RED LAKE NATION

GROUP INSURANCE ELECTION FORM

Policy # 0370074

For billing groups 22, 23, 25, 26, 29 and 30

Name:_____ Date of Hire:_____

Social Security #:_____ Billing Division:_____

Annual Salary:_____ Effective Date:_____

Date of Birth:_____ **Costs are on a bi-weekly payroll basis (26 paychecks a year)**

IMPORTANT! *This form must be returned to your employer prior to the end of the enrollment period.*
New hire enrollment period: If your form is not signed, dated and returned *within 31 days after the effective date of this form,* you will automatically be enrolled in the employer-funded plan.
Re-enrollment period: If your form is not signed, dated and returned *before* the effective date of the plan year for which elections are being made, you will automatically be enrolled in a plan most similar to the one you were enrolled last year.

Re-enrollment: Evidence of Insurability will also be required if you elect coverage that exceeds or if you are increasing your coverage by any level. Your coverage amount is the total of any basic and/or additional coverage purchased.
Late Entrant: Evidence of Insurability is required if you were previously eligible for supplemental and/or dependent coverage at initial enrollment or a change in status, but did not elect it.

	Long Term Disability:	Cost
A)	60% of salary to a maximum of $3,500 a month	*Employer Paid*

See your Plan Administrator or refer to your enrollment materials for details about pre-existing condition limitations and/or exclusions. Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include such items as disability income or other amounts you receive or are entitled to receive under: workers compensation or similar occupational benefit laws; state compulsory benefit laws; automobile liability and no fault insurance; legal judgments and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability programs or insurance; and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs.

	Employee Life/Accidental Death & Dismemberment:	Volume	Cost
A)	Flat Benefit amount of $50,000	$50,000	*Employer Paid*

Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet. See your Plan Administrator or refer to your employee booklet for details about other life coverage exclusions.

Additional Employee Life:

Coverage is 100% paid by the employee

Your coverage:
$_____ (must be in $10,000 increments)

Rate
(per $1,000) .46100

Calculate your cost: _____ (Coverage amount divided By $1,000) X (Rate) .46100 = $_____ (Employee Cost Per month)

Your Cost $ _____

Life coverage amounts that are medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet. See your Plan Administrator or refer to your employee booklet for details about other life coverage exclusions. The maximum amount an employee can elect is $340,000.

Spouse Life		Volume	Cost
A)	Flat Benefit amount of $3,000	$3,000	*Employer Paid*

Child Life		Volume	Cost
A)	Flat Benefit amount of $1,000	$1,000	*Employer Paid*

Dependent Information: You must complete the following for those dependents covered by your elections.
* Live birth to age 19 (25 if full time student)

Name: (first, middle, last)	Birthdate	Social Security #	Relationship

Please indicate the name and expected date of graduation for those dependents who are full time students age 19 and over:

Name: (first, middle, last)	Birthdate	Social Security #	Relationship	Name/Address of College/University	Expected Graduation Date

Primary Beneficiary Information: Designate your beneficiary(ies) below.

Name: (first, middle, last)	Birthdate	Social Security #	Current Mailing Address	Contact #	Relationship	Percentage

If the Primary Beneficiary(ies) named above are not living, then pay:

Name: (first, middle, last)	Birthdate	Social Security #	Current Mailing Address	Contact #	Relationship	Percentage

Delayed Effective Date: (1) Employee – Initial insurance, and any increased or additional insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective. (2) Dependents - Initial insurance coverage will be delayed if a dependent is totally disabled on the date that insurance would otherwise be effective. Exception: Newborn children are insured from live birth.

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline any of the above coverages, I cannot later change my mind during the plan year and elect these coverages, unless I experience a change in status.

_____ _____

Employee Signature Date

Subscribed and sworn to before this
_____ day of _____, 20_____.

_____
Notary Public