



Group Supplemental Life Enrollment Form

1. FOR EMPLOYEE TO COMPLETE

Employee Last Name	First	Middle Initial	Employer Name Costco Wholesale Policy- 596704
Warehouse Name & Number	Social Security No. - -		Employee No.

2. EMPLOYEE COVERAGE ELECTIONS: *Please carefully read the back of this form for more detailed information*

- Elect new coverage: \$ _____ Increase or Decrease Supplemental Life To: \$ _____
- Cancel Supplemental Life Coverage

You may elect coverage in increments of \$10,000 up to five times your Basic Annual Earnings or \$1 million, whichever is less. *Evidence of Insurability may be required. Details are on the reverse side of this form.*

CALCULATION WORKSHEET: Calculate your Maximum Allowable Benefit

Full Time:	2080 Hours	x	\$ _____	x	5	=	\$ _____	← If not an increment of \$10,000, this maximum is rounded down to the nearest \$10,000.
			Hourly Rate				Maximum Total	
Part Time:	1560 Hours	x	\$ _____	x	5	=	\$ _____	
			Hourly Rate				Maximum Total	

**Spouse and Child Life Coverage is available only when you elect coverage for yourself.*

3. SPOUSE COVERAGE ELECTIONS *

Spouse Last Name	First	Middle Initial	Spouse Date of Birth / /	Social Security No. - -
<input type="checkbox"/> Elect new coverage: \$ _____	<input type="checkbox"/> Increase or Decrease Supplemental Life To: \$ _____			
<input type="checkbox"/> Cancel Supplemental Life Coverage	You may elect coverage in increments of \$10,000 up to 50% of the employee coverage amount. <i>Evidence of Insurability may be required. Details are on the reverse side of this form.</i>			

4. CHILD(REN) COVERAGE ELECTIONS *

Child Last Name	First	Middle Initial	Child Date of Birth / /	Social Security No. - -
1.			/ /	- -
2.			/ /	- -
3.			/ /	- -
<input type="checkbox"/> Elect new coverage -- Flat \$5,000 per child	<input type="checkbox"/> Cancel Child(ren) Life Coverage			

4. BENEFICIARY INFORMATION: *A beneficiary may be changed upon written request. The beneficiary for life insurance on the lives of your spouse or children will automatically be you, if surviving, otherwise your estate, subject to policy provisions.*

	Relation To You	Benefit Percent
Primary		
Secondary		

Signature _____ Date _____

COSTCO WHOLESALE GROUP SUPPLEMENTAL LIFE ENROLLMENT FORM

Please review the options outlined below to determine which statement applies to you.

If an Evidence of Insurability form is required, one will be sent to your home address within 45 days of your election date. It should be completed and mailed directly to Unum Provident as instructed on the form. **Your completed enrollment form must be returned to Corporate Benefits for processing within 30 days of your effective date.** The insurance carrier must approve some coverage elections before coverage will take effect. No premiums will be withheld until coverage is approved.

1. **I am, or my spouse is, newly eligible for Supplemental Life Benefits:**

- ✓ You may elect coverage for yourself in increments of \$10,000, up to five (5x's) times your Basic Annual Earnings or \$1 millions, whichever is less.
- ✓ If you elect coverage in excess of \$300,000 you **must** complete an Evidence of Insurability statement.
- ✓ You may elect coverage for your spouse in increments of \$10,000, not to exceed 50% of your coverage amount, to a maximum of \$300,000.
- ✓ If may elect coverage for your spouse in excess of \$150,000 you must complete an Evidence of Insurability statement for your spouse.

(To calculate the maximum, use the calculation worksheet in Box 2 on the reverse side.)

2. **I am not enrolled in Supplemental Life benefits, and I would like to enroll due to a family status change or open enrollment:**

- Please indicate → Status Change _____ Date of Change _____
(Status changes include marriage, divorce and birth of a child. See page 29 of the Summary Plan Description for a complete list of status changes.)
- Open Enrollment

- ✓ Decide the amount you want to elect for yourself and/or your spouse. Refer to the coverage limits noted above in Option #1.
- ✓ You must complete an Evidence of Insurability statement. Coverage will not take effect until approved by the insurance company.

3. **I am currently, or my spouse is currently, enrolled in Supplemental Life Coverage, and I/we want to increase or decrease coverage due to a family status change or open enrollment:**

- Please indicate → Status Change _____ Date of Change _____
(Status changes include marriage, divorce, and birth of a child. See page 29 of the Summary Plan Description for a complete list of status changes.)
- Open Enrollment (Evidence of Insurability statement must be sent to Unum Provident no later than January 31st of the following year)

- ✓ Coverage may be increased in \$10,000 increments. You can also increase your life benefits by \$20,000 or your spouse's benefits by \$10,000 without any evidence of insurability. Or,
- ✓ You may increase your life benefits by more than \$20,000 and your spouse's benefits by more than \$10,000, **but you must complete an Evidence of Insurability statement.**
- ✓ If you want to decrease coverage for yourself or your spouse, please indicate the new amounts on the reverse side of this enrollment form.