South Dakota School District Benefits Fund
P.O. BOX 1059
Pierre, SD 57501
605-773-2500

Reference: Basic Term and Optional Life Insurance is offered to all new eligible employees.

Dear new employee:

As parts of our policy for life insurance, employees are eligible to continue their plan through the South Dakota School Districts should they leave employment through a direct billed program. If you are being rehired or accepting employment through another school and presently have the continued plan you will no longer be eligible to continue paying your premiums directly and will need to change your deductions to a payroll deduction.

If you have been paying your premiums through the continued benefit to NFP-National Account Services for your Sun Life policy, you must contact Yvonne Henricks at 1-888-870-2774 or her direct line at 602-635-1275 to inform her of your re-employment through the schools.

Thank you and we continue to look forward to serving you.

Sincerely,

SDSDBF
Protective Trust Support/
Customer Service
800-543-7808
605-773-2500

Basic Term Insurance Enrollment Form *
Voluntary Term Life Insurance - Employees , Spouse, Children

PLEASE CHECK ONE OF THE FOLLOWING

New Enrollment_____ Change Only_____ (Check one) **Effective Date _____**

This form may be used for Supplemental Life Insurance that is being offered to you. You may also use this form to enroll your spouse/child(ren) for life insurance, and/or make necessary changes (i.e. beneficiary). **Evidence of Insurability will be required if you did not purchase additional life as a new hire and are now electing coverage for the first time.**

SECTION I - EMPLOYEE INFORMATION

Name Last, First			**SSN**	**Date of Hire**
Date of Birth	**Age**	**Sex** M or F	**Employer**	
Employee Address Number and Street			**City, State, Zip**	
Salary			**Job title**	

SECTION II - BASIC LIFE & SUPPLEMENTAL BENEFICIARY DESIGNATION

Primary Beneficiary

First, Middle Initial, Last Name	Date of Birth	Relationship / % of Proceed
Address	City, State, Zip Code	Social Security Number

First, Middle Initial, Last Name	Date of Birth	Relationship / % of Proceed
Address	City, State, Zip Code	Social Security Number

Contingent Beneficiary

First, Middle Initial, Last Name	Date of Birth	Relationship
Address	City, State, Zip Code	Social Security Number

I UNDERSTAND that the Beneficiary for any dependent coverage will be the insured Employee unless otherwise noted. As a covered Employee, you have the right to select a Beneficiary in accordance with the provisions of your policy. You may also have the right to change the beneficiary designation. If more than one Beneficiary is designated, payment will be made in equal shares to each of the designated Beneficiaries which survive the insured, unless some other allocation is specified by you in writing in accordance with the provisions of the policy. If no designated Beneficiary survives the insured, settlement will be made in accordance with the terms of the policy.

_____ _____

Signature **Date**

(Please continue)

SECTION III – Supplemental Life/AD&D Selection

Employee Coverage:
Amount of Coverage: ☐

Premium per Month: ☐

For all other amounts enter coverage amount and premium here _____/_____.

Employees may enroll in voluntary life for spousal or child(ren) coverage but must not exceed employees amount.

SECTION IV – Supplemental Spouse Life/AD&D Selection

Please make selection below. For rates, please refer to the attached page and enter premiums in the appropriate column. Premiums are based on spouse's age.

Spouse Name_____ DOB_____SSN_____

Spouse coverage, please circle election:

	$5,000	**$10,000**	**$15,000**	**$20,000**	**$25,000**
Premium Per Month					
Please Circle	Accept	Accept	Accept	Accept	Accept

SECTION V – Voluntary Child(ren) Life Selection

Dependent Child(ren) coverage, please circle election:

	$5,000	**$10,000**
Premium Per Month	$1.13	$2.25
	Accept	Accept

Child(ren) premium amounts remain the same regardless of the number of children. It is the responsibility of the employee to notify us when the child is no longer eligible. Please list child(ren) ,SSN & DOB on separate sheet.

SECTION VI - ELIGIBILITY AND AUTHORIZATION

I have read, understand and agree to the provisions printed and acknowledge that the information I have provided is accurate to the best of my knowledge. I AUTHORIZE the payroll deductions for the above specified coverage's and release other necessary information to the administrators of this program.

_____ _____

Signature **Date**

SECTION VII - WAIVE SUPPLEMENTAL COVERAGE

*My signature below certifies that I have been given the opportunity to participate in the Associated School Boards of South Dakota benefit program. The benefits have been clearly explained to me. After careful consideration I have decided not to participate in the benefits listed above. I understand that if I later decide to apply for coverage under this plan I may be required to furnish evidence of insurability.

_____ _____

Employee Signature - I WAIVE coverage. **Date**