

# HPP AD&D AND LTC ENROLLMENT FORM



Name		Empl ID#
------	--	----------

## Accidental Death and Dismemberment Insurance

This optional insurance allows employees to insure themselves and eligible family members against covered accidents in an amount up to \$500,000. Dependents covered under this plan are covered only for a specified percentage of the employee's elected coverage (see Plan Booklet for specific details.) Evidence of insurability is never required to enroll in this coverage. Coverage is effective on the first of the month following the date the enrollment form is submitted to the GME Office (or on the date it is submitted if it is the first day of the month).

**Select one of the following options:**

- Employee Only Coverage (\$.19 per \$10,000 of coverage)
- Employee and Family Coverage (\$.36 per \$10,000 of coverage)
- Waive

**Coverage amount desired:** \$ \_\_\_\_\_

**Designate at least one Primary and one Contingent Beneficiary (if more than one, state percent of benefit to go to each person):**

Primary Beneficiary: \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Relationship to Employee: \_\_\_\_\_

**(Employee is beneficiary for coverage on family members)**

## Long Term Care Insurance

**If you enroll in Long Term Care Insurance, you must also complete and return a separate CNA**

**Application** - Rates are in the CNA Long Term Care information packet. Parents and grandparents must complete a different application and are billed directly by the insurance carrier.

This optional insurance provides coverage for nursing home, adult day care and home-based care. Coverage is available for an employee, his/her spouse, and the parents and grandparents of the employee and spouse. I understand that if I enroll during my Initial Enrollment Period (3 months following date of hire or transfer into a position eligible to enroll in this coverage), I will not be required to provide evidence of insurability for coverage on myself. If I wish to enroll after my Initial Enrollment Period, I will be required to apply and provide evidence of insurability. Evidence of insurability is always required for my spouse, parents, and grandparents.

**I choose to enroll in the Long Term Care Insurance and am enclosing my CNA application form:**

- Myself
- Waive
- My Spouse
- Waive

I have read and understand the information provided. I agree to the terms of the plans selected with this form. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize payroll deductions of premiums as required.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Benefit Dept Use Only	Entry Date:	Entered By:	QC By:	QC Date:
-----------------------	-------------	-------------	--------	----------