California Schools Benefit Trust
Flex Life and AD&D
Insurance Plan Highlights
Policy # 912777

Who is eligible for this coverage?	**Group 1:** All Full-Time Capistrano Unified School District (CUSD) Certificated Employees, Classified Employees and Teamsters, actively employed, working 20 hours or more each week or 0.5 FTE on a regularly scheduled basis with your employer in the U.S (and their eligible spouses and children up to age 26.)
What does my Employer cover?	Your employer is providing you with $30,000 of term Life and AD&D insurance.
What additional Life coverage can I apply for?	If you are an eligible employee in Group 1 you may purchase additional Life coverage for yourself and your dependents*. Employee: **$10,000 to a maximum of $500,000** Spouse: **Flat $10,000 increments to a maximum of $500,000** Child: **Flat $2,000 increments to a maximum of $10,000.** The maximum death benefit for a child between the ages of live birth and six months is $1,000. *You must enroll in additional Life coverage in order to elect dependent Life coverage.
Can I be denied coverage?	If you and your eligible dependents enroll during this enrollment period, you may apply for any amount of coverage up to: • $200,000 for employees up to age 59, without answering any medical questions. • $100,000 for employees from age 60 to age 69. without answering any medical questions. • Employees age 70 and over require EOI for any amount. Your Spouse may apply for any amount of coverage up to: • $50,000 for your spouse who is under age of 60, without answering any medical questions. • Spouse age 60 and over, EOI is required for any amount If you want coverage over the amount you are guaranteed, you will need to provide answers to health questions. In addition, if you enroll outside your enrollment period, you will need to answer health questions for the entire amount of coverage you apply for and no amount is guaranteed for approval.
How do I apply?	To apply for coverage, complete and return your enrollment form to your Insurance Department by your enrollment deadline.
When is my coverage effective?	Your coverage is effective on your benefit eligibility date or on the first of the month following your approval by underwriting, if health questions were required.
What if I am out of work when the enrollment occurs?	Your insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

	For Employee and Dependents: If you are absent from work due to injury, sickness, temporary layoff or leave of absence on the date your coverage would normally begin or increase, your coverage/dependent coverage will begin or increase on the date you return to active employment. If your eligible dependent is totally disabled, your dependent's coverage will begin on the date your eligible dependent is no longer disabled. This provision does not apply to a newborn child while dependent insurance is in effect.
How much does the coverage cost?	See below.

Term Life 10thly Cost

Age	Employee rate per $1,000	Spouse rate per $1,000
Under 25	$0.030	$0.030
25-29	$0.030	$0.030
30-34	$0.033	$0.033
35-39	$0.050	$0.050
40-44	$0.084	$0.084
45-49	$0.143	$0.143
50-54	$0.251	$0.251
55-59	$0.439	$0.439
60-64	$0.539	$0.539
65-69	$0.797	$0.797
70-74	$1.487	$1.487
75+	$1.487	$1.487
Child life 10thly rate $0.372 per $2,000:		

Term life calculation worksheet

Coverage amount		Increment		Rate		Tenthly cost	
Employee	$	÷	$1,000	X	$	=	$
Spouse	$	÷	$1,000	X	$	=	$
Children	$	÷	$2,000	X	$	=	$

Anniversary aging:
Your rate is based on your insurance age, which is your age immediately prior to and including the anniversary/effective date.

Spouse aging:
Spouse rate is based on employee's insurance age.

Do my life insurance benefits decrease with age?

Coverage amounts will reduce according to the following:

Age:	Insurance amount reduces to:
75	60% of the original amount
80	35% of the original amount
85	27.5% of the original amount
90	20% of the original amount
95	7.5% of the original amount

Coverage may not be increased after a reduction.

Is the coverage portable (can I keep it if I leave my employer)?	If you retire, reduce your hours or leave your employer, you can continue coverage for yourself, your spouse and your dependent children at group rates (rates may be different than under the group plan). Portability is not available for people who have a medical condition that could shorten their life expectancy — but they may be able to convert their term life policy to an individual life insurance policy.
Are there any life insurance exclusions or limitations?	Life insurance benefits will not be paid for deaths caused by suicide within the first 24 months after the date your coverage becomes effective. If you increase or add coverage, these enhancements will not be paid for deaths caused by suicide within the first 24 months after you make these changes.
Will my premiums be waived if I'm disabled?	If you become disabled (as defined by your plan) and are no longer able to work, your life premium payments will be waived until your disability period ends.
When does my coverage end?	Your and your dependents' coverage under the Summary of Benefits ends on the earliest of: • the date the policy or plan is cancelled; • the date you no longer are in an eligible group; • the date your eligible group is no longer covered; • the last day of the period for which you made any required contributions; • the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage. In addition, coverage for any one dependent will end on the earliest of: • the date your coverage under a plan ends; • the date your dependent ceases to be an eligible dependent; • for a spouse, the date of a divorce or annulment • for dependent coverage, the date of your death. Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Underwritten by Unum Life Insurance Company of America, Portland, Maine

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EN-1772 (9-13) FOR EMPLOYEES

Underwritten by:
Unum Life Insurance
Company of America
2211 Congress Street,
Portland, Maine 04122

TERM LIFE INSURANCE ENROLLMENT FORM

Policy #912777

for

California Schools Benefits Trust

dba Metropolitan Employees Benefits TrustView Account Hierarchy

Applicant Name:

Social Security #: __ __ __ - __ __ - __ __ __ __

Hours Worked per Week: _________

Date of Birth:

Date of Hire:

Annual Earnings: $ _______________

You can purchase Life coverage for yourself and your dependents.

Employee Non-Medical Maximum	Spouse Non-Medical Maximum
• $200,000 (up to age 59) • $100,000 (age 60 up to age 69) • Employees age 70 and older, EOI required for all amounts	• $50,000 (up to age 59) • Spouse age 60 and older, EOI required for all amounts

Note: Any Life amounts over the non-medical maximum are subject to medical evidence of insurability.
The cost of your coverage may vary slightly due to rounding differences.

LIFE ELECTIONS:

Your Life Coverage: $ _____________
in increments of $10,000.
Not to exceed $500,000.

Spouse Life Coverage: $ ___________
in increments of $10,000.
Not to exceed $500,000.

Child(ren) Life Coverage: $ __________
in increments of $2,000.
Not to exceed $10,000.

Spouse Information *(complete only if spouse coverage is selected)*
Name: ________________________________
Social Security #: __ __ __ - __ __ - __ __ __ __
Date of Birth: __ __ / __ __ / __ __ __ __
(Spouse primary beneficiary will automatically be Employee)

Employee Beneficiary Information:

Primary Beneficiary (ies)

Name: ______________________________________
Relationship: ____________________ Benefit %:____

Name: ______________________________________
Relationship: ____________________ Benefit %:____

Contingent Beneficiary (ies)

Name: ______________________________________
Relationship: ____________________ Benefit %:____

Name: ______________________________________
Relationship: ____________________ Benefit %:____

I understand that any coverage I am requesting is subject to all the terms of the policy including any exclusions, any provisions requiring the submission of Evidence of Insurability and approval by Unum, and any provisions specifying a Delayed Effective Date in the event that I am absent from work or an eligible dependent is totally disabled on the date coverage would otherwise begin. I also understand that if I submit Evidence of Insurability for additional coverage, the Effective Date for the additional coverage will be the first of the month coincident with or next following the date Unum approves my submission.

I certify that all statements are true to the best of my knowledge and belief and I understand a copy of this form will be made available at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective.

Employee Signature: ____ **Date:** __ __ / __ __ / __ __ __ __

PLEASE RETURN COMPLETED FORMS TO YOUR INSURANCE DEPARTMENT

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