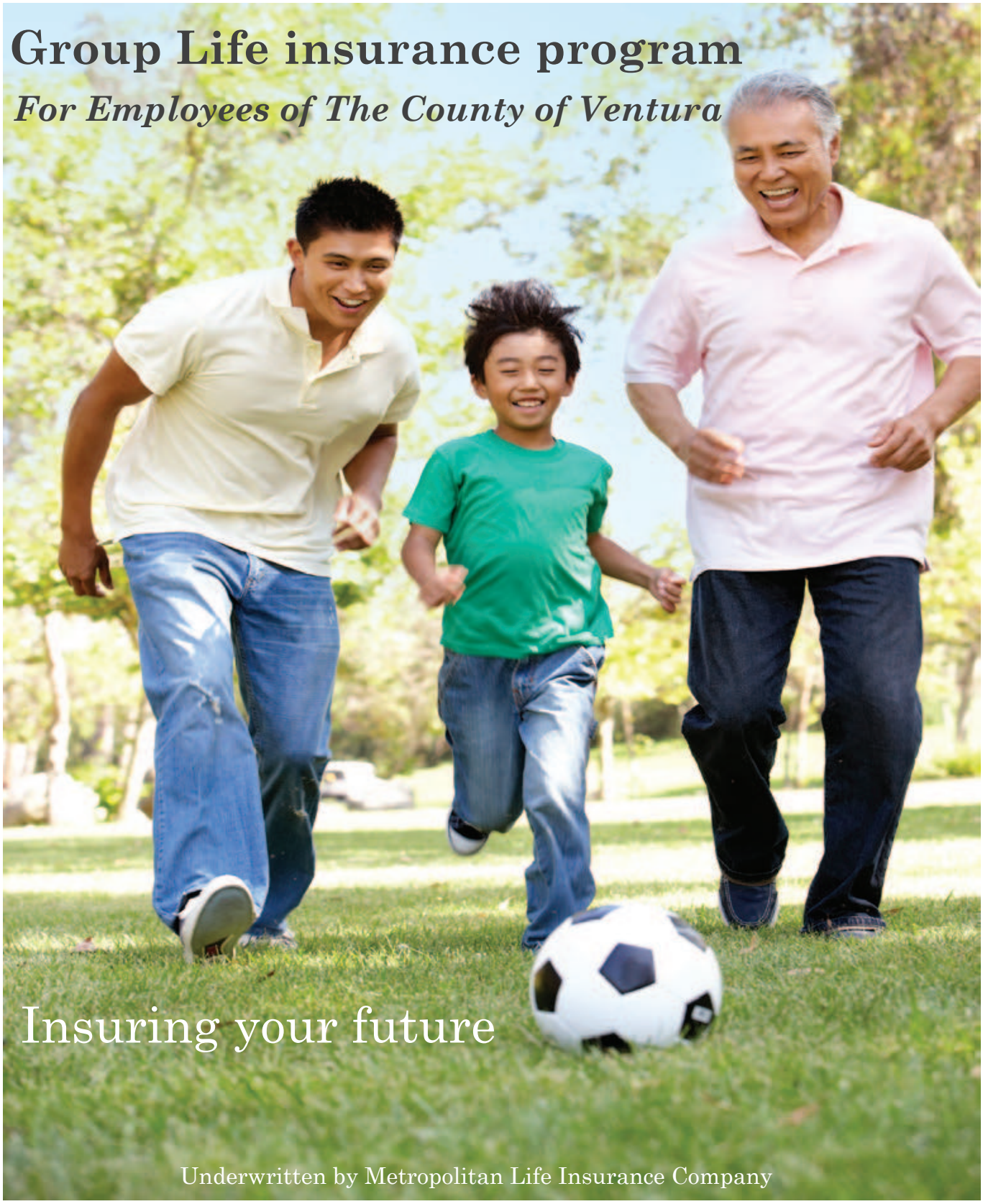
Group Life insurance program

For Employees of The County of Ventura



Insuring your future

Underwritten by Metropolitan Life Insurance Company

COUNTY of VENTURA

MetLife®

Enrollment Information Booklet

Welcome

What do I need to do?

The County of Ventura is proud to partner with Metropolitan Life Insurance Company to provide group life insurance benefits. The County of Ventura group life insurance program offers you an affordable way to provide protection for your family.

Before enrolling, there are two very important questions you need to answer: Why do I need life insurance? and How much do I need?

Why do I need life insurance?

Think about it. If you died what would happen to the people who depend on you for financial support?

Group Term Life insurance provides a base level of protection that can be enhanced by personal savings, individual life insurance and Social Security benefits. This coverage will help protect your family against the unexpected loss of your life and income during your working years.

Insurance proceeds may be used as supplemental income for your family to pay off debts such as mortgage or medical expenses, or could be used to pay for your funeral/burial costs. Other popular uses of proceeds include establishing a college fund for your children or leaving funds for your favorite charities.

How much life insurance do I need?

Everyone's needs are unique and it helps to evaluate your family's financial situation before choosing the exact amount.

Visit our online insurance needs calculator on **http://www.lifeonlinecalculator.com/** to estimate how much.

How do I elect coverage?

This booklet provides information to help you answer those questions and the instructions to enroll for coverage. Enrolling is easy and can be done in four simple steps:

Step 1: Determine your needs

Step 2: Review your coverage options

Step 3: Calculate your costs

Step 4: Enroll

F75111-2 Rev 6-2017

Step 1 Determine your needs

To estimate the amount of life insurance you need, you'll want to determine what you must protect in the event of your death.

Assets & Income

What would be available to your family now, if you weren't here to provide for them?

Spouse/Domestic Partner's annual income x number of years to age 65	$_____
Cash, savings bonds, stocks, securities (current value)	$_____
Company savings plan (401(k), 457, Roth IRA or other)	$_____
Cash value of life insurance	$_____
Other assets* or income (other than your own)	$_____

**Equity in your home, if you plan to sell or borrow against it for cash.*

A = $_____

Basic Necessities

What basic needs do you and your family have?
(multiply the items below by the number of years required, if applicable)

Home – remaining mortgage or rent (120 months is a basic rule of thumb)	$_____
Annual household operating expenses (utilities, food, clothing, insurance, repairs, property taxes, etc.)	$_____
Childcare	$_____
Health – health insurance premiums or medical/hospital expenses not covered by insurance	$_____
Debt – balances on credit cards, car loans, etc	$_____

B = $_____

Comfort Zone

What kind of special or one-time expenses may come along?

Tuition	$_____
Wedding	$_____
New residence	$_____
Elder care x number of years	$_____
Estate taxes, probate fees, attorney fees	$_____
Emergency fund	$_____
Funeral expenses (average is $5,000 - $10,000)	$_____
Golden years (money put aside for survivor's retirement)	$_____

Complete the Equation

Complete the equation that most closely reflects your particular needs:

Basic Necessities	**B - A** = $_____ *(Compare to current Life Insurance amount)*
Comfort Zone	**(B + C) - A** = $_____ *(Compare to current Life Insurance amount)*

Remember, your calculation is based on today's costs and doesn't account for inflation or changes in annual earnings. Review your needs periodically to ensure that your needs will be met now and in the future.

Contact your HR Department Representative/Liaison if you need assistance with calculations. Click the link below for the listing:

Department Representative Contact Information

Step 2

Review your coverage options

Now that you understand your need for life insurance and know how much may be enough, you're ready to consider the options available to you under The County of Ventura's group life insurance plan.

Guaranteed coverage opportunity

You may elect guaranteed optional life coverage within the first 90 days of INITIAL eligibility (only) – with no Supplemental Enrollment/Statement of Health (SOH) Form required.

Coverages and amounts available include:

- **For you (Life and AD&D):** $10,000, one times your base annual earnings, two times your base annual earnings, or three times your base annual earnings - not to exceed $500,000.
- **For your spouse/Domestic Partner:** Up to $10,000
- **For your children:** Up to $5,000

What coverage is available?

If eligible, you are automatically enrolled in Basic Life coverage (but must complete the *Basic/Optional Life Insurance Beneficiary Designation Form* to designate your beneficiaries). You may also elect optional coverage for you and your dependents. Electing or increasing coverage after the initial 90-day enrollment period will require you to also complete the *Supplemental Enrollment/Statement of Health (SOH) Form*.

Coverage type	Coverage options	Additional information
Basic Life and Accidental Death and Dismemberment (AD&D)	• $50,000	• All coverage guaranteed • Includes matching AD&D amount
Optional Life and AD&D	• Choice of $10,000, or one, two, or three times your base annual earnings to a maximum of $500,000	• Includes matching AD&D amount • Coverage increases due to salary increase are guaranteed to the plan maximum
Dependent Life	• Option 1: Spouse/Domestic Partner $5,000 Child $2,000 • Option 2: Spouse/Domestic Partner $10,000 Child $5,000	• An employee must be participating in the Optional Life plan to elect dependent coverage • Children are eligible from live birth up to age 26 • Spouses/Domestic Partners and Children can be added within 31 days of marriage/DP or birth/adoption.

Will my benefits reduce?

Reductions in your basic and optional life insurance amount will occur on the beginning of the pay period following your 70th and 75th birthdays. Your life insurance coverage reduces to 65 percent of the face amount on your 70th birthday. It further reduces to 50 percent of the original amount at age 75. All coverage terminates at retirement.

Step 3 Calculate your costs

Review this section to learn about costs associated with coverage. Please note that rates shown are biweekly.

What is the cost for coverage?

Employee Optional Term Life and AD&D

Please note rates increase with age.

Age	Biweekly rate per $1,000
Under 25	$0.030
25-29	0.035
30-34	0.044
35-39	0.049
40-44	0.073
45-49	0.099
50-54	0.141
55-59	0.246
60-64	0.360
65-69	0.593
70 and over	0.958

All rates shown are subject to change.

Dependent Life (biweekly rates)

Option 1: $0.87
Option 2: $1.15

Calculate your costs

Example:

Step 1: Calculate your annual earnings:

$ _____ x 26 pay periods = $ _____

Regular biweekly pay (no overtime)* — Annual Earnings

*For full-time employees, biweekly base salary; For part-time employees, biweekly scheduled hours times hourly rate.

Step 2: Calculate your cost:

$ _____ (Annual Earnings) x _____ (Increments (1x, 2x or 3x)) = $ _____ (Coverage Amount (Round to next $1,000))

$ _____ (Coverage Amount) ÷ $1,000 = _____ (Coverage Units) x _____ (Biweekly Rate) = $ _____ (Biweekly Premium)

Contact your HR Department Representative if you need assistance with estimated premium calculations. Click the link below for the listing.

Department Representative Contact Listing

Step 4 Enroll

To take advantage of guaranteed coverage amounts, you must enroll within 90 days of your initial eligibility.

Step 1: To elect Optional Life Insurance for yourself, please complete pages 1, 3 & 4 on the *Group Life Insurance Enrollment* form.

Step 2: If electing coverage for your dependents, please also complete page 2 of the *Group Life Insurance Enrollment* form.

Step 3: Return completed *Group Life Insurance Enrollment* form to CEO/HR/Benefits (email to Benefits.ServiceRep@venturacounty.gov or your HR Department Representative.

Don't forget to sign your completed forms!

Step 4: If electing coverage beyond your initial 90-day eligibility period, increasing current coverage, or want to enroll in a coverage amount that would exceed $500,000 maximum, a health assessment is required. If any of these apply to you submit the enrollment form and MetLife will email you directly with next steps on how to complete their Health Assessment process. If you are in your initial 90-day enrollment period and are electing a plan that exceeds $500,000, we will automatically enroll you in the corresponding plan at the $500,000 maximum. If MetLife approves the higher maximum, we will enroll you in that plan after we receive the approval notification from MetLife

Questions?

Please contact HR Department Representatives if you need additional assistance.

Frequently asked questions

What is Term Life insurance?

Group Term Life insurance provides affordable protection that is available for a specified period of time. The benefit would be paid if the insured were to die during that "term".

You can buy large amounts of insurance, at a reasonable cost. There is no cash value build up. This coverage can be enhanced by your personal savings, individual life insurance, and social security benefits. If eligible, you are automatically enrolled in Basic Life coverage however, you must enroll in Optional Life coverage.

What is Accidental Death and Dismemberment (AD&D) insurance?

AD&D coverage provides beneficiaries with additional financial protection if an insured person's death is due to a covered accident or provides a benefit if dismemberment occurs as a result of a covered accident. AD&D provides protection for covered accidents occurring at any time, whether at work or elsewhere.

What is included in my life insurance plan?

Beyond paying a benefit in the event of your death, your group life insurance plan has other important features.

- **Waiver of premium** – If you become disabled before age 60, your life insurance premiums may be waived.
- **Accelerated Death Benefit** – If an insured employee becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100 percent of the life insurance amount (Basic and Optional combined).

Can I take my coverage with me if I leave or retire?

If you are no longer eligible for coverage as an active employee, you may port your group life insurance coverage (portable coverage ends at age 70) or you may convert your coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Can I elect additional coverage if I experience a family status change?

Yes**.** You may add coverage for a newly born or newly adopted child or a new spouse or domestic partner without completing the Supplemental Enrollment/Statement of Health (SOH) Form if coverage is elected within 31 days of the birth/adoption or marriage/registration.

How do I pay premiums?

Your life insurance premiums are deducted directly from your paycheck.

Why do I need to designate a beneficiary?

By naming a beneficiary, you are able to ensure that your life insurance benefit is being passed on to those you want to help the most.

Events such as marriage, birth/adoption of children, divorce, or death may dramatically change the intent of how you would want your life insurance benefit paid.

Some common beneficiary choices are:

- **Primary beneficiary** – The person or persons named will receive the benefit.
- **Contingent beneficiary** – If the primary beneficiary is no longer living, the benefit is paid to this person.
- **Default beneficiary** – If you do not name a beneficiary, policy benefits will be paid in order of the policy's default beneficiary definition, as follows – spouse/Domestic Partner, children, parents, brothers and sisters, your estate.

Medical Underwriting process

How does the medical underwriting process work?

- If medical underwriting is required, (more than 90 days from original eligibility,) submit enrollment form to COV. COV will submit your information to MetLife. You will receive an email from MetLife to submit your health assessment directly to them. Once submitted:
- Metlife underwriting may approve the coverage without needing additional information, or
- If additional underwriting is required, the applicant may be asked to complete a questionnaire, provide access to medical records, take a medical exam, etc. MetLife will directly notify the applicant of any additional medical requirements and will incur all of the costs associated with the entire underwriting process.
  - If it's determined that an exam is necessary, the applicant is able to schedule an exam over the phone using the instructions provided by MetLife.
- Once all medical underwriting is complete, you will receive written notification from MetLife regarding the underwriting decision.

Tip: To complete the Supplemental Enrollment/Statement of Health (SOH) which will be sent to you directly by MetLife via email, you should first gather your medical records, including the name and address of physicians, hospitals and clinics you've visited in the past three years, as well as any details regarding diagnosis and treatment.

What is Medical Underwriting?

The process by which MetLife evaluates an applicant's eligibility based on age, answers on the Supplemental Enrollment/Statement of Health (SOH) process and additional medical information, if applicable.

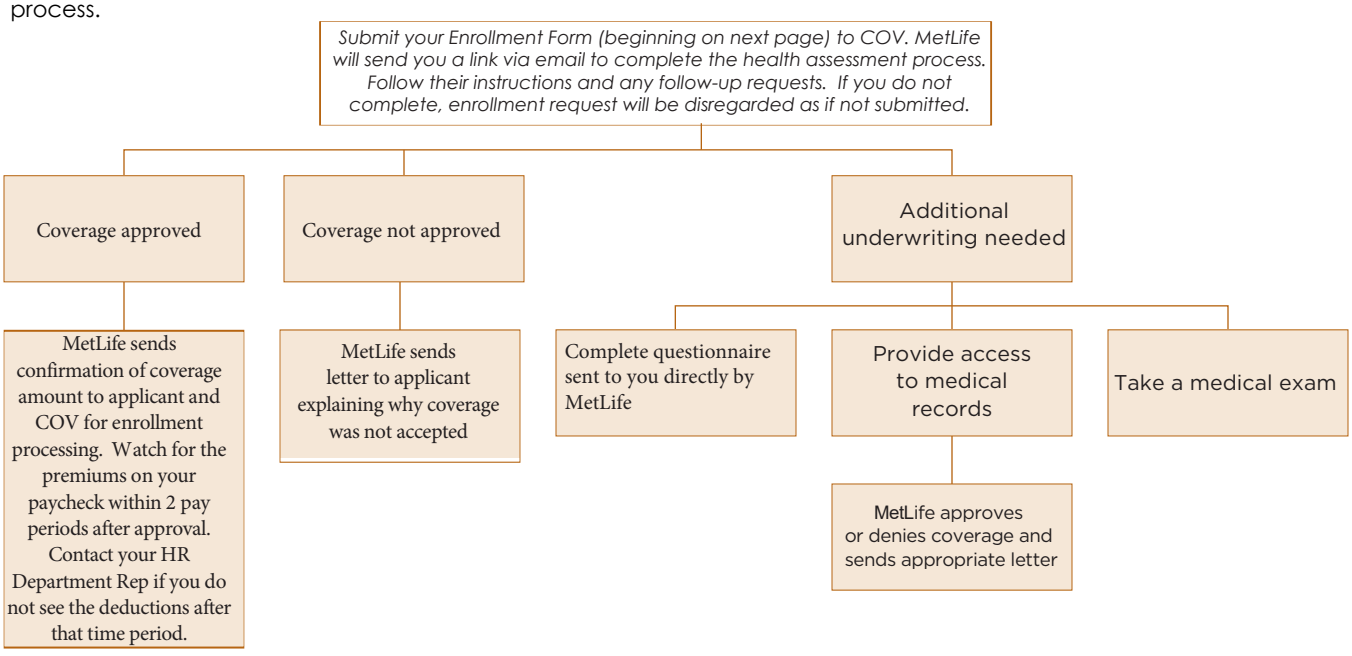
a) electing an insurance amount that exceeds the guaranteed issue limit; or

b) if the employee is applying after the guaranteed issue window; or

c) adding a new spouse/ Domestic Partner to existing dependent life insurance.

Medical underwriting flow chart

The following flow chart provides an overview of the medical underwriting process.



SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
County of Ventura, 800 S Victoria Ave, #1970, Ventura, CA 93009-1970
Phone: 805-654-2570 Fax: 805-654-2665 Email: Benefits.ServiceRep@venturacounty.gov

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM OPTIONAL LIFE

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
County of Ventura	**0154209**	**0154209**	**0005**	☐ **0001** ☐ **0002** ☐ **0003**

Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		

Phone #	Date of Birth (MM/DD/YYYY)	Employee ID

Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that as described in my enrollment materials, contributions may be required for the benefits I select below. If you enroll for certain Contributory Insurance, a portion of your contributions for such insurance will be allocated to reduce the Policyholder's cost of certain Noncontributory Insurance under the Group Policy.

► You must complete the Supplemental Enrollment process (provided separately) including the Health Information and the Authorization form:

- If you are enrolling for more than $500,000 of Optional Life Insurance.
- If you are currently enrolled and increasing your Optional Life Insurance, Dependent Spouse/Domestic Partner Life Insurance, and/or Dependent Child Life Insurance by any amount.
- If you are enrolling due to a Qualifying Event and enrolling after the 31-day enrollment period for Dependent Spouse/Domestic Partner Life Insurance and/or Dependent Child Life Insurance.
- If you are enrolling after the initial 90-day enrollment period and enrolling for any amount of Optional Life Insurance, Dependent Spouse/Domestic Partner Life Insurance, and/or Dependent Child Life Insurance.

Term Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

☐ Optional Life [1] and Optional AD&D

☐ $10,000 ☐ 1x ☐ 2x ☐ 3x Basic Annual Earnings up to a maximum of $500,000. Or $1,000,000 (Health Assessment Approval Required)

☐ Dependent Life:

☐ Option 1 – Dependent Spouse/Domestic Partner [2] Life[1,3] $5,000 / Dependent Child Life[3] $2,000

☐ Option 2 - Dependent Spouse/Domestic Partner [2] Life[1,3] $10,000 / Dependent Child Life[3] $5,000

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such relationship.

[3] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF02-1
ADM *applies to residents of Connecticut, North Dakota, and Utah)*

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Full Time Student[1]?	
		☐ Yes ☐ No	☐ Male ☐ Female
		☐ Yes ☐ No	☐ Male ☐ Female
		☐ Yes ☐ No	☐ Male ☐ Female
		☐ Yes ☐ No	☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

[1] Full Time Student means your dependent child, age 18 or older, enrolled as a full-time student in an accredited college, university, or secondary school, or a vocational or trade school. Age limits will be subject to state limits, as applicable.

GEF02-1
ADM
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GEF02-1
ADM *applies to residents of Connecticut, North Dakota, and Utah)*

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

New York (only applies to Accident and Health Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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FW *applies to residents of Connecticut, North Dakota and Utah)*

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.
☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%
If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):				
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

GEF09-1a
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GEF09-1
DEC *applies to residents of Connecticut, North Dakota and Utah)*

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

PAYMENT AUTHORIZATION

By signing below, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.

Sign Here

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1a
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SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
County of Ventura, 800 S Victoria Ave, #1970, Ventura, CA 93009-1970
Phone: 805-654-2570 Fax: 805-654-2665 Email:
Benefits.ServiceRep@venturacounty.gov

EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%

Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	5 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%

Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Henry Doe - Trustee, his successors or successor in trust under the John Henry Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008. Trust Tax ID number 99-555555.			N/A	Trust	100%

Total = 100%

Example 4: If the beneficiary is a charity/organization.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Charity/Organization Name, 20 Main Street, Anywhere, CA 99999, 805-555-1919			N/A	Charity/ Organization	100%

Total = 100%

Dependent Life Insurance Change Request Form

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

MetLife®

EMPLOYER NAME: The County of Ventura

POLICY NUMBER: 0154209

REASON FOR COMPLETING CHANGE REQUEST:

☐ Adding Dependent(s) - List all eligible being added
☐ Dropping Dependent(s) - List only dependent(s) to drop
☐ Updating Other Information as of: _____ (date)

Eligible Dependents who may be enrolled are:

a. Your legal spouse or domestic partner;
b. Your children from live birth up to age 26 years (a child may only be covered by one parent);
c. Your child who becomes disabled while covered under this Group Policy and is continuously disabled (incapable of self-sustaining employment and chiefly dependent upon you for support and maintenance).

EMPLOYEE INFORMATION (please print)

First name	Middle initial	Last name	Employee ID

DEPENDENT INFORMATION (please print)

Dependent's Full Name (first, middle initial, last)	**Social Security Number**	**Relationship To You**	**Living in Your Home?** (Yes/No)	**Date of Birth**

SIGNATURE REQUIRED

Employee's signature	Date signed
X	

Basic/Optional Life Insurance
Beneficiary Designation Form

You may submit this form at initial enrollment in Basic Life or at any time to update your beneficiaries for Basic and/or Optional Life insurance. If you are unsure whether your beneficiary information is current, submit a new form to ensure accuracy, and keep a copy for your records. You may also submit or update beneficiary information through VCHRP; however, beneficiary information submitted on paper forms will not appear in VCHRP. In the event of a claim, we will review both paper and VCHRP submissions and rely on the most recent designation on file for that plan.

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

MetLife®

EMPLOYER NAME: The County of Ventura **POLICY NUMBER:** 0154209

Insured's name (last, first, middle initial)	Insured's employee ID

Address (street, city, state, zip)

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address

INSTRUCTIONS:

1. Clearly print or type the information below.
2. Sign and date the completed form.
3. Return to CEO/HR/Benefits (Benefits.ServiceRep@ventura.org or L#1970).

This beneficiary designation applies to the coverages noted below:

☐ All group term life coverages **OR** ☐ Basic Life/AD&D only ☐ Optional Life/AD&D only

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children" , without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

SIGNATURE REQUIRED

Policyowner's signature	Date
X	

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EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%

Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	5 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%

Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Henry Doe - Trustee, his successors or successor in trust under the John Henry Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008. Trust Tax ID number 99-555555.			N/A	Trust	100%

Total = 100%

Example 4: If the beneficiary is a charity/organization.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Charity/Organization Name, 20 Main Street, Anywhere, CA 99999, 805-555-1919			N/A	Charity/ Organization	100%

Total = 100%

Frequently Asked Questions

Supplemental Enrollment/Statement of Health (SOH) Form

Q. Where do I start?

Complete the Supplemental Enrollment Form/for amounts you are requesting.

1) Determine Your Coverage Election (If applicable up to $1,000,000 available at 1x, 2x & 3x with Underwriting:
   - ☐ Optional Life
     - o ☐ $10,000 ☐ 1x, ☐ 2x, ☐ 3x Base Annual Earnings, up to a maximum of $500,000
   - ☐ Dependent Life (Spouse/Domestic Partner, Child)
     - o ☐ Option 1: $5,000 / $2,000
     - o ☐ Option 2: $10,000 / $5,000
2) Determine Amount Subject to Underwriting (**COV will default into $500K plans, if you requested and are approved for the up to $1Million plans we will enroll you if later approved.
   A) How much coverage are you electing? _____
   B) How much coverage do you have today? _____
   C) A-B =_____ (place this amount on the Supplemental Enrollment form)

Q. What is a Statement of Health (SOH)?

A Statement of Health (SOH) includes a series of questions about your overall health. Depending on your employer/group's plan and the amount of coverage you request, you may be asked to complete an SOH form in order for MetLife to evaluate your life insurance application.

Q. Why would I be asked to complete a Statement of Health (SOH)?

If you applied for group insurance coverage, you may be required to complete a Statement of Health based on MetLife's rules for your company's group life insurance plan.

Examples of SOH triggers may include:

- You requested coverage after the first 90 days of initial eligibility
- You are currently enrolled and increasing your coverage or requested enrollment in any up to $1,000,000 coverage limit. (See above ** for default info for any eligible enrollment in first 90 days)

Q. What is medical underwriting?

The process by which MetLife evaluates an applicant's eligibility for the group insurance requested based on age, answers on the SOH inquiry directly from MetLife and additional medical information, if applicable.

Q. Is the information on my Statement of Health (SOH) kept confidential?

Yes. We apply strict standards for privacy and confidentiality as with all of our MetLife processes and data.

Q. If I answer "yes" to one of the SOH questions, will I be required to submit additional medical information?

You may be required to provide details explaining your response on the SOH. Once submitted, some answers may require additional medical information in the form of an Attending Physician's Statement (APS) or a paramedical exam, which MetLife will order.

CONTINUED

Q. What is a paramedical exam?

A paramedical exam is a simple physical exam performed by a medical professional that takes approximately 30 minutes, at no cost to you. The exam includes blood and urine samples. If you are required to complete a paramedical exam, you will be contacted by a MetLife approved vendor to schedule an appointment by telephone, e-mail or U.S. mail. You may also initiate scheduling your paramedical exam online if you completed your SOH form online.

Q. Why would I need a paramedical exam?

The need for a paramedical exam is determined by your age, the amount of insurance coverage you are requesting, and your answers on the SOH form. An exam and other medical testing may be required to provide MetLife with the information needed to determine your insurability under the plan.

Q. If I have an existing medical condition and I'm required to complete an SOH, should I still continue with the process?

Yes. Even individuals with relatively serious medical conditions may still be eligible for insurance coverage.

Q. What happens to my Statement of Health (SOH) once I complete it?

MetLife will review your submission and generate a response within 10 business days after receiving the information. The response will either notify you of the final determination regarding your requested insurance coverage or request additional information.

Q. Once I submit my Statement of Health (SOH), how can I make changes, if necessary?

Please contact the MetLife Statement of Health Unit at 1-800-638-6420 (prompt 1).

Q. What happens if I am declined for this coverage?

If your Statement of Health is declined, it will not affect any coverage already in existence.

Q. Can I dispute a declination?

Yes. You may dispute a declination subject to the terms identified in the declination letter which must include medical documentation to support the reason for the dispute.

Q. If I have questions, who may I contact for help?

For any questions relating to your Statement of Health form, please call 1-800-638-6420, prompt 1.
Learn more about Statement of Health process through our interactive online tutorial, by visiting www.metlife.com/sohtutorial.


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