GROUP TERM LIFE, ACCIDENTAL DEATH & DISMEMBERMENT and DISABILITY, INSURANCE ENROLLMENT FORM

Life Insurance Company of North America (LINA)

EMPLOYER: Marion County

Return completed form to: MCEmployeeBenefits@co.marion.or.us

Please use this form to apply for coverage. Simply fill in any requested information below. Don't forget to include your Social Security Number, herein shown as SSN, Birthdate, sign your name and enter today's date.

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ SSN _____ Date of birth _____

Home Address _____ City _____ State _____ Zip _____

Email _____ Phone _____ Employee ID # _____ Gender: _____

Have you smoked or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

Has your Spouse or Domestic Partner smoked or used any form of tobacco in the past 12 months? ☐ Yes ☐ No

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER**

To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer.

❑ I am currently married and my date of marriage is _____

❑ I am currently in a Domestic Partnership and the date of formation of my Domestic Partnership is _____

Spouse or Domestic Partner Name _____ SSN _____ Date of birth _____ Gender _____

YOUR COVERAGE ELECTIONS

View the Summary of Benefits for costs and instructions for how to calculate premium.

Employee-Paid Term Life Insurance – Policy # FLX0964730 Underwritten by LINA

Choose your desired coverage amount below and who you would like to cover. See the Summary of Benefits for costs.

Who You Want to Cover	Coverage Amount	Accept your desired coverage amount or decline coverage below.
☐ Employee	Units of $10,000 up to the lesser of 6 times annual compensation or $500,000 Guaranteed Issue Amount***: $100,000	☐ $10,000 ☐ $100,000*** ☐ $500,000**** ☐ Other _____ *Amount must be a multiple of $10,000.*
☐ Spouse or Domestic Partner	Units of $10,000 up to $300,000, not to exceed 100% of the employee's benefit Guaranteed Issue Amount***: $25,000	☐ $10,000 ☐ $25,000*** ☐ $300,000**** ☐ Other _____ *Amount must be a multiple of $10,000. The amount cannot exceed 100% of the employee's coverage.* ☐ Decline Coverage
☐ Children	☐ $2,000 ☐ $5,000 ☐ $10,000**** Guaranteed Issue Amount***: All amounts	☐ Decline Coverage *If Children are elected, all eligible dependent children will be covered.*

Employee-Paid Accidental Death and Dismemberment Insurance (AD&D) – Policy #OK0966319 Underwritten by LINA

Employee & Spouse or Domestic Partner	The Term Life insurance costs above include an equal amount of Voluntary Accidental Death & Dismemberment (AD&D) Insurance under Policy #FLX0964730.

Employee-Paid Short Term Disability – Policy # VDT0961169 Underwritten by LINA

Review your available plan below before accepting or declining coverage.

Who You Want to Cover	Coverage Amount	Accept your desired coverage amount or decline coverage below.
❑ Employee	60% of your weekly covered earnings to a maximum of $1,500**** per week	❑ Accept Coverage ❑ Decline Coverage

*** Guaranteed Issue Amount is only available if enrolling within the first 31 days of eligibility. For any coverage that is not Guarantee Issue, you must complete the Evidence of Insurability Form. Amounts of insurance may be limited by state law.

****This is the maximum coverage amount that you can choose under this plan. Coverage elected during this enrollment period will take effect on the later of 01/01/2026, the date your election form is received by your Employer, or if applicable the date your Evidence of Insurability Form is approved by the Insurance Company.

**Domestic Partner is defined in the Group Policy. For purposes of this form, wherever the term Spouse appears, it shall also include Domestic Partner and Domestic Partners registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your employer. Spouse includes Partners in Civil Union relationships for residents of State registered Domestic Partners for residents of Oregon.

To calcualte your monthly premium for Short Term Disability:

Employee's Monthly Cost of Coverage:

Age	Monthly Rate per $10 of Weekly Benefit
0-54	$0.084
55-59	$0.102
60-64	$0.121
65-99	$0.132

Step 1: Divide your annual salary by 52 to calculate your weekly earnings.
Step 2: Multiply this amount 0.60 (60%) to get your gross weekly benefit.
Step 3: Use the chart to the left to find your monthly rate based on your age.
Step 4: Multiply your rate by your gross weekly benefit, or the max weekly benefit ($1,500) whichever is less.
Step 5: Divide the total by 10. This is your monthly cost.

For example using a 30 year old employee with an annual salary of $50,000:
$50,000 / 52 = $961.54
$961.54 x .6 = $576.92
$576.92 x 0.084 = $4.85 per month

To calcualte your monthly premium for Voluntary Term Life (includes Accidental Death and Dismemberment):

Employee's Monthly Cost of Coverage:

Age	Cost Per $1,000		Age	Cost Per $1,000	
	Non-Smoker	Smoker		Non-Smoker	Smoker
0-19	$0.146	$0.192	60-64	$1.130	$1.610
20-24	$0.146	$0.192	65-69	$2.116	$2.938
25-29	$0.146	$0.192	70-74	$3.761	$5.056
30-34	$0.151	$0.201	75-79	$5.605	$7.268
35-39	$0.179	$0.246	80-84	$10.306	$12.867
40-44	$0.254	$0.360	85-89	$10.306	$12.867
45-49	$0.400	$0.570	90-94	$25.939	$32.409
50-54	$0.584	$0.846	95-99	$25.939	$32.409
55-59	$0.957	$1.360			

Step 1: Use the chart to the left to find your monthly rate based on your (and your spouse's) age as of your effective date.
Step 2: Multiply this rate by your desired coverage amount, in units.

For example: $150,000 of coverage is 150 units.
For an employee who is 30 year old, and a non-smoker, you would calculate as follows: 150 x .151 = $22.65 per month

SIGN TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. I understand that coverage is subject to the insurance company's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within **3** months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for **12** months for the Disability coverage.

Caution: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Please Sign Here Signature _____ Date _____

Proceed to the next page to designate your beneficiary for your life insurance policy(ies)

BENEFICIARY SECTION

To ***specify a beneficiary***, complete the section below. You will be the beneficiary for your spouse and children unless you specify otherwise. If there is not enough room to specify all beneficiaries, attach, sign and date a separate page using the format below.

Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Complete this section if electing coverage under Term Life Insurance Policy # FLX0964730. The Employee will be his or her spouse's beneficiary unless specified otherwise. When specifying multiple beneficiaries, the insured must indicate the percentage of distribution for each and the total must equal 100%. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

Employee's Primary Beneficiary(ies) Name, Address and Phone Number:	Relationship	SSN	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies) Name, Address and Phone Number:	Relationship	SSN	Date of Birth	% (total must equal 100%)

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____

Employee Signature _____ Date _____