

2026 VOLUNTARY COVERAGES FORM

GENERAL INFORMATION

Name of Employee _____ Soc. Sec. # _____ - _____ - _____ Date of Birth _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Address _____ City _____ State _____ Zip _____

Home Phone # () _____ Work Phone # () _____ Job Title _____

☐ Salaried ☐ Hourly Weekly Hours Worked: _____ Annual earnings: _____

STANDARD INSURANCE COMPANY VOLUNTARY LIFE (Employee Paid)

☐ Decline

Term Life Insurance - See below for coverage and cost

Employee (up to \$80,000 guarantee issue when first eligible)

(max. is lesser of \$300,000 or 5X earnings)

☐ Yes

Life Amount _____

If enrolling, have you used tobacco in any form in the last 12 months?

☐ Yes ☐ No

Spouse (up to \$20,000 guarantee issue when first eligible)

(max. is lesser of 50% of employee election or \$150,000)

☐ Yes ☐ No

Name _____

Date of Birth _____

Life Amount _____

If enrolling, has your spouse used tobacco in any form in the last 12 months?

☐ Yes ☐ No

Child(ren) (all amounts guarantee issue)

(through age 25)

☐ Yes ☐ No

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

☐ \$5,000/\$0.92 per month

☐ \$10,000/\$1.84 per month

Rates cover all children

STANDARD INSURANCE COMPANY VOLUNTARY TERM LIFE RATES & CALCULATION Monthly cost for your age or your spouse's age and amount of coverage selected. No Medical History Statement required up to \$80,000 for you and up to \$20,000 for your spouse if application is made when first eligible for Employer's benefit program, otherwise subject to underwriting approval by Standard.

Contact HR if Medical History Statement required. Election amounts available in multiples of \$10,000.

	Non-Tobacco Rates	Tobacco Rates
Age	Per \$10,000 of Coverage	
<24	\$0.46	\$0.71
25-29	\$0.55	\$0.78
30-34	\$0.74	\$1.11
35-39	\$0.83	\$1.29
40-44	\$1.18	\$1.82
45-49	\$2.08	\$3.11
50-54	\$3.20	\$4.79
55-59	\$5.46	\$7.92
60-64	\$6.53	\$9.45
65-69	\$12.53	\$17.57
70-74	\$22.57	\$30.46
75-79	\$33.82	\$43.95
80-89	\$62.49	\$78.11
90+	\$147.63	\$197.29

General Information & Monthly Premium Calculation

Employee Rates are based on Employee's Age as of 1/1 each year

Spouse Rates are based on Spouse's Age as of 1/1 each year

Monthly Premium Calculation

Voluntary Age Rates: Per \$10,000 of Coverage

Step 1: Select your Volume (amount of coverage)	= \$
Step 2: Multiply your Volume by your Age Rate	= \$
Step 3: Divide the amount in Step 2 by \$10,000	= \$

Monthly Premium

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STANDARD INSURANCE COMPANY VOLUNTARY AD&D (Employee Paid)

Accidental Death & Dismemberment

☐ Employee ☐ Employee/Family ☐ Decline

Benefit Amount Monthly Cost

STANDARD INSURANCE COMPANY VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT & RATES

Write in desired benefit amount above. Maximum benefit is 10 times annual salary up to \$500,000.

Election amounts available in multiples of \$50,000.

MONTHLY COST			MONTHLY COST		
Benefit	Employee Only Rate	Employee & Family Rate	Benefit	Employee Only Rate	Employee & Family Rate
\$50,000	\$0.865	\$1.527	\$300,000	\$5.19	\$9.16
\$100,000	\$1.730	\$3.054	\$350,000	\$6.06	\$10.69
\$150,000	\$2.595	\$4.581	\$400,000	\$6.92	\$12.22
\$200,000	\$3.460	\$6.108	\$450,000	\$7.79	\$13.74
\$250,000	\$4.325	\$7.635	\$500,000	\$8.65	\$15.27

VOLUNTARY METLIFE GROUP LEGAL (Employee Paid)

Group Legal Plan: ☐ Yes ☐ Decline

METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY ACCIDENT (Employee Paid)

Group Accident Insurance

Low Plan **High Plan** ☐ Decline

☐ Employee Only ☐ Employee Only

☐ Employee + Spouse ☐ Employee + Spouse

☐ Employee + Children ☐ Employee + Children

☐ Employee + Spouse/Children ☐ Employee + Spouse/Children

METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY ACCIDENT RATES

Check desired plan above. See Employee Guide for specifics on benefits of Low and High plans.

LOW PLAN MONTHLY COST		HIGH PLAN MONTHLY COST	
Employee Only	\$6.47	Employee Only	\$12.10
Employee + Spouse	\$12.62	Employee + Spouse	\$23.59
Employee + Children	\$14.58	Employee + Children	\$27.23
Employee + Spouse/Children	\$17.51	Employee + Spouse/Children	\$32.71

2026 VOLUNTARY COVERAGES FORM

METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY CRITICAL ILLNESS (Employee Paid)

☐ Decline

Group Critical Illness Insurance - See below for coverage and cost

Employee

(Initial benefit of \$15,000 or \$30,000)

☐ Yes

Date of Birth _____

Initial Benefit Amount ☐ \$15,000 ☐ \$30,000

(Amts are guarantee issue when actively at work)

Spouse

(50% of employee's Initial Benefit Amount)

☐ Yes ☐ No

Name _____

SSN _____

Date of Birth _____

Child(ren)

(50% of employee's Initial Benefit Amount through age 25)

☐ Yes ☐ No

METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY CRITICAL ILLNESS RATES & CALCULATION Employee, spouse and child(ren) premiums will be based on the employee's age and benefit amount. Monthly premiums will be calculated as premium rates per \$1,000 from the rate table below, multiplied by benefit amount divided by 1,000.

	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse/Children	<u>Monthly Premium Calculation</u>	
Age	Per \$1,000 of Coverage				All rates based on Employee's Age as of 1/1	
<25	\$0.18	\$0.31	\$0.36	\$0.49	Step 1:	
25-29	\$0.19	\$0.34	\$0.37	\$0.52		
30-34	\$0.27	\$0.46	\$0.45	\$0.64	Select Initial Benefit Amount	= \$
35-39	\$0.38	\$0.65	\$0.56	\$0.83	Step 2:	
40-44	\$0.58	\$0.96	\$0.76	\$1.14	Multiply Step 1 by Age Rate	= \$
45-49	\$0.84	\$1.39	\$1.02	\$1.57	Step 3:	
50-54	\$1.19	\$1.97	\$1.37	\$2.15	Divide Step 2 by \$1,000	= \$
55-59	\$1.65	\$2.76	\$1.83	\$2.94		Monthly Premium
60-64	\$2.37	\$3.99	\$2.55	\$4.17		
65-69	\$3.55	\$5.96	\$3.73	\$6.14		
70+	\$5.53	\$9.11	\$5.71	\$9.29		

METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY HOSPITAL INDEMNITY (Employee Paid)

Group Hospital Indemnity Insurance

Low Plan

- ☐ Employee Only
☐ Employee + Spouse
☐ Employee + Children
☐ Employee + Spouse/Children

High Plan

- ☐ Employee Only
☐ Employee + Spouse
☐ Employee + Children
☐ Employee + Spouse/Children

☐ Decline

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METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY HOSPITAL INDEMNITY RATES

Check desired plan above. See Employee Guide for specifics on benefits of Low and High plans.

LOW PLAN MONTHLY COST		HIGH PLAN MONTHLY COST	
Employee Only	\$8.88	Employee Only	\$17.53
Employee + Spouse	\$16.41	Employee + Spouse	\$32.39
Employee + Children	\$14.58	Employee + Children	\$28.79
Employee + Spouse/Children	\$22.11	Employee + Spouse/Children	\$43.65

Beneficiary Designation for Employee Insurance

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the Standard insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%

Name (Last, First, Middle Initial)	SSN	Date of Birth	Relationship	Address	Phone	Shares %

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%

Name (Last, First, Middle Initial)	SSN	Date of Birth	Relationship	Address	Phone	Shares %

2026 VOLUNTARY COVERAGES FORM

Terms & Conditions

Application Agreement

I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or my children listed on this application. I attest that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract. I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I attest that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations.

Release of Information

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

By signing below, I acknowledge that I have read, understand, and agree to the Terms & Conditions on all pages of this form.

➔ X

Please sign your name. Do not print.

Date Signed

Note: Please sign and date even if no dependent or voluntary plan deductions.