CHAPMAN UNIVERSITY

ENROLLMENT FOR SUPPLEMENTAL LIFE 2025

You will be required to provide evidence of insurability. This may include medical questions, a medical exam and/or a physician's statement. These requirements will also apply for any amounts of coverage requested outside of Open Enrollment or your initial eligibility period.

Covered Person	**Coverage Options ***	**Coverage Cost** *Age*	 *Rate per $1,000*
Employee	$10,000 increments up to $500,000 (not to exceed 5x your annual salary)	<25 25-29 30-34 35-39 40-44	$0.05 $0.06 $0.08 $0.09 $0.09
Spouse/Registered Domestic Partner	$5,000 increments up to $200,000 (not to exceed 50% of employee amount)	45-49 50-54 55-59 60-64 65-69 70+	$0.14 $0.22 $0.42 $0.64 $1.23 $2.01
Child(ren)	$2,500 increments up to $10,000	<26	$0.20 (covers all eligible children

*****Please note the following benefit reductions:

- Employee and Spouse/RDP: Coverage decreases to 65% at age 70 and to 50% at age 75
- Child(ren): benefit is limited to $1,000 for children under the age of six months

Additional Benefits

In addition to the death benefit paid upon the insured person's passing, supplemental life coverage contains these added benefits:

- **Accelerated Death Benefit:** Up to 75% of the coverage amount (no more than $500,000) can be paid upon diagnoses of a terminal illness.
- **Continuation for Disability:** If your active employment ends due to disability at age 60 or older, your coverage will continue.
- **Waiver of Premium for Disability:** If you become totally disabled prior to age 60 and can't work for at least 6 months, you won't have to pay premiums for coverage while disabled.
- **Portable Coverage:** If you end your employment with Chapman University, you can take your coverage with you! Your premiums, which may change, will be paid directly to the insurance company.

Coverage amount election:

I elect to purchase supplemental life insurance. You can elect up to 5x your annual salary to a maximum of $500,000* for yourself and up to $200,000* in coverage for your spouse. You may also purchase up to $10,000 in coverage for your dependent children.

[Subject to the terms and conditions outlined in the Certificate of Group Insurance.]

Employee $_____

Spouse $_____

Child $_____

Beneficiary Designation:

Primary Beneficiary _____ Date of birth_____ %_____

Address _____ Relationship _____

Primary Beneficiary _____ Date of birth _____ %_____

Address _____ Relationship _____

Contingent Beneficiary _____ Date of birth_____ %_____

Address _____ Relationship _____

Contingent Beneficiary _____ Date of birth _____ %_____

Address _____ Relationship _____

_____ _____

Employee Name Employee ID

_____ _____

Signature Date