EMPLOYEE LIFE INSURANCE ELECTION FORM

(PLEASE PRINT)

Hanford Employee Welfare Trust (HEWT)

PAYROLL NO.	LAST NAME FIRST NAME MIDDLE INITIAL	SOC. SEC. NO.	COMPANY: ◯ O&E ◯ HAMTC ◯ HGU

BASIC LIFE/ACCIDENTAL DEATH AND DISMEMBERMENT

Check One Only:

◯ 2 times base annual salary (all employees)

◯ 1 times base annual salary (salaried only, at no employee cost)

◯ Decline Insurance

PERSONAL ACCIDENT INSURANCE

Check One Only:

Effective Date: _____

◯ 1. I hereby apply for personal accident insurance in the amount I have indicated on this form. I authorize the company to deduct from my pay such amounts as are now, or may be in the future, required of me for such insurance. Check (✓) one.

◯ Employee ◯ Or Family (includes employee)

Level of Coverage: $ _____ ,000 (units of $10,000 to 250,000, and increments of $50,000 thereafter; maximum of $750,000.*)

◯ 2. I decline the personal accident coverage.

*Amounts greater than $500,000 cannot exceed 10 times employee's annual salary.

BARGAINING UNIT DEPENDENT LIFE INSURANCE

Check One Only:

◯ 1. I wish to insure my eligible dependents under the dependent life insurance plan. I hereby authorize my employer to make the necessary deduction from my pay to cover my contribution for this insurance.

Check One: →	◯ Schedule A	◯ Schedule B	◯ Schedule C	◯ Schedule D	◯ Schedule E	◯ Schedule F
Spouse/Domestic Partner	$ 5,000	$ 10,000	$ 15,000	$ 20,000	$ 25,000	$ 30,000
Each Eligible Child	$ 100	$ 200	$ 300	$ 300	$ 300	$ 300
(15 days to 6 mos.)	$ 1,000	$ 2,000	$ 2,000	$ 2,000	$ 2,000	$ 2,000
(6 mos. to 23 yrs.)						

◯ 2. I understand that I am eligible to enroll in the dependent life insurance plan. Although I presently have an eligible dependent(s), I do not wish to enroll in the plan at this time. If I wish to enroll later, I understand that I will be required to submit a statement of physical condition to determine insurability.

◯ 3. I presently do not have an eligible dependent. I understand I may enroll in the plan within 31 days following the first day any person becomes my eligible dependent.

Note: Spouse/Domestic Partner coverage is limited to one half of your employee basic life coverage amount.

OR

SALARIED DEPENDENT LIFE INSURANCE

Check One Only:

◯ 1. I wish to insure my eligible dependents under the dependent life insurance plan. I hereby authorize my employer to make the necessary deduction from my pay to cover my contribution for this insurance.

Check One: → OR	◯ Schedule S (Spouse/ Domestic Partner) $ 10,000	◯ Schedule T (Spouse/ Domestic Partner) $ 20,000	◯ Schedule U (Spouse/ Domestic Partner) $ 30,000	◯ Schedule V (Spouse/ Domestic Partner) $ 40,000	◯ Schedule W (Each Eligible Child) (15 days to 23 yrs.) $ 5,000
Check One: → (Spouse/Domestic Partner)	◯ Schedule SW $ 10,000	◯ Schedule TW $ 20,000	◯ Schedule UW $ 30,000	◯ Schedule VW $ 40,000	
(Each Eligible Child) (15 days to 23 yrs.)	$ 5,000	$ 5,000	$ 5,000	$ 5,000	

◯ 2. I understand that I am eligible to enroll in the dependent life insurance plan. Although I presently have an eligible dependent(s), I do not wish to enroll in the plan at this time. If I wish to enroll later, I understand that I will be required to submit a statement of physical condition to determine insurability.

◯ 3. I presently do not have an eligible dependent. I understand I may enroll in the plan within 31 days following the first day any person becomes my eligible dependent.

Note: Spouse/Domestic Partner coverage is limited to one half of your employee basic life coverage amount.

I authorize the Company to deduct the required amount for this coverage from my pay. I understand insurance rates are reviewed and subject to change.

EMPLOYEE SIGNATURE	DATE

RETURN TO BENEFITS ADMINISTRATION - H2-23. Retain a copy for your records.

OFFICIAL USE ONLY