OPTIONS

APL SUPPLEMENTAL INSURANCE

EMPLOYEE NAME_____ DATE OF BIRTH_____

ADDRESS_____CITY_____ST_____ZIP_____

SOCIAL SEC #_____ DATE OF HIRE_____

GENDER **M F** TOBACCO **Y N** CELL/HOME#_____

BENEFICIARY NAME_____RELATIONSHIP _____DATE OF BIRTH_____

_____

SPOUSE NAME_____DATE OF BIRTH_____AGE_____

TOBACCO **Y N** SOCIAL SEC #_____ ACTIVELY WORKING **Y N**

EMPLOYER_____ JOB TITLE_____

_____

CHILD(REN)

NAME_____ DATE OF BIRTH_____ GENDER **M F**

NAME_____ DATE OF BIRTH_____ GENDER **M F**

NAME_____ DATE OF BIRTH_____ GENDER **M F**

NAME_____ DATE OF BIRTH_____ GENDER **M F**

NAME_____ DATE OF BIRTH_____ GENDER **M F**

SIGNATURE: _____DATE: _____

☐ **I DECLINE PARTICIPATION AT THIS TIME.**

1. ACCIDENT PLAN – On/Off Job Coverage 24/7

EXAMPLES OF PAYOUTS PER ACCIDENT

Accidental Death- $60,000	**Hosp/ICU - $250-$500 a day**	**Fractures – Up to $15,000**
Common Carrier- $120,000	**Hosp. Admission - $1,250**	**Dislocations – Up to $15,000**
Emergency Room - $300	**ICU Admission - $2,500**	**Lacerations w/ Stitches-$125-$500**
Urgent Care - $150	**Follow Up treatment - $100**	**Major Diagnostic Exam - $250**
Doctor Office - $150	**X-Ray - $300**	**Telemedicine - $35**

PLAN 1 ☐ EMPLOYEE $7.80 ☐ EMP+CHILDREN $13.71 ☐ EMP+SPOUSE $12.07 ☐ FAMILY $18.37

2. CRITICAL ILLNESS W/ CANCER – CANCER, HEART ATTACK, STROKE, MAJOR ORGAN TRANSPLANT, END STAGE RENAL FAILURE. CHILDREN FREE TO AGE 26. $100 WELLNESS

AGE	☐ $10,000 LUMP SUM PAYOUT		☐ $20,000 LUMP SUM PAYOUT	
	☐ EMPLOYEE	☐ FAMILY	☐ EMPLOYEE	☐ FAMILY
18-29	$3.18	$5.77	$4.73	$8.05
30-39	$5.47	$9.41	$9.20	$14.96
40-49	$9.86	$16.10	$17.91	$28.13
50-59	$16.50	$25.98	$31.04	$47.86
60-64	$21.68	$33.60	$41.65	$63.60
65-99	$33.11	$50.70	$64.58	$97.92

3.HOSPITAL CONFINEMENT- $1500 INITIAL HOSPITAL ADMISSION,

$100-$200 A DAY IN HOSPITAL, UP TO $1000 SURGERY. $100 ER/UC VISIT, $50 DR VISIT.

PLAN 1 ☐ EMPLOYEE $11.70 ☐ EMP+CHILDREN $19.59 ☐ EMP+SPOUSE $20.86 ☐ FAMILY $28.08

** RATES ARE BIWEEKLY **

4. SHORT TERM DISABILITY – Cover Off job Accidents and On/Off job Sickness. 7 day Elimination Period and 6 Month Duration. (Circle desired monthly benefit.)

MONTHLY BENEFIT	BI-WEEKLY RATES 18-54	55-59	60+
$1,000	$10.66	$13.34	$19.94
$1,100	$11.73	$14.67	$21.93
$1,200	$12.79	$16.01	$23.93
$1,300	$13.86	$17.34	$25.92
$1,400	$14.93	$18.67	$27.91
$1,500	$15.99	$20.01	$29.91
$1,600	$17.06	$21.34	$31.90
$1,700	$18.12	$22.68	$33.90
$1,800	$19.19	$24.01	$35.89
$1,900	$20.26	$25.34	$37.88
$2,000	$21.32	$26.68	$39.88
$2,100	$22.39	$28.01	$41.87
$2,200	$23.46	$29.34	$43.86
$2,300	$24.52	$30.68	$45.86
$2,400	$25.59	$32.01	$47.85
$2,500	$26.65	$33.35	$49.85
$2,600	$27.72	$34.68	$51.84
$2,700	$28.79	$36.01	$53.83
$2,800	$29.85	$37.35	$55.83
$2,900	$30.92	$38.68	$57.82
$3,000	$31.98	$40.02	$59.82
$3,100	$33.05	$41.35	$61.81
$3,200	$34.12	$42.68	$63.80
$3,300	$35.18	$44.02	$65.80
$3,400	$36.25	$45.35	$67.79
$3,500	$37.32	$46.68	$69.78
$3,600	$38.38	$48.02	$71.78
$3,700	$39.45	$49.35	$73.77
$3,800	$40.51	$50.69	$75.77
$3,900	$41.58	$52.02	$77.76
$4,000	$42.65	$53.35	$79.75
$4,500	$47.98	$60.02	$89.72
$5,000	$53.31	$66.69	$99.69

5. LIFE INSURANCE -

30 Year Term Life: Select Amounts for Employee and Dependents

Employee /Spouse Biweekly Life Rates

Volume	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000
	$	$	$	$	$	$

Child Biweekly Life Rates

Volume	$25,000/ All Children	$50,000/ All Children
	$5.53	$11.07

☐ **EMPLOYEE: Type _____Age _____ Volume _____ Premium _____**

☐ **SPOUSE: Type _____Age _____ Volume _____ Premium _____**

☐ **CHILD(ren): Type _____Age _____ Volume _____Premium _____**

Employee can elect up to $150,000, Spouse can elect up to $100,000, and Children up to $50,000. Must elect coverage on self in order to cover spouse or children.

** RATES ARE BIWEEKLY **

SUPPLEMENTAL INSURANCE ENROLLMENT

CHECK THE BOX OF PRODUCTS CHOSEN: *RATES ARE BIWEEKLY*

INITIAL ON THE LINE:

- ☐ **ACCIDENT INSURANCE** _____
- ☐ **CANCER CRITICAL INSURANCE** _____
- ☐ **HOSPITAL INSURANCE** _____
- ☐ **LIFE INSURANCE** _____
- ☐ **SHORT TERM DISABILITY** _____
- ☐ **I DECLINE PARTICIPATION AT THIS TIME** _____

I WOULD LIKE TO ENROLL IN THE PLANS SELECTED ABOVE THROUGH MY EMPLOYER. I UNDERSTAND THAT PREMIUMS ARE AN ESTIMATION AND 100% MY RESPONSIBILITY. I AGREE MY EMPLOYER MAY DEDUCT PREMIUMS FROM MY PAYCHECK.

SIGNATURE _____DATE _____

***If you have any questions please contact Brian Patureau at (504)239-4520**