

STATE BOARD FOR COMMUNITY COLLEGES AND OCCUPATIONAL EDUCATION



Voluntary AD&D Benefits Summary

ELIGIBILITY:

All active benefit eligible employees of the Policyholder domiciled in the United States and their eligible dependents. Employee means a citizen or permanent resident of the United States or a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations. Eligible dependents include your spouse* and unmarried dependent children who are financially dependent upon the employee for more than half of his/her own support and maintenance until the end of the month of their 25th birthday or marriage, whichever occurs first.

*The term "spouse" used throughout this document means legal spouse or domestic partner (as defined by the Benefits Advisory Committee).

EFFECTIVE DATE OF COVERAGE:

Your insurance is effective on the later of (a) the policy effective date or (b) your date of hire provided the Policyholder receives your completed enrollment form and payroll deduction authorization.

COVERAGE:

This plan offers protection on a worldwide basis, 24 hours a day, 365 days a year against any covered accident in the course of business or pleasure, including accidents on or off the job, in or away from the home, commuting, traveling by train, airplane, automobile or other private and public conveyances.

BENEFITS:

Accidental Death & Specific Loss

Benefits are payable when covered injuries result in loss within 365 days after the date of the accident. Certain losses are payable at 100% of the Principal Sum and other losses are payable at a lesser percentage, as follows:

- Loss of Life, Loss of Two Members*,
- Loss of Speech & Hearing Principal Sum
- Loss of One Member*, Loss of
- Speech or Hearing ½ Principal Sum
- Loss of Thumb and Index Finger
- of the Same Hand ¼ Principal Sum

*Member or Members means hand/hands, foot/feet or eye/eyes.

ADDITIONAL FEATURES:

Paralysis Benefits - When you suffer injuries, which result in hemiplegia, paraplegia or quadriplegia commencing within 60 days after the accident, and continuing for one year, we will pay benefits as follows:

- For Hemiplegia 50% of Principal Sum
- For Paraplegia 75% of Principal Sum
- For Quadriplegia 100% of Principal Sum

Seat Belt Benefit - When you or a covered dependent receives injuries covered by the policy which result in loss of life, we will pay an additional 10% of the Principal Sum not to exceed \$25,000 if, at the time of the accident, you were the operator of or a passenger in a private passenger automobile and utilizing a seat belt. A doctor, coroner, traffic officer or other person of competent authority must verify seat belt usage.

Child Education Benefit - If a dependent child is enrolled in and attending either the 12th grade or an accredited college or university on the date of a covered accident which results in your death, we will pay 5% of your Principal Sum or \$5,000 per child per year, whichever is less, for each year of full-time uninterrupted college or university attendance completed during the four consecutive years following the child's graduation from the 12th grade. If no dependent child insured under the policy qualifies for the benefit we will pay \$1,000 to your beneficiary.

Spouse Education Benefit - If you have family coverage and suffer loss of life in a covered accident, we will pay your surviving spouse within 54 months from the date of the accident, the expense incurred for any licensed professional or trade school training program not to exceed \$5,000. This benefit is payable provided the spouse has: (a) enrolled for the purpose of obtaining an independent source of support or maintenance; (b) successfully completed the program; and (c) received a certificate or degree upon completion. There is a \$1,000 benefit payable to your beneficiary if your insured surviving spouse does not qualify for this benefit.

Day Care Benefit - If you suffer injuries which result in payment of the Principal Sum, a benefit of 5% of your Principal Sum not to exceed a maximum benefit of \$5,000 per child will be paid for each child enrolled in an accredited day-care facility. If not already enrolled, each child must be enrolled within 90 days after the date of your injuries. Benefits will be paid to each child's legal representative. If no dependent child insured under the policy qualifies for the benefit we will pay \$1,000 to your beneficiary.

Premium Waiver - If you, due to a covered injury, suffer loss of life, coverage for any insured dependents will continue without premium payment until whichever of the following occurs first: (a) the date your spouse remarries; (b) the date the insurance terminates; (c) the date an unmarried dependent child ceases to be eligible due to age or marriage; or (d) the date the 12 month Benefit Period ends.

Exposure & Disappearance - If, while insured under the policy, an Insured or a dependent is unavoidably exposed to the elements because of a covered accident which results in the disappearance, sinking or damaging of a conveyance on which the Insured or dependent is covered by the policy and in which the Insured or dependent was riding, and if as a result of such exposure the Insured or dependent suffers a loss for which benefits are otherwise payable hereunder, such loss will be covered under the policy.

If, while insured under the policy, an Insured or dependent disappears because of a covered accident resulting in the sinking or disappearance of a conveyance on which the Insured or dependent is covered by the policy and in which the Insured or dependent was riding, and if the body of the Insured or dependent has not been found within 52 weeks after the date of such accident, it will be presumed, subject to no evidence to the contrary, that the Insured or dependent suffered loss of life as a result of injuries covered by the policy.

AGE REDUCTIONS:

Principal Sum Benefits for covered individuals age 70 and over will be payable as follows: from age 70 through age 74 benefits reduce to 65% of the original amount; from age 75 through age 79 benefits reduce to 45% of the original amount; from age 80 through age 84 benefits reduce to 30% of the original amount and from age 85 and later benefits reduce to 15% of the original amount.

PRINCIPAL SUM AMOUNTS – Guaranteed Issue:

EMPLOYEE: You may select a Principal Sum amount from a minimum of \$10,000 to a maximum of \$500,000 in Increments of \$10,000.

Amounts over \$250,000 may not exceed ten (10) times your annual salary.

FAMILY COVERAGE: Should you purchase coverage for all eligible members of your family your spouse's principal sum is 50% of yours and each child's principal sum is 20% of yours. If there are no children covered, your Spouse's benefit increases to 60% of yours. If there is no spouse covered, each child's benefit increases to 25% of yours.

NOTE: Spouse and/or All Children coverage cannot be purchased on a "standalone" basis, i.e., Employee Participation is also required.

PREMIUMS:

The monthly premium for each \$10,000 unit of Principal Sum is:

Employee Only	\$.24
Employee & Family	\$.47

Premiums for this coverage will be withdrawn automatically by payroll deduction on a monthly basis.

You can select your Principal Sum amount and monthly premium from the attached chart.

CONVERSION PRIVILEGE:

Conversion coverage is available to you and your covered dependent(s) in the event the insurance provided by the certificate should end because your eligibility ends. You must send us a written application for conversion coverage and the initial premium within 31 days after your coverage under the policy ends. The conversion coverage will be issued in accord with: (a) our rules and (b) the conversion law in effect when application is made.

The conversion coverage: (a) shall provide indemnity for specific loss in an amount not to exceed the Principal Sum applicable to you or a dependent under the certificate; and (b) may be substantially different from the certificate.

DEFINITIONS:

"Injuries" means accidental bodily injuries: (a) received while insured under this policy and (b) resulting independently of sickness and all other causes.

"Licensed Professional or Trade School Training Program" means a certificate or degree program of a professional or trade school.

Paralysis:

"Hemiplegia" means complete loss of function of one side of the body with involvement of the arm and leg.

"Paraplegia" means complete loss of function of the lower extremities of the body with involvement of both legs.

"Quadriplegia" means complete loss of function of both the upper and lower extremities of the body with involvement of both arms and legs.

"Seat Belt" means any factory-installed passive restraint device or child passive restraint device which meets published federal safety standards.

EXCLUSIONS:

This plan does not cover: (a) expense or loss for suicide while sane; (b) expense or loss for intentionally self-inflicted injury while sane; (c) loss caused by act of declared or undeclared war; (d) injuries received while participating in training exercises or maneuvers of an armed service while a member of an armed service; (e) injuries received while traveling by air (except as provided in the policy/certificate); (f) injuries received because the insured person was under the influence of any controlled substance unless administered on the advice of a physician; (g) injuries received because the insured person was intoxicated; or (g) injuries received while traveling in any aircraft which is owned or leased by: (1) the Policyholder, subsidiary or affiliate of the Policyholder; or (2) a director, officer or employee of the Policyholder, subsidiary or affiliate of the Policyholder.

HOW TO ENROLL:

1. Complete the Employee Section on the attached Voluntary Enrollment Form.
2. Complete the Employee Coverage Election section by placing an [X] in the Employee Only or the Employee and Family box and indicate the insurance amount in the appropriate area.
3. If you have chosen to purchase Spouse and/or Dependent Children coverage please complete the Dependent Information section of the Voluntary Enrollment Form.
4. Complete the Beneficiary section on the Voluntary Enrollment Form.
5. Sign and date the Voluntary Enrollment Form.
6. Return your Voluntary Enrollment Form to your human resources office.

This benefits summary outlines the provisions detailed in the master policy issued to the State Board for Community Colleges and Occupational Education. Complete benefit, definition and exclusionary details are in the Policy. Should there be any discrepancy between the Policy and this outline, the Policy will prevail.

State Board for Community Colleges and Occupational Education

Voluntary AD&D Enrollment Form



Underwritten by: Mutual of Omaha Insurance Company

Employer Section

Company Name: **State Board for Community Colleges and Occupational Education**

City: Denver	State: CO	Zip Code: 80230
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College/Agency Name:

Group I.D.: T66BA-P-51585	Class: 0001	Effective Date:	Hours worked per week:
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Current Base Pay \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Semimonthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Annually	Benefit Eligibility Date:	Occupation:
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Employee Section (Please Print)

Social Security:	Name: Last First M.I.
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Birth Date: Mo. Day Yr.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status:
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Street Address:

City:	State:	Zip Code:
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Voluntary AD&D Coverage Election Review & Check As Applicable

		Yes	No	Benefit Amount	Premium Amount
Voluntary AD&D	Employee Only	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____
Voluntary AD&D	Employee & Family	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	\$ _____

Dependent Information (Please Print)

Name of Dependent(s)	Gender	Relationship	Birth Date			Social Security Number
			Mo.	Day	Yr.	
Spouse:						
Child(ren):						

Beneficiary for Death Benefits – Right to Change Beneficiary is Reserved to the Insured.

(If more than one beneficiary is named, the beneficiaries shall share equally unless otherwise stated below.)

Primary Beneficiary				Secondary Beneficiary			
Last Name	First	M.I.	Relationship to Insured	Last Name	First	M.I.	Relationship to Insured

Instructions: Application must be made within 31 days from the date the employee becomes eligible (or as otherwise stated in the plan). If plan is contributory, form **MUST** be signed and dated to authorize payroll deductions.

I represent that the information I have provided in this Enrollment Form is complete, true and accurate, to the best of my knowledge.

Signature of Employee _____ **Date** _____ / _____ / _____