



## Costco Wholesale Group Supplemental Life and AD&D Enrollment Form (Puerto Rico)

### 1. FOR EMPLOYEE TO COMPLETE

Employee Last Name	First	Middle Initial	Employee ID	Social Security Number

### 2. EMPLOYEE LIFE INSURANCE COVERAGE ELECTIONS:

*Please carefully read the back of this form for more detailed information*

- Elect new coverage: \$ \_\_\_\_\_
  Increase or Decrease Supplemental Life To: \$ \_\_\_\_\_  
 Decline / 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.*

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

### 3. SPOUSE LIFE INSURANCE COVERAGE ELECTIONS \*

Spouse Last Name	First	Middle Initial	Spouse Date of Birth	Social Security No.
			/ /	- -

- Elect new coverage: \$ \_\_\_\_\_
  Increase or Decrease Supplemental Life To: \$ \_\_\_\_\_  
 Decline / Cancel Supplemental Life Coverage

You may elect coverage in increments of \$10,000 up to 50% of the employee coverage amount. *Evidence of Insurability may be required. Details are on the reverse side of form.*

### 4. CHILD(REN) LIFE INSURANCE COVERAGE ELECTIONS \*

Child Last Name	First	Middle Initial	Child Date of Birth	Social Security No.
1.			/ /	- -
2.			/ /	- -
3.			/ /	- -

- Elect new coverage -- Flat \$5,000 per child
  Decline / Cancel Child(ren) Life Coverage

### 5. AD&D COVERAGE ELECTIONS (Does not require Evidence of Insurability Statement)

Coverage is available in \$50,000 increments up to \$1,000,000, provided any amount in excess of \$250,000 does not exceed 10 times your annual earnings. Please indicate the type and amount of coverage you are electing.

- Employee Only
  Employee and Children
 Employee and Family

Amount of Coverage \$ \_\_\_\_\_  No Coverage / Cancel Current Coverage

**6. BENEFICIARY INFORMATION:** *A beneficiary may be changed upon written request. The beneficiary for life/AD&D 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 SUPPLEMENTAL LIFE ELIGIBILITY INFORMATION

Please review the Life Insurance 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 can elect coverage for yourself in increments of \$10,000, up to five (5x's) times your basic annual earnings, to a maximum of \$1,000,000.
- ✓ **If you elect coverage in excess of \$300,000 you must complete an Evidence of Insurability statement.**
- ✓ You can 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 you elect coverage for your spouse in excess of \$150,000 you must complete an Evidence of Insurability statement for your spouse.**

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, birth of a child. Please see your Group Benefit Plan Booklet 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, birth of a child. Please see your Group Benefit Plan Booklet for a complete list of status changes.)

→  **Open Enrollment**

- ✓ 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 can 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.

### CALCULATION WORKSHEET: Calculate your Maximum Allowable Benefit

**Full Time:** 2080 Hours x \$ \_\_\_\_\_ x 5 = \$ \_\_\_\_\_  
Hourly Rate Maximum Total

**Part Time:** 1560 Hours x \$ \_\_\_\_\_ x 5 = \$ \_\_\_\_\_  
Hourly Rate Maximum Total