MEMO
October 15, 2018

TO: **Mayor/Chair and Council/Board**

CC: Benefits Administrator

FROM: Anna-Maria Wijesinghe
Manager, Member and Association Services

RE: Group Insurance For Elected Officials

UBCM offers comprehensive group insurance coverage to all local government staff and elected officials in British Columbia. Historically, UBCM has offered group insurance benefits to elected officials and a number of our members have taken advantage of these benefits. With local government elections approaching, we wanted to remind members about this offer and provide details of the coverage and enrolment process as described below.

COVERAGE OFFERED TO ELECTED OFFICIALS

The following is information about the procedures for enrollment in the UBCM Group Benefits Plan for Elected Officials offered by our current carrier, Pacific Blue Cross/ BC Life:

A) Available Benefits

Elected officials who meet the eligibility requirements may now participate in the following benefits:

- Extended Health Care
- Dental
- Employee and Family Assistance Plan (EFAP)
- Optional Life Insurance
- Optional Accidental Death and Dismemberment

(Elected Officials are excluded from participating in Group Life, Dependent Life, Accidental Death and Dismemberment, Short Term and Long Term Disability and Critical Illness because these benefits are based on salary earned while employed.)

B) Eligibility

There must be a minimum of three (3) elected official applicants in your local government to enroll. Applications made by local governments that **do not currently** have their staff benefit plans under the UBCM Group Benefits Plan will be reviewed for consideration.

C) <u>Benefit Provisions & Costs</u>

1. Extended Health and Dental

For those local governments that have their staff benefits through the UBCM Group Benefits Plan, there is the option to provide your elected officials with the **same** level of benefits/plan design that you provide to your non-union staff for Extended Health and Dental. Under this approach, the existing group rates for the non-union staff plan would apply.

If you do not have staff benefits under the UBCM Group Benefits Plan, or you do not wish to provide the same level of benefits to Elected Officials, then you can choose a standard package. The standard package cost and benefit limits include:

a. Standard Extended Health Benefit Plan (Standard EHB):

- 80% reimbursement of eligible expenses
- Lifetime maximum of $50,000
- $25 per year single or family deductible
- 60 day trip duration
- **Premium of <u>$46.73</u> per month for single coverage and <u>$105.13</u> per month for couple/family coverage**

b. Enhanced Extended Health Benefit Plan (Enhanced EHB):

- 80% reimbursement of eligible expenses
- Lifetime maximum of $50,000
- $25 per year single or family deductible
- 60 day trip duration
- Vision Care to a maximum of $300 every two years
- $100 every two years for eye exams
- $300 per year for each covered practitioner (acupuncture, chiropractic, naturopath, physiotherapy, massage, podiatry, speech and psychologist)
- **Premium of <u>$57.10</u> per month for single coverage and <u>$128.46</u> per month for couple/family coverage**

c. Dental:

- 80% reimbursement of Plan A "Routine" expenses
- 50% reimbursement of Plan B "Major Restorative" expenses
- No annual maximum on Plan A or B
- **Premium of <u>$49.94</u> per month for single coverage and <u>$129.57</u> per month for couple/family coverage**

2. Employee and Family Assistance Plan (EFAP):

- Premium of **<u>$3.50</u>** per month for single coverage and family coverage
- Employee and Family Assistance plan, delivered through a partner, Homewood Health, services provided include telephone assessment, consultation, resources, support, advice and coaching on a full range of issues faced by individuals, parents, families, teens and young adults throughout their lives.
- https://www.pac.bluecross.ca/group/group-efap.aspx

3. Optional Life Insurance:

Optional Group Life may be purchased in multiples of $10,000 or $25,000. However, only one multiple can be chosen and will apply to everyone in the group purchasing the optional group life coverage. **A rate sheet is attached.**

4. Optional Accidental Death & Dismemberment (AD&D):

BC Life's Optional AD&D provides added financial security should one be faced with accidental death, accidental dismemberment of part or all of a limb, or loss of sight, hearing or speech. The monthly cost of this benefit is **$0.055 per $1,000 of coverage**.

D) Enrollment

Once you have the minimum three Elected Officials wanting to enroll they must register as a group and choose **one** of the following combinations of coverage:

Option 1: Standard EHB and Dental benefits
Option 2: Enhanced EHB and Dental benefits
Option 3: Option 1 (Standard EHB & Dental) and EFAP
Option 4: Option 2 (Enhanced EHB & Dental) and EFAP
Option 5: Either the optional life and/or optional AD&D benefits ***(applications can be made independent of one another)***
Option 6: A combination of option (1) and (5)
Option 7: A combination of option (2) and (5)
Option 8: A combination of option (3) and (5)
Option 9: A combination of option (4) and (5)

Each elected official will need to fill out the attached enrollment form with the same options.

For those local governments that have their staff benefits through the UBCM Group Benefits Plan, the elected officials will be added as a separate class to your existing contract/policy.

Enrollment for benefits must be made within four (4) months of appointment to council, therefore, the **deadline for enrollment is February 28, 2019**. Failure to apply within the required timeline will elicit PBC late-applicant rules (which may include providing evidence of insurability, back-billing of premiums, and/or coverage restrictions). Also, enrollment must be for the **full term of office**; this is to protect against abuse of the Plan.

We strongly recommended having all elected officials who do not wish to participate complete Part 6 of the application form to waive group benefits to indicate that the benefits have been offered.

It would be our preference that the payments of premiums follow the same structure as your non-union staff plans. That is, if your non-union staff plans are 100% employer paid then that arrangement should continue for Elected Officials, understanding that each local government may have different policies.

If the elected official is new or returning, please fill out the applicable attached forms to join the Plan:

1. Application for Group Benefits; and/or
2. For optional life - "Application for Optional Life"
3. For optional AD&D - "Voluntary Accidental Death & Dismemberment"

When the forms are completed please attach all the documents and include a covering letter summarizing the names of the elected officials that are applying for these benefits. Please forward all completed forms to:

Elected Officials' Benefits
c/o Anna-Maria Wijesinghe
Union of BC Municipalities
Suite 60 – 10551 Shellbridge Way
Richmond, B.C. V6X 2W9

For further details regarding coverage or if you would like assistance with the enrollment of your elected officials, please contact:

Anna-Maria Wijesinghe, UBCM
Manager, Member & Association Services
Ph: 604.270.8226 ext. 111
Email: amwijesinghe@ubcm.ca

Nathan Roeters,
Account Executive, PBC
Ph: 604.419.2412
Email: nroeters@pac.bluecross.ca

If you are not currently participating in the UBCM Group Benefits Plan, we would encourage you to request a quote. We can provide you with information on cost savings, as well as the other advantages of participation.

E) Retiring Council Members or Elected Officials Not In Office

Please note that retiring council members or elected officials not currently in office should **not** remain on your benefits plans. You must inform Pacific Blue Cross/BC Life that coverage is to be terminated. **The effective date of termination will be no later than the end of December 2018.**

Retiring council members and elected officials no longer in office have the option of converting to individual policies (within 60 days for Extended Health and Dental benefits and 31 days for Optional Life and Optional AD&D) with the advantage of not needing to provide medical evidence.

- For information on individual health and dental benefits available to those not on the Group Plan any longer, we would encourage you to provide the following link: https://www.pac.bluecross.ca/group/group-conversion.aspx. Conversion options are available for 60 days.

- For those wishing to convert to an individual life insurance policy must apply within 31 days after terminating the group coverage and if they are under the age of 65. For more information regarding conversion, members may contact BC Life at email: BCLClaimsServices@pac.bluecross.ca

PACIFIC BLUE CROSS™ UBCM

DO NOT WRITE IN THIS SPACE

APPLICATION FOR GROUP BENEFITS

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2149 | enrollment@pac.bluecross.ca

APPLICANTS — Please complete BLACK portions of this application.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete RED portions of this application.
See page 3 for tips for completing this application.

☐ New applicant ☐ Returning Applicant

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Dental effective date (mm-dd-yyyy)	Extended health effective date (mm-dd-yyyy)
BC Life effective date (mm-dd-yyyy)	Other effective date (mm-dd-yyyy)	ID number

PART 2 — APPLICANT INFORMATION

First name	Last name	Middle initial	Birthdate (mm-dd-yyyy)	Sex ☐ M ☐ F

Street address	City	Province	Postal code

Email address	Do you have a government health/medical plan in any province or territory? ☐ Yes ☐ No

Please provide the information requested in the table below.
List any additional children in *Part 8 — Additional Information*.

Does your spouse/child have a government health/medical plan in any province or territory?

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX	RELATIONSHIP TO YOU		SCHOOL NAME + STUDENT NUMBER*
Spouse			(mm-dd-yyyy)	☐ M ☐ F	☐ Common-Law ☐ Married	☐ Yes ☐ No	
First child			(mm-dd-yyyy)	☐ M ☐ F		☐ Yes ☐ No	
Second child			(mm-dd-yyyy)	☐ M ☐ F		☐ Yes ☐ No	
Third child			(mm-dd-yyyy)	☐ M ☐ F		☐ Yes ☐ No	
Fourth child			(mm-dd-yyyy)	☐ M ☐ F		☐ Yes ☐ No	

*Complete this section if child is over the maximum age as stated in your Group Benefit Contract and attending school full-time.
If you have a child with a disability, include a *Disabled Dependent Application Form* which is available online at www.pac.bluecross.ca.
Their coverage will be continued beyond the minor maximum age if certain criteria are met.

PART 3 — COORDINATION OF BENEFITS

If you or any of your dependents were covered under another plan within the last 6 months, please indicate the following:

Name of insurance company	Name of member with other insurance company	Group/policy number	Policy effective date (mm-dd-yyyy)	ID or certificate number

Employment type ☐ Full-time ☐ Part-time ☐ Retiree	Benefits covered under the other plan ☐ EHC ☐ Dental	Is the plan still active? ☐ Yes ☐ No — termination date (mm-dd-yyyy): ____________

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PART 4 — EMPLOYER/PLAN ADMINISTRATOR TO COMPLETE THIS

Name of company/organization	Division	Sub-division (if applicable)	Class	Section ID

Applicant's occupation	PBC office use: Occ. code	Employment type ☐ Full-time ☐ Part-time ☐ Retired ☐ Hour bank ☐ Other: ______

Payroll number	Date of full-time hire (mm-dd-yyyy)	Date of rehire (mm-dd-yyyy)	Applicant's salary $ ______ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually	Hours per week

If we have questions, how can we contact you? ☐ **Telephone:** ______ ☐ **Email:** ______

PART 5— EMPLOYEE AND EMPLOYER/PLAN ADMINISTRATOR SIGNATURES

I agree to the conditions of the contract between my employer/plan administrator and Pacific Blue Cross/BC Life and authorize my employer to deduct the required contributions from my earnings. I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse Pacific Blue Cross/BC Life up to the amount advanced to me pending such settlement or judgement.

I consent to Pacific Blue Cross/BC Life collecting, using and disclosing my personal information where reasonably necessary for the purposes of my enrolment or coverage under this group plan. I consent to the disclosure of my personal information to agents and representatives of Pacific Blue Cross/BC Life and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also consent to the disclosure of my personal information to my employer/plan administrator when required or permitted by contract between Pacific Blue Cross/BC Life and my employer/plan administrator; and to the retention, use and disclosure of my personal information in accordance with the Pacific Blue Cross/BC Life privacy policy.

The privacy policy is available from your employer/plan administrator, online at www.pac.bluecross.ca or by calling Pacific Blue Cross/BC Life at 604 419-2000.

Applicant's signature X	Applicant's full name (print)	Date (mm-dd-yyyy)
Employer/Plan administrator's signature X	Employer/Plan administrator's full name and title (print)	Date (mm-dd-yyyy)

PART 6 — WAIVER OF GROUP BENEFITS: Complete this section if waiving benefits

The Pacific Blue Cross Extended Health Care (EHC) plan is not the same as coverage under a government health/medical plan in any province or territory. If another plan covers you/your dependent(s) for EHC or Dental benefits, you may waive such benefits under this plan. Before you sign this form, read your employee booklet or ask your employer to explain the benefits to you. You should fully understand all the benefits and plan rules.

SECTION A — Waiver certified by employer

I do not want coverage for the following: ☐ Extended Health Care ☐ Dental Care ☐ For myself and my dependents ☐ Dependents only

EMPLOYER/PLAN ADMINISTRATOR — I hereby certify that: minimum participation requirements, as stipulated in the contract, have been met; this plan requires members/employers to contribute to the cost of coverage; benefit coverage is not a condition of employment.

Employer/Plan administrator's signature X	Date (mm-dd-yyyy)

SECTION B — Waiver due to coverage under another plan

I choose to waive the benefit(s) below because I am covered by another plan (named in *Part 4 — Coordination of Benefits*):
☐ Extended Health Care ☐ Dental care ☐ For myself and my dependents ☐ Dependents only

If the other plan terminates, I understand that there may be time limits for applying for coverage under this Pacific Blue Cross plan. If I apply late, or if I apply while the other plan is still active, I understand that dental coverage may be restricted to $250 per person for the first year, and/or my dependents and I will have to provide evidence of good health, and Pacific Blue Cross may decline to cover me or my dependents.

Employee signature is required for SECTIONS A and B

I have been offered the opportunity to participate in my employer's benefits plan under the policy number(s) on page 1. I have carefully studied the benefits and the plan rules, and I understand that if I apply at a later date for any benefit(s) that I am now waiving, as explained above, dental coverage may be restricted to $250 per person for the first year of coverage, and/or I will be required to prove, at my own expense, that I and my dependents are in good health. Pacific Blue Cross and/or BC Life reserve the right to refuse my application if my health or my dependents' health is not considered satisfactory.

Employee's signature X	Date (mm-dd-yyyy)

PART 7 — ADDITIONAL INFORMATION

TIPS FOR COMPLETING THIS APPLICATION

1. List all your dependents (your spouse and children) even if they are waiving coverage.
2. You may waive Dental Care and Extended Health Care coverage if you have similar coverage under another plan. Otherwise these and other benefits may be waived if the group plan rules specifically allow you to do so.

   If you are waiving benefits, complete *Part 7 — Waiver of Group Benefits*.
3. Time limits may apply. Sign and date the application and submit it to your employer or Plan administrator as soon as possible.

INCOMPLETE INFORMATION MAY DELAY THE PROCESSING OF YOUR APPLICATION.

MAIL YOUR APPLICATION

Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF

4250 Canada Way
Burnaby, BC V5G 4W6

FAX IT

604 419-2149

EMAIL IT

enrollment@pac.bluecross.ca

www.pac.bluecross.ca

British Columbia Life & Casualty Company

Application for Optional Life Insurance

Medical Underwriting Department
PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Toll-free 1 888-275 4672
Fax 604 419-8055

Group's name	Division	Sub-division	Group's number	ID number	Class number

Application for Employee

Name

Sex ☐ Female ☐ Male

Date of birth (mm/dd/yyyy)

Occupation

Height (inch/cm)

Weight (lbs/kg)

Employment status ☐ Active ☐ On leave or disability

Amount of optional life insurance being applied for $ ______

I hereby appoint the following beneficiary for any amount of Optional Life Insurance payable after my death in accordance with the terms of the Policy. I reserve the right to change my appointment of beneficiary as far as it is legally permissible to do so.

Beneficiary (full legal name) ______ Relationship ______

Employee signature ______ Date (mm/dd/yyyy) ______

Application for Spouse (if applying)

Name

Sex ☐ Female ☐ Male

Date of birth (mm/dd/yyyy)

Occupation

Height (inch/cm)

Weight (lbs/kg)

Amount of optional life insurance being applied for $ ______

I hereby appoint the following beneficiary for any amount of Optional Life Insurance payable after my death in accordance with the terms of the Policy. I reserve the right to change my appointment of beneficiary as far as it is legally permissible to do so.

Beneficiary (full legal name) ______ Relationship ______

Spouse signature ______ Date (mm/dd/yyyy) ______

Applicant's statement of health

Please tick "Y" (yes) or "N" (no) in the appropriate column for each person applying for coverage.

	Employee Y	Employee N	Spouse Y	Spouse N
1. Have you ever consulted a physician, ever been treated for, or had any known indication of:				
(a) Chest pain or heart disorders?	☐	☐	☐	☐
(b) High blood pressure?	☐	☐	☐	☐
(c) Cancer or tumors?	☐	☐	☐	☐
(d) Diabetes?	☐	☐	☐	☐
(e) Arthritis or rheumatism?	☐	☐	☐	☐
(f) Nervous or mental disorder?	☐	☐	☐	☐
(g) Lung disorder?	☐	☐	☐	☐
(h) Small or large bowel disorder?	☐	☐	☐	☐
(i) Stomach or liver disorder?	☐	☐	☐	☐
(j) Kidney or urinary disorder?	☐	☐	☐	☐
(k) Hernia?	☐	☐	☐	☐
(l) Back, limb or joint disorder?	☐	☐	☐	☐
(m) Blood or circulatory disorder?	☐	☐	☐	☐
(n) Hepatitis B or C or B carrier state?	☐	☐	☐	☐
(o) Neurological disorder, seizure or multiple sclerosis?	☐	☐	☐	☐
2. Have you:				
(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	☐	☐	☐	☐
(b) been absent from work because of sickness or injury during the last six months?	☐	☐	☐	☐
(c) undergone treatment for alcoholism or drug habit?	☐	☐	☐	☐
3. Are you aware of any symptoms or complaints for which you have not yet consulted a physician or received treatment?	☐	☐	☐	☐
4. Are you, your spouse or dependents taking any prescribed medication? If yes, provide name of medication(s) and reason for use in space provided on the back.	☐	☐	☐	☐
5. Have you:				
(a) ever been treated for or had any known indication of Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other immunological disorder?	☐	☐	☐	☐
(b) had any positive test results indicating exposure to the AIDS virus?	☐	☐	☐	☐
6. Have you any physical impairments, deformities, or illness not covered in questions 1-5?	☐	☐	☐	☐
7. Have you consulted any physician in the last two years apart from basic checkups?	☐	☐	☐	☐
8. Have you had any weight change within the last 12 months? If yes, state number of lbs/kgs gained or lost and reason for change in space provided on the back.	☐	☐	☐	☐
9. Have you:				
(a) used any tobacco products within in the past 12 months (cigarettes, patch, chewing tobacco, gum, etc.)? If yes, indicate type, amount and frequency: ______	☐	☐	☐	☐
(b) ever used marijuana, cocaine, hallucinogenic or narcotic drugs, sedatives or tranquilizers, except as prescribed by a physician?	☐	☐	☐	☐
10. Have you engaged or do you intend to engage in any hazardous sports such as motor racing, scuba diving, or hang gliding or have you flown in an aircraft other than as a fare-paying passenger?	☐	☐	☐	☐
11. Have you or your spouse had a request for life or health insurance declined, postponed, rated, or restricted in any way?	☐	☐	☐	☐
12. Do you or your spouse now have or are you applying for other life or disability income insurance? If yes, indicate type of insurance, amount, benefit and elimination periods as applicable in space provided on the back.	☐	☐	☐	☐

If you answered yes to any of these questions, please give complete details in the space provided on the back.

Please turn over...

See notice on reverse side.

Detach this stub and retain for your records.

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BC Life British Columbia Life & Casualty Company

Application for Optional Life Insurance

Medical Underwriting Department
PO Box 7000 Vancouver BC V6B 4E1
Telephone 604 419-8040 Toll-free 1 888-275 4672
Fax 604 419-8055

Applicant's statement of health (continued)

Please tick "Employee" or "Spouse" on the left and give complete details of all questions answered "Y" (yes) on previous page. If additional space is needed, use separate sheet.

	Illness/Condition and/or Medication	Dates and Duration	Treatments and Results (fully recovered or remaining effects)	Names and full address of doctor(s) or hospital(s)
Employee ☐ Spouse ☐ Question#____				
Employee ☐ Spouse ☐ Question#____				
Employee ☐ Spouse ☐ Question#____				
Employee ☐ Spouse ☐ Question#____				
Employee ☐ Spouse ☐ Question#____				
Employee ☐ Spouse ☐ Question#____				
Employee ☐ Spouse ☐ Question#____				

Family medical history

	Employee Y	Employee N	Spouse Y	Spouse N
Have your parents or siblings ever had cancer, high blood pressure, heart or kidney disease, diabetes, mental or nervous disorder? If yes, give complete details in the space provided:	☐	☐	☐	☐

		Age (if living or age at death)	Details of any health disorder	Cause of death (if applicable)
Employee ☐ Spouse ☐	Father			
Employee ☐ Spouse ☐	Mother			
Employee ☐ Spouse ☐	Siblings			

Authorization

I declare all recorded answers included on this form are full, complete and true as of this date.

I authorize any person or institution, including the Medical Information Bureau, that has any records or knowledge of my health to give BC Life and its reinsurers any such information. I understand this information will be used by BC Life to determine my eligibility for coverage and may be used in connection with any claim filed with BC Life. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of written notification describing the use of the Medical Information Bureau.

I, the employee, authorize the necessary payroll deductions.

Address	Postal code	Phone
Employee's signature		Date (mm/dd/yyyy)
Spouse's signature (if applying)		Date (mm/dd/yyyy)

Please recheck the form and make sure all questions on both sides have been answered. If all the requested information is not provided, this form will be returned to you for further completion.

Mail to: PO Box 7000, Vancouver, BC V6B 4E1.

NOTIFICATION – Please read carefully and detach for your own records.

Information regarding your insurability will be treated as confidential. British Columbia Life & Casualty Company or its reinsurers may, however, make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction. Their address is: **Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7.**

British Columbia Life & Casualty Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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British Columbia Life & Casualty Company

PO Box 7000, Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way, Burnaby, BC

APPLICATION FOR VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (VAD&D) BENEFITS

Applicant - complete this section

Surname First Name Middle Initial

ID Number (e.g. S.I.N.)

Name of Company/Organization

Class Number	Policy Number

Effective date Mo/Day/Yr

Check one and fill in amounts:

- ❑ New Applicant - amount requested $ ____________________
- ❑ Change my insured amount
  from $ ____________________
  to $ ____________________

Check One:

I wish to insure:

- ❑ myself only
- ❑ myself and my family

BENEFICIARY DESIGNATION - I hereby designate as revocable beneficiary in the event of my death:

Full Legal Name	Relationship	Share of Proceeds
		%
		%

TRUSTEE DESIGNATION (Complete only if a Beneficiary is under age 18).

I hereby appoint as revocable Trustee to receive from BC Life any amount which may be due to my beneficiary, while such beneficiary is a minor:

Surname of Trustee	First Name	Middle Initial

I agree to the conditions of the contract between my employer and BC Life and authorize my Employer to deduct required contributions from my earnings. By providing my Social Insurance Number, I authorize BC Life to use it for identification purposes only. I confirm that the information I have provided is true and complete.

X ______________________________
Signature Date

® BC Life is the registered trade-name of British Columbia Life & Casualty Company, a wholly–owned subsidiary of Pacific Blue Cross.

30-20-410 04/04 CUPE 1816

UBCM Optional Life

Provisions

- Waiver of premium to age 65
- Suicide excluded in first two years of coverage
- Medical evidence required
- Coverage terminates at age 65
- Conversion available to employee only
- Spouse benefit cannot exceed employee's combined basic and optional life

Non-Smokers Rate Schedule per $1,000 Insured Benefit

Age Band	Females	Male
Under 30	$0.045	$0.063
30 - 34	$0.045	$0.081
35 - 39	$0.063	$0.090
40 - 44	$0.077	$0.119
45 - 49	$0.128	$0.204
50 - 54	$0.221	$0.306
55 - 59	$0.383	$0.587
60 - 64	$0.629	$1.088

Smokers Rate Schedule per $1,000 Insured Benefit

Age Band	Females	Male
Under 30	$0.060	$0.120
30 - 34	$0.060	$0.120
35 - 39	$0.080	$0.140
40 - 44	$0.130	$0.230
45 - 49	$0.210	$0.440
50 - 54	$0.370	$0.670
55 - 59	$0.650	$1.250
60 - 64	$1.110	$2.180