NWFA The Trust
Your Employee Benefits Partner

Plans Underwritten by:
Standard Insurance Company, 1100 SW 6th Ave, Portland, OR 97204
Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166

2024 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 _____ Benefit Amount _____ Monthly Cost ☐ Decline

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

High Plan
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Children
☐ Employee + Spouse/Children

☐ Decline

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

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2024 VOLUNTARY COVERAGES FORM

METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY CRITICAL ILLNESS (Employee Paid)

☐ Decline

Group Critical Illness Insurance - See below for coverage and cost

Employee	Spouse	Child(ren)
(Initial benefit of $15,000 or $30,000)	(50% of employee's Initial Benefit Amount)	(50% of employee's Initial Benefit Amount through age 25)
☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No
Date of Birth _____	Name _____	
Initial Benefit Amount ☐ $15,000 ☐ $30,000	SSN _____	
(Amts are guarantee issue when actively at work)	Date of Birth _____	

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
Age	**Per $1,000 of Coverage**			
<25	$0.18	$0.31	$0.36	$0.49
25-29	$0.19	$0.34	$0.37	$0.52
30-34	$0.27	$0.46	$0.45	$0.64
35-39	$0.38	$0.65	$0.56	$0.83
40-44	$0.58	$0.96	$0.76	$1.14
45-49	$0.84	$1.39	$1.02	$1.57
50-54	$1.19	$1.97	$1.37	$2.15
55-59	$1.65	$2.76	$1.83	$2.94
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

Monthly Premium Calculation

All rates based on Employee's Age as of 1/1

Step 1:
Select Initial Benefit Amount =$

Step 2:
Multiply Step 1 by Age Rate =$

Step 3:
Divide Step 2 by $1,000 =$

Monthly Premium

METROPOLITAN LIFE INSURANCE COMPANY VOLUNTARY HOSPITAL INDEMNITY (Employee Paid)

Group Hospital Indemnity Insurance

☐ Decline

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

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

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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 %

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2024 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.