage exceeds the Guaranteed Issue amount

Supplemental Life Insurance Benefits			
<i>Current Voluntary Life Insurance information is located in paychex under the benefits tab. If making changes, indicate current amount of coverage, and the new total amount with the new rates.</i>			
Current Voluntary Life Insurance	Increased Amount	New Total	New Monthly Rates
<i>Example - \$50,000</i>	\$20,000	\$70,000	\$14.00
<i>Employee</i> \$	\$	\$	\$
<i>Spouse</i> \$	\$	\$	\$
<i>Child</i> \$	\$	\$	\$
<i>Employee and Spouse premiums are calculated separately.</i> You will be notified of a rate increase if your age bracket changes.		Total Monthly Rate(s)	\$
		Mo. Difference X 12 / 26 =	\$ <i>per pay period</i>

Deduction Authorization:

By signing this form, I hereby authorize the City to take any applicable deductions from my salary and to pay such sums as are due to selected carriers. This authorization shall apply to any increase or decrease due to the City and is to continue in effect until termination of my employment or until terminated by written notice served to me. Coverage and payment obligation are effective through the calendar month in which such notice is served or termination of employment occurs.

Voluntary Life Insurance with Accidental Death and Dismemberment (AD&D)
SUMMARY OF BENEFITS

Sponsored by: City of Cathedral City

All Full-Time and Regular Part-Time Employees

Life Benefit	Employee	Spouse	Dependent
Amount	Choice of \$10,000 increments Not to exceed 5 times your annual salary	Choice of \$5,000 increments Employee must elect coverage for spouse to be eligible. Not to exceed 50% of employee approved amount.	\$10,000 Child: 1 day to age 26 Employee must elect coverage for dependents to be eligible.
Minimum Amount	\$10,000	\$5,000	\$10,000
Maximum Amount	\$500,000	\$250,000	\$10,000
Guarantee Issue for Newly Eligible Employees	\$150,000	\$30,000	\$10,000
Current Eligible Employees	You or your spouse may elect or increase insurance coverage up to 2 increments on a guaranteed acceptance basis during your company's defined annual open enrollment period, provided that you or your spouse have not been previously declined, withdrawn, or pending for coverage.		
AD&D Benefit	Employee	Spouse	
Amount	Optional coverage can be purchased by you for additional premium. Benefit amount equal to the life amount elected by you. Cost included in the schedule.	Same as employee	
Benefit Reduction	Employee	Spouse	
Benefits will reduce:	35% at age 70 An additional 15% of original amount at age 75 Benefits terminate at retirement	35% at employee age 65 An additional 15% of original amount at employee age 75 Benefits terminate at employee retirement.	
Additional Benefits			
See Definition:	Accelerated Death Benefit		
See Definition:	Portability		
See Definition:	Conversion		
See Definition:	Seat Belt, Airbag, and Common Carrier		
See Definition:	Accident Plus		
Eligibility	Employee	Spouse and Dependents	
	All employees in an eligible class. You are able to take advantage of this coverage now without a health examination. You may not be offered this opportunity again, or may be responsible for the cost of required examinations.	Cannot be in a period of limited activity on the day coverage takes effect.	

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: CATHDRLCTY	GROUP POLICY #: 000010183270 000010183608 000010183269 000400001000-17646	Billing Division or Location: 1514485

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) City of Cathedral City		County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Street Address		City	State	Zip
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single		Home Phone ()	Work Phone ()

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly \$ _____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

~~Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.~~

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Basic Group Life/AD&D <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$	Employer Paid
		Long Term Disability <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$	Employer Paid

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Has Employee or Spouse used any type of tobacco or nicotine in the past 12 months?	Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
Voluntary Employee Optional AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No*	Equal to Life Insurance Amount	\$
Voluntary Spouse Life Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$	\$
Voluntary Spouse Optional AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No*	Equal to Life Insurance Amount	\$
Voluntary Dependent Child Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No*	\$10,000	\$
Voluntary Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No*	Weekly Benefit Amount \$ _____	\$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

C. Beneficiary Information (Complete ONLY for Life/AD&D)				
Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.				

D. Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
<input type="checkbox"/> REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company. I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
<input type="checkbox"/> NOT ENROLL myself in the Program. I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
<input type="checkbox"/> NOT ENROLL my dependents in the Program. I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name: _____ Employee Signature: _____ Date: _____

Employee Monthly Premium
Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
Refer to Program Specifications for your maximum benefit amounts.
Benefits and premium amounts reflect age reductions.

AGE	Monthly Rate per \$1,000	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000
<25	0.0920	\$0.92	\$1.84	\$2.76	\$3.68	\$4.60	\$5.52	\$6.44	\$7.36	\$8.28	\$9.20
25-29	0.0920	\$0.92	\$1.84	\$2.76	\$3.68	\$4.60	\$5.52	\$6.44	\$7.36	\$8.28	\$9.20
30-34	0.1010	\$1.01	\$2.02	\$3.03	\$4.04	\$5.05	\$6.06	\$7.07	\$8.08	\$9.09	\$10.10
35-39	0.1370	\$1.37	\$2.74	\$4.11	\$5.48	\$6.85	\$8.22	\$9.59	\$10.96	\$12.33	\$13.70
40-44	0.2000	\$2.00	\$4.00	\$6.00	\$8.00	\$10.00	\$12.00	\$14.00	\$16.00	\$18.00	\$20.00
45-49	0.3310	\$3.31	\$6.62	\$9.93	\$13.24	\$16.55	\$19.86	\$23.17	\$26.48	\$29.79	\$33.10
50-54	0.5060	\$5.06	\$10.12	\$15.18	\$20.24	\$25.30	\$30.36	\$35.42	\$40.48	\$45.54	\$50.60
55-59	0.7720	\$7.72	\$15.44	\$23.16	\$30.88	\$38.60	\$46.32	\$54.04	\$61.76	\$69.48	\$77.20
60-64	1.1810	\$11.81	\$23.62	\$35.43	\$47.24	\$59.05	\$70.86	\$82.67	\$94.48	\$106.29	\$118.10
65-69	1.9190	\$19.19	\$38.38	\$57.57	\$76.76	\$95.95	\$115.14	\$134.33	\$153.52	\$172.71	\$191.90
70-74	3.1480	\$6,500	\$13,000	\$19,500	\$26,000	\$32,500	\$39,000	\$45,500	\$52,000	\$58,500	\$65,000
		\$20.46	\$40.92	\$61.39	\$81.85	\$102.31	\$122.77	\$143.23	\$163.70	\$184.16	\$204.62
75-79	3.1480	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$15.74	\$31.48	\$47.22	\$62.96	\$78.70	\$94.44	\$110.18	\$125.92	\$141.66	\$157.40
80+	3.1480	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
		\$15.74	\$31.48	\$47.22	\$62.96	\$78.70	\$94.44	\$110.18	\$125.92	\$141.66	\$157.40

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:
Use this formula to calculate premium for benefit amounts over \$100,000.

Age	Monthly Rate Per \$1,000	X	Benefit In \$1,000's	=	Monthly Cost
Example: 35	0.1370	X	150	=	\$20.55
		X		=	

Dependent Children Rate = \$1.50 monthly

Premium covers all dependent children regardless of the number of children.

Spouse Monthly Premium
Life and Accidental Death and Dismemberment Premium for sample benefit amounts

Employee and Spouse premiums are calculated separately.
 Spouse premiums will be calculated based on Spouse age.
 Refer to Program Specifications for your maximum benefit amounts.

Benefits and premium amounts reflect age reductions.

AGE	Monthly Rate per \$1,000	\$5,000	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
<25	0.0920	\$0.46	\$0.92	\$1.38	\$1.84	\$2.30	\$2.76	\$3.22	\$3.68	\$4.14	\$4.60
25-29	0.0920	\$0.46	\$0.92	\$1.38	\$1.84	\$2.30	\$2.76	\$3.22	\$3.68	\$4.14	\$4.60
30-34	0.1010	\$0.51	\$1.01	\$1.52	\$2.02	\$2.53	\$3.03	\$3.54	\$4.04	\$4.55	\$5.05
35-39	0.1370	\$0.69	\$1.37	\$2.06	\$2.74	\$3.43	\$4.11	\$4.80	\$5.48	\$6.17	\$6.85
40-44	0.2000	\$1.00	\$2.00	\$3.00	\$4.00	\$5.00	\$6.00	\$7.00	\$8.00	\$9.00	\$10.00
45-49	0.3310	\$1.66	\$3.31	\$4.97	\$6.62	\$8.28	\$9.93	\$11.59	\$13.24	\$14.90	\$16.55
50-54	0.5060	\$2.53	\$5.06	\$7.59	\$10.12	\$12.65	\$15.18	\$17.71	\$20.24	\$22.77	\$25.30
55-59	0.7720	\$3.86	\$7.72	\$11.58	\$15.44	\$19.30	\$23.16	\$27.02	\$30.88	\$34.74	\$38.60
60-64	1.1810	\$5.91	\$11.81	\$17.72	\$23.62	\$29.53	\$35.43	\$41.34	\$47.24	\$53.15	\$59.05
65-69	1.9190	\$9.60	\$19.19	\$28.79	\$38.38	\$47.98	\$57.57	\$67.17	\$76.76	\$86.36	\$95.95
70-74	3.1480	\$3,250	\$6,500	\$9,750	\$13,000	\$16,250	\$19,500	\$22,750	\$26,000	\$29,250	\$32,500
		\$10.23	\$20.46	\$30.69	\$40.92	\$51.16	\$61.39	\$71.62	\$81.85	\$92.08	\$102.31
75-79	3.1480	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$7.87	\$15.74	\$23.61	\$31.48	\$39.35	\$47.22	\$55.09	\$62.96	\$70.83	\$78.70
80+	3.1480	\$2,500	\$5,000	\$7,500	\$10,000	\$12,500	\$15,000	\$17,500	\$20,000	\$22,500	\$25,000
		\$7.87	\$15.74	\$23.61	\$31.48	\$39.35	\$47.22	\$55.09	\$62.96	\$70.83	\$78.70

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:

Use this formula to calculate premium for benefit amounts over \$50,000.

Age	Monthly Rate Per \$1,000	X	Benefit In \$1,000's	=	Monthly Cost
35	0.1370	X	75	=	\$10.28
		X		=	

Dependent Children Rate = \$1.50 monthly

Premium covers all dependent children regardless of the number of children.