THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA

OFFICE OF HUMAN RESOURCES

Making Changes in

Supplemental Insurance

Employee, Spouse or Child Term Insurance

Your initial enrollment period is within 31 days of the date you or your spouse first became eligible for coverage under the plan. Please note that Hartford Life liberalized child life underwriting, and you can elect coverage on eligible children at any time up to a maximum of $10,000 per child. During your employment, you may elect to apply for changes in your supplemental term life insurance coverage(s) at any time, subject to insurance underwriting approval. Supplemental term life insurance is optional life insurance coverage available on the employee, their spouse or their dependent children. The employee pays the costs of any selected supplemental coverage(s) through payroll deductions, upon approval and acceptance by Hartford Life. This insurance is available to all full-time employees who have completed 60 days of employment, as specified in the Group Insurance Policy. In accordance with the terms of our Policy, if you are requesting an increase in supplemental employee or spouse term life insurance, or are electing supplemental term life benefits on yourself or your spouse outside of your initial enrollment period, you must complete and submit a statement of good health to Hartford Life.

In order to apply for changes in supplemental term life insurance coverage(s) you must:

1. Request a Supplemental Life Change Form from Employee Benefit or your Business Manager.
2. Complete the Supplemental Life Change Form and return it to Employee Benefits:

Archdiocese of Atlanta
Employee Benefits
2401 Lake Park Drive S.E.
Smyrna, GA 30080-8862

3. Upon receipt of the completed change form, Employee Benefits will send you a Hartford Personal Health Statement.
4. Complete the Employee Section of this form.
5. Return the completed/signed original Hartford Personal Health Statement to Hartford, per the directions on the form. NOTE: Keep a copy for your records.
6. Upon approval by Hartford, you will be advised of the amount of your payroll contribution.

If you have questions concerning your benefits or would like to make changes to your coverage, please email Rosa Montano-Parker, Senior Benefits Specialist, at rmontano-parker@archatl.com.

CHANGE IN BENEFICIARY OR SUPPLEMENTAL LIFE CHANGE FORM
EMPLOYEE BASIC AND GROUP SUPPLEMENTAL TERM LIFE INSURANCE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

1. Fill in the following blocks for all coverages:

Employee Last Name First M.I.			Employer **Roman Catholic Archdiocese of Atlanta**
Employee Address City State Zip			
Office Name & Number		Employee Classification	Employee No.
S.S. # - -	Date of Birth / /	Sex ❑ Male ❑ Female	This section for Employer to complete: Wages $___**N/A**___/year Date of Hire _____/_____/_____

2. Enter the requested change in the amount of supplemental life insurance coverage, which may not exceed the maximum amount of insurance for which you are eligible under the policy described in this brochure:

☒ **EMPLOYEE BASIC LIFE & AD&D $50,000** – Provided by the Roman Catholic Archdiocese of Atlanta.

❑ **NO CHANGE TO EMPLOYEE SUPPLEMENTAL LIFE** – Initial enrollment or most recent supplemental life change form on file is in effect. Note: If no change is indicated below, current election remains in force even if "No Change" is unmarked.

❑ **CHANGE EMPLOYEE SUPPLEMENTAL LIFE – Effective date determined by approval from Hartford Life.**

From $_____ Change to: $_____ (Increments of $10,000 to a maximum $250,000.) Note: Evidence of good health will be required for all coverage elections or increases after your initial enrollment period.

❑ **NO CHANGE TO SPOUSE SUPPLEMENTAL LIFE** – Initial enrollment or most recent supplemental life change form on file is in effect. Note: If no change is indicated below, current election remains in force even if "No Change" is unmarked.

❑ **CHANGE SPOUSE SUPPLEMENTAL LIFE – Effective date determined by approval from Hartford Life.**

From $_____ Change to: $_____ (Increments of $10,000 to a maximum $100,000.) Note: Evidence of good health is required for all coverage elections or increases after your initial enrollment period.

❑ **NO CHANGE TO CHILD(REN) LIFE** – Initial enrollment or most recent supplemental life change form on file is in effect.

❑ **CHANGE CHILD(REN) LIFE – Effective upon date received by employer and subject to immediate payroll deduction.**

Note: Life amount elected is a per child amount, effective for all dependent children.

From $_____ Change to: $_____ (Increments of $2,000 to a maximum of $10,000 per child.)

3. Complete if applying for spouse and/or children's coverage:

Spouse Last Name First M.I.	Names of Children	Dates of Birth
Spouse Date of Birth / / S.S. # - -		

4. ☐ NO CHANGE - COMPLETE SECTION BELOW ONLY IF CHANGING BENEFICIARY DESIGNATION ON FILE:

I hereby rescind my previous beneficiary designations and make the following beneficiary designations which replace and supercede all previous designations made before the date signed below:

Primary Beneficiary Name:_____ Relationship: _____

Secondary Beneficiary Name:_____ Relationship: _____

A beneficiary may be changed upon written request. The beneficiary for life insurance on the lives of your spouse or children will automatically be you, if surviving, otherwise your estate, subject to policy provisions.

5. Are you actively working on a regular basis? ❑ Yes ❑ No

This means you are performing in the usual way, all of the regular duties of your job on a regularly scheduled basis, at least 30 hours per week, but not less than 1,500 hours annually. If "No", explain: _____

_____

6. Please read the certification statement, then sign, date and return this form to your Benefits Office.

I hereby apply for the changes in my Group Supplemental Term Life Insurance plan, and if applicable make the changes in beneficiaries, as shown above and authorize my employer to make the appropriate payroll deductions for the additional coverage(s) applied for upon their approval. I understand that late enrollments or increases in my Employee and/or Spouse Supplemental Life coverages do not become effective until approved by The Hartford. I represent that the statements above are true and complete to the best of my knowledge and belief and are binding on any person claiming an interest in the coverage issued.

_____ _____

Employee's Signature Date