

SEIU Local 521

North American Insurance Trust Voluntary Group Term Life Insurance

Below is a brief description of your Employer's Voluntary Life Insurance coverage with Principal Life Insurance Company. This is only a summary, for detailed information regarding coverage, definitions, exclusions, limitations, reductions, conversion and claims, please refer to the employee benefit booklet.

EMPLOYEE:

Classification: All eligible, full-time employees who work at least 20 hours per week for the employer on a regular basis.

Amount of Insurance: Increments of \$10,000 to a maximum of \$250,000

Guaranteed Issue: **\$100,000** New applications only, all increases in coverage subject to underwriting.

Reduction: To 50% at Age 65. Benefits terminate at age 70.
PORTABILITY of coverage is available at Retirement or Termination

Billing: Direct Quarterly Billing

SPOUSE

Amount of Insurance: Up to 50% of the employee's coverage election to a maximum of \$100,000 and a minimum of \$10,000.

Guaranteed Issue: **\$50,000** - Spouse must be performing normal daily activities, not confined to home or hospital.

Reduction: Same as employee.

CHILD

Eligibility: Ages 14 days to 19 years old (25 if a fulltime student). Child must be performing normal daily activities, not confined to home or hospital.

Guaranteed Issue: All amounts are guarantee issue.

Amount of Insurance: \$2,500, \$5,000, or \$10,000 per child.

NOTE:

No medical questions required up to \$100,000 for eligible members (\$50,000 for spouse), during the initial enrollment period.

**Return Completed Application to:
Thomas E. Mestmaker Insurance & Associates, Inc.
P.O. Box 2302
Bakersfield CA 93303**

Only the group policy contains all terms and provisions of coverage

Principal Life Insurance Company

Valley Benefits

Meeting the insurance needs of SEIU Local 521 union members!

SEIU Local 521

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OTHER FEATURES:

Portability
Disability waiver prior to age 60.
Accelerated Death Benefits
Common Carrier provision

VOLUNTARY LIFE RATES

<u>Age of Employee</u>	<u>Monthly Rate Per \$1,000</u>	
Up to Age 29		\$.07
30 to 34		\$.09
35 to 39		\$.12
40 to 44		\$.19
45 to 49		\$.32
50 to 54		\$.54
55 to 59		\$.85
60 to 64		\$ 1.31
65 to 69		\$ 2.36
Child(ren):	\$2,500	\$.50/month
	\$5,000	\$1.00/month
	\$10,000	\$2.00/month

Sample Calculation:	A 44 year-old tobacco-free employee wants \$50,000 for himself, \$20,000 for his spouse (also age 44) and \$5,000 for his child(ren):			
	# of 1,000			
Employee	50	x	\$0.19	Rate per \$1,000 = \$ 9.50
Spouse	20	x	\$0.19	Rate per \$1,000 = \$ 3.80
Child(ren)	5	x	\$1.00(1)	Rate per unit = \$ 1.00
Total cost per month:				\$ 14.30
			(1)\$1.00 is the rate for dependent child(ren) coverage regardless of the number of dependent child(ren) being covered.	

Premiums will be billed on a quarterly basis

Only the group policy contains all terms and provisions of coverage

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**MEMBER & EMPLOYEE APPLICATION FOR
TERM LIFE INSURANCE SEIU Local 521**

North American Insurance Trust
underwritten by Principal Life Insurance Company



Meeting the insurance needs of SEIU Local 521 union members!

- I wish to apply for coverage under the Family Life Insurance Plan.
- I wish to increase my present coverage.
- I have I have not made a previous application for Family Life Insurance

1. Employer: _____

2. Employer Phone: _____

3. Email Address: _____

4. Employee Name _____

5. Social Security No.: _____

Age: _____ Sex: Male Female

Height: _____ Weight: _____

6. Home Address: _____

Phone: _____

7. Occupation: _____

8. Birthdate: _____ Birthplace: _____

9. Basic Annual Salary: \$ _____

10. Beneficiary: _____

11. Relationship: _____

9. I am currently covered under the North American Insurance Trust for: \$ _____;

Increase to: \$ _____

10. Amount Applied for:

\$20,000 \$50,000 \$100,000

\$ _____

(Rounded to the next \$10,000; to a maximum of \$250,000)

11. Do you wish coverage for your eligible spouse?

Yes No

Spouse amount applied for:

\$10,000 \$20,000 \$ _____ Not to exceed:

(a) 50% of Employee's Amount; (b) \$150,000

12. Spouse Beneficiary: _____

Relationship: _____

13. Do you wish coverage for your children?

Yes No (\$2,500)

Yes No (\$5,000)

Yes No (\$10,000)

COMPLETE ONLY IF APPLYING FOR SPOUSE AND/OR DEPENDENT COVERAGE

SPOUSE INFORMATION

NAME	HEIGHT	WEIGHT	SEX	AGE	BIRTHDAY

CHILD INFORMATION

NAME	HEIGHT	WEIGHT	SEX	AGE	BIRTHDAY

THIS SECTION TO BE COMPLETED BY EMPLOYER'S INSURANCE DEPARTMENT

Name: _____ Date of full-time employment: _____

Group Insurance Eligibility Date: _____

Health Questionnaire: Please complete this section if you are applying: as a late applicant, for an increase in coverage, for an amount above the Guaranteed issue amount. Please check the appropriate box and give full details to any "yes" answers in the space provided. Attach additional sheets if more space is needed.

- 1.) ON AN EMPLOYEE OVER THE \$100,000 GUARANTEED ISSUE AMOUNT; 2.) ON A SPOUSE OVER THE \$50,000 GUARANTEED ISSUE AMOUNT; 3) WHENEVER EVIDENCE OF INSURABILITY IS OTHERWISE REQUIRED.

	Employee		Spouse	
	Yes	No	Yes	No
2 Have you ever had life or health insurance coverage denied, declined, postponed, offered only at higher than standard rates or otherwise not been granted coverage for which you applied?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Have you consulted a physician or practitioner or been diagnosed, test or treated within the past 10 years for any: disorder or disease of the heart or blood vessels; stroke; high blood pressure; diabetes; cancer; drug or alcohol abuse; disorder of the immune system; mental or nervous disorder; disorder of the blood ; Disease; or, Multiple Sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Do you have AIDS or have you been diagnosed or treated for AIDS, ARC, or AIDS related conditions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Have you consulted a physician or practitioner or been diagnosed, tested or treated within the past 10 years for any medical condition or illness not listed in this application, or are you currently under treatment or observation for such a condition or illness, or do you plan any operation or visit to a doctor for any such condition or illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Within the past 12 months, have you used any form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

QUESTION NO.	TREATMENT DATES		NAME	HEALTH DETAILS	ATTENDING PHYSICIANS NAME, ADDRESS AND PHONE #
	FROM	TO			

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. However, Canada Life and its reinsurers may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or submit a claim for benefits to such a company, the Bureau will, upon request, supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We or our reinsurers may also release information in our files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FRAUD WARNING: A person who knowingly and with intent to defraud or deceive any insurance company submits an application or statement of claim containing any materially false, incomplete, or misleading information may be subject to civil or criminal penalties.

Date

Employee Signature

Spouse Signature

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