

GOPB Head Start Interest Form for Supplemental Benefits 2019

All rates are listed per deduction (24, Semi-monthly)

**Question should be directed to your Colonial Life Representative:
Ginny Clark – 214.223.9158 phone – 214.206.9010 fax – gclarkatwork@yahoo.com**

PLEASE PRINT CLEARLY

Employee First Name	Initial	Employee Last Name	Date of Birth	Sex
Street Address		City	State	Zip Code
Social Security Number				
Email Address	Date of Hire	Phone Number	Job Title	

Are you or any person applying for coverage Medicare eligible? Yes No

ACCIDENT INSURANCE: Add/Change Decline/Cancel
Preferred On/Off-job Coverage. \$125 initial ER/Urgent Care/Dr. Office visit per covered accident, \$1,000 per covered Hospital Confinement (\$2,000 for ICU), \$250 Daily Hospital Confinement benefit, payouts for broken bones, surgeries, therapy and more. Includes a \$40,000 accidental death policy. \$50 wellness benefit.

Employee Only	Employee + Spouse	Employee + Children	Employee + Family
<input type="checkbox"/> \$10.85	<input type="checkbox"/> \$16.32	<input type="checkbox"/> \$18.48	<input type="checkbox"/> \$23.72

COMPLETE DEPENDENT INFORMATION ON LAST PAGE IF ELECTING DEPENDENT COVERAGE -- COMPLETE BENEFICIARY DESIGNATION ON LAST PAGE

DISABILITY INSURANCE: Add/Change Decline/Cancel
Pays out up to 60% of your monthly earnings when you can't be at work due to an illness, injury, or giving birth.

3 month Benefit Period	Employee Age	\$800 Monthly Benefit	\$1000 Monthly Benefit	\$1200 Monthly Benefit	\$1500 Monthly Benefit	\$2000 Monthly Benefit
0 day Accident/ 7 day sickness elimination	17-49	<input type="checkbox"/> \$12.76	<input type="checkbox"/> \$15.95	<input type="checkbox"/> \$19.14	<input type="checkbox"/> \$23.93	<input type="checkbox"/> \$31.90
	50-64	<input type="checkbox"/> \$15.60	<input type="checkbox"/> \$19.50	<input type="checkbox"/> \$23.40	<input type="checkbox"/> \$29.25	<input type="checkbox"/> \$39.00
	65-74	<input type="checkbox"/> \$18.88	<input type="checkbox"/> \$23.60	<input type="checkbox"/> \$28.32	<input type="checkbox"/> \$35.40	<input type="checkbox"/> \$47.20

Monthly Salary or Dollars Per Hour \$_____ (benefit cannot exceed 60% of your monthly earnings)

HOSPITAL CONFINEMENT GAP INSURANCE: Add/Change Decline/Cancel
\$1000 Hospital Confinement Benefit and up to \$2500 Outpatient Surgical Benefit per calendar year per covered person, \$100 Observation Room benefit (less than 20 hours) up to maximum of 2 visits per calendar year per person (not payable same day Confinement Benefit or Outpatient Surgical benefit), \$100 Rehab Unit Benefit (up to 15 days). Includes \$50 wellness benefit.

Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
17-49	<input type="checkbox"/> \$12.48	<input type="checkbox"/> \$23.45	<input type="checkbox"/> \$16.23	<input type="checkbox"/> \$27.20
50-59	<input type="checkbox"/> \$17.28	<input type="checkbox"/> \$32.58	<input type="checkbox"/> \$21.03	<input type="checkbox"/> \$36.33
60-64	<input type="checkbox"/> \$22.05	<input type="checkbox"/> \$41.63	<input type="checkbox"/> \$25.80	<input type="checkbox"/> \$45.38
65-74	<input type="checkbox"/> \$27.65	<input type="checkbox"/> \$52.28	<input type="checkbox"/> \$31.40	<input type="checkbox"/> \$56.03

We will not pay benefits for hospital confinement due to giving birth within the first 9 months after the effective date of this policy. Pre-existing conditions for which you have been treated, had medical testing, received medical advice or taken medication within the past 12 months will not be covered for 12 months.

- Yes No **Do you certify that you are currently covered by health insurance that qualifies as minimum essential coverage as defined by federal law?**
- Yes No **Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment from a member of the medical profession for AIDS or AIDS related complex (ARC)?**
- Yes No **If adding Spouse coverage, answer as applies to Spouse**
- Yes No **If adding Child(ren) coverage, answer as applies to Child(ren)**
- Yes No **Within the past 12 months, other than colds, flu or normal pregnancy, has you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle?**
- Yes No **If adding Spouse coverage, answer as applies to Spouse**
- Yes No **Within the past 12 months, have you received medical advice/ sought treatment (including medication) for heart attack/surgery, congestive heart failure, stroke, transient ischemic attack, blood pressure reading of 160/100 +, kidney disease (except stones), insulin dependent diabetes, diabetes diagnosed prior to age 40, cancer other than skin cancer, hepatitis B or C, cirrhosis, Hodgkin's disease, leukemia?**
- Yes No **If adding Spouse coverage, answer as applies to Spouse**
- Yes No **If adding Child(ren) coverage: Within the past 12 months, has any dependent been hospitalized for respiratory disorders including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer), or seizures?**

COMPLETE DEPENDENT INFORMATION ON LAST PAGE IF ELECTING DEPENDENT COVERAGE

CANCER ASSIST INSURANCE (Level 3 example): Add/Change Decline/Cancel

Hospital Confinement - \$250 per day up to 30 days, 31+ days \$500 per day; Radiation/ Chemotherapy \$750 per week, Experimental Treatments \$300 per day, Transportation (up to \$1200 round trip), Lodging benefits (\$75 per day up to 70 days per calendar year), Surgery benefits, Nursing benefits and more. Includes \$75 wellness benefit. *Waiting Period: Benefits will not be payable if Cancer is diagnosed within the first 30 days from the coverage effective date.*

Employee Only	Employee + Spouse	Employee + Children	Employee + Family
<input type="checkbox"/> \$12.38	<input type="checkbox"/> \$20.73	<input type="checkbox"/> \$12.60	<input type="checkbox"/> \$20.95

Yes No Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment from a member of the medical profession for AIDS or AIDS related complex (ARC)?

Yes No If adding Spouse coverage, answer as applies to Spouse

Yes No If adding Child(ren) coverage, answer as applies to Child(ren)

Yes No Have you ever been diagnosed with, or treated for Cancer of any type or form?

Yes No If adding Spouse coverage, answer as applies to Spouse

Yes No If adding Child(ren) coverage, answer as applies to Child(ren)

COMPLETE DEPENDENT INFORMATION ON LAST PAGE IF ELECTING DEPENDENT COVERAGE -- COMPLETE BENEFICIARY DESIGNATION ON LAST PAGE

CRITICAL ILLNESS INSURANCE Add/Change Decline/Cancel

\$15,000 Lump-sum benefit payable upon diagnosis of Heart Attack, Stroke, Permanent Paralysis due to a Covered Accident, Coma, Major Organ Failure, End Stage Renal Failure, Occupational Infection HIV or Hepatitis B, C, or D, Blindness, and Coronary Artery Bypass Graft Surgery. May payout up to 3x. Includes \$50 wellness benefit.

Employee coverage - \$15,000; Spouse coverage - \$7,500; Dependent Coverage - \$3,750. 12/12 Pre-existing condition exclusion applies.

Issue Age	Employee Only		Employee & Spouse		Employee & Children		Employee & Family	
	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco
17-24	<input type="checkbox"/> \$2.88	<input type="checkbox"/> \$3.63	<input type="checkbox"/> \$4.35	<input type="checkbox"/> \$5.55	<input type="checkbox"/> \$2.88	<input type="checkbox"/> \$3.63	<input type="checkbox"/> \$4.35	<input type="checkbox"/> \$5.55
25-29	<input type="checkbox"/> \$3.41	<input type="checkbox"/> \$4.61	<input type="checkbox"/> \$5.25	<input type="checkbox"/> \$7.05	<input type="checkbox"/> \$3.41	<input type="checkbox"/> \$4.61	<input type="checkbox"/> \$5.25	<input type="checkbox"/> \$7.05
30-34	<input type="checkbox"/> \$4.01	<input type="checkbox"/> \$5.88	<input type="checkbox"/> \$6.23	<input type="checkbox"/> \$9.08	<input type="checkbox"/> \$4.01	<input type="checkbox"/> \$5.88	<input type="checkbox"/> \$6.23	<input type="checkbox"/> \$9.08
35-39	<input type="checkbox"/> \$5.81	<input type="checkbox"/> \$8.36	<input type="checkbox"/> \$8.93	<input type="checkbox"/> \$12.83	<input type="checkbox"/> \$5.81	<input type="checkbox"/> \$8.36	<input type="checkbox"/> \$8.93	<input type="checkbox"/> \$12.83
40-44	<input type="checkbox"/> \$7.01	<input type="checkbox"/> \$10.98	<input type="checkbox"/> \$10.73	<input type="checkbox"/> \$16.88	<input type="checkbox"/> \$7.01	<input type="checkbox"/> \$10.98	<input type="checkbox"/> \$10.73	<input type="checkbox"/> \$16.88
45-49	<input type="checkbox"/> \$9.26	<input type="checkbox"/> \$14.28	<input type="checkbox"/> \$14.18	<input type="checkbox"/> \$21.90	<input type="checkbox"/> \$9.26	<input type="checkbox"/> \$14.28	<input type="checkbox"/> \$14.18	<input type="checkbox"/> \$21.90
50-54	<input type="checkbox"/> \$11.96	<input type="checkbox"/> \$18.11	<input type="checkbox"/> \$18.38	<input type="checkbox"/> \$27.75	<input type="checkbox"/> \$11.96	<input type="checkbox"/> \$18.11	<input type="checkbox"/> \$18.38	<input type="checkbox"/> \$27.75
55-59	<input type="checkbox"/> \$14.88	<input type="checkbox"/> \$23.13	<input type="checkbox"/> \$22.80	<input type="checkbox"/> \$35.55	<input type="checkbox"/> \$14.88	<input type="checkbox"/> \$23.13	<input type="checkbox"/> \$22.80	<input type="checkbox"/> \$35.55
60-64	<input type="checkbox"/> \$18.56	<input type="checkbox"/> \$27.93	<input type="checkbox"/> \$28.50	<input type="checkbox"/> \$42.90	<input type="checkbox"/> \$18.56	<input type="checkbox"/> \$27.93	<input type="checkbox"/> \$28.50	<input type="checkbox"/> \$42.90
65-70	<input type="checkbox"/> \$22.61	<input type="checkbox"/> \$34.31	<input type="checkbox"/> \$34.73	<input type="checkbox"/> \$52.73	<input type="checkbox"/> \$22.61	<input type="checkbox"/> \$34.31	<input type="checkbox"/> \$34.73	<input type="checkbox"/> \$52.73

Yes No Within the last 12 months, has the proposed insured used any tobacco products?

Yes No Have you ever tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment from a member of the medical profession for AIDS or AIDS related complex (ARC)?

Yes No If adding Spouse coverage, answer as applies to Spouse

Yes No If adding Child(ren) coverage, answer as applies to Child(ren)

Yes No In the past 10 years, has the proposed insured been diagnosed with or sought medical treatment for: heart attack, heart surgery, heart disease, emphysema, organ transplant, congestive heart failure, diabetes, stroke, hepatitis B or C, blood pressure reading of 160/100 or above, kidney disease except stones, COPD, cirrhosis or liver disease, transient ischemic attack, cancer other than skin cancer, abnormal catheterization?

Yes No If adding Spouse coverage, answer as applies to Spouse

Yes No If adding Child(ren) coverage, answer as applies to Child(ren)

COMPLETE DEPENDENT INFORMATION BELOW IF ELECTING DEPENDENT COVERAGE -- COMPLETE BENEFICIARY DESIGNATION BELOW

WHOLE LIFE INSURANCE - CONTACT ME FOR SPECIFIC RATES FOR ME AND/OR FAMILY AT PHONE NUMBER _____

Provides life-long protection for you and those who depend on you. Fixed benefit amount that is paid off at 95 years of age. Guaranteed cash value that allows for policy loans. Rates remain level. Premiums are estimates within the 10 year age range – rates may vary based on actual age. Other benefit amounts available upon request.

Issue Age	\$10,000		\$15,000		\$25,000		\$75,000		\$100,000	
	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco
25	\$5.01	\$6.50	\$6.77	\$9.00	\$10.28	\$13.99	\$25.06	\$32.60	\$32.92	\$42.96
35	\$6.91	\$9.45	\$9.61	\$13.42	\$15.01	\$21.37	\$38.66	\$49.94	\$51.04	\$66.08
45	\$10.12	\$13.58	\$14.43	\$19.62	\$23.04	\$31.70	\$60.81	\$80.00	\$80.58	\$106.16
55	\$16.42	\$24.15	\$23.88	\$35.48	\$38.79	\$58.13	\$96.62	\$132.18	\$128.33	\$175.75
65	\$29.58	\$44.16	\$43.62	\$65.49	\$71.70	\$108.14	\$160.75	\$213.08	\$213.83	\$283.53

DEPENDENT SECTION

Spouse First, Middle Initial, Last Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)
<input type="checkbox"/> Yes <input type="checkbox"/> No Is Spouse Disabled or unable to work		
Number of Children under age 26 to be covered _____		

BENEFICIARY DESIGNATION

Primary Beneficiary 1 First, Middle Initial, Last Name	Relationship to Employee	Date of Birth	Percent %
Primary Beneficiary 2			%
Contingent Beneficiary			%

Unless you otherwise request, the employee named above will be the beneficiary of any spouse and child(ren) insurance applied for. If no one is named above, proceeds will be payable to the Estate of the insured.

I verify that the information provided in this enrollment form is accurate and complete. I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that the plans are covered under the Cafeteria Plan, and I will not be able to change my election during the Plan Year except during the annual Open Enrollment period, or within 30 days of a qualifying event.

Employee Signature

Date