



DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

BASIC LIFE INSURANCE FACT SHEET

1. Active employees of the District are covered for \$10,000 of Life and Accidental Death & Dismemberment insurance, with Retirees insured for \$5,000.
2. Conversion Privilege: If you leave your present employment, you may convert the Life portion regardless of your medical condition, provided you do so within 31 days following termination.
3. Employees who fail to enroll when first eligible must wait 12 months and then submit satisfactory medical evidence of insurability attested to by a physician in order to qualify for this plan.
4. In case of Total and Permanent Disability, prior to age 60, waiver of premium may be applied – if approved, no further premium paid.
5. You may designate anyone you wish as the beneficiary of your coverage.
6. An individual's insurance will terminate upon the earliest of the following:
 - a. Termination of master policy
 - b. Non-payment of premiums
 - c. Proper notice of withdrawal of employee
 - d. Termination of employment

IMPORTANT NOTE:

- This fact sheet is merely intended to summarize the benefits of the Basic Group Life Insurance Plan.
- The Certificate of Insurance you receive from the Plan Administrator will completely explain all terms and coverage of your insurance.



Symetra Life Insurance Company

777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135

Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690

Phone 1-800-426-7784 | Fax 1-866-348-0058 | TTY/TDD 1-800-833-6388

GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-020377-00

Employer/Policyholder Name Dudley-Charlton Regional School District

68 Dudley-Oxford Road

Dudley

MA

01571

Street Address

City

State

Zip Code

Employee Occupation/Job Title

Employee Date of Employment

☐ Full Time Employee

☐ Part Time Employee

Effective Date of Coverage

\$ / ☐ HR ☐ WK ☐ MO ☐ YR

Basic Earnings

Class Number (if applicable)

I. EMPLOYEE/ENROLLEE INFORMATION

Name

Sex

☐ M

☐ F

Street Address

City

State

Zip Code

Home Telephone Number

Date of Birth

Marital Status

II. BENEFITS (Please check if you wish to enroll)

	Yes	No	Indicate the benefit amount
Employee Life			x BAE ¹ or \$
Employee AD&D			x BAE ¹ or \$
Employee Supplemental Life			x BAE ¹ or \$
Employee Supplemental AD&D			x BAE ¹ or \$
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Supplemental Life			
Spouse & Child ²			x BAE ¹ or \$

¹BAE: Basic Annual Earnings as defined in your contract.

²List Dependents' names and birthdates (use another page if needed).

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

- ☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution)**.
- ☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature

Date Signed

Group Benefits are insured by Symetra Life Insurance Company.

Age

[illegible]

Dudley-Charlton Regional School District
01-020377-00



Supplemental Accidental Death & Dismemberment Weekly Cost

Employee

Benefit Amount	Cost
\$5,000	\$0.03
\$10,000	\$0.07
\$15,000	\$0.10
\$20,000	\$0.14
\$25,000	\$0.17
\$30,000	\$0.21
\$35,000	\$0.24
\$40,000	\$0.28
\$45,000	\$0.31
\$50,000	\$0.35
\$55,000	\$0.38
\$60,000	\$0.42
\$65,000	\$0.45
\$70,000	\$0.48
\$75,000	\$0.52
\$80,000	\$0.55
\$85,000	\$0.59
\$90,000	\$0.62
\$95,000	\$0.66
\$100,000	\$0.69