



**EMPLOYEE BENEFITS SUMMARY | 50055653**  
**ROMAN CATHOLIC BISHOP OF SALT LAKE CITY DBA CATHOLIC**  
**DIOCESE OF SALT LAKE CITY**

FOR ALL FULL TIME ACTIVE EMPLOYEES EXCLUDING JUDGE MEMORIAL HS EMPLOYEES

<b>GROUP TERM LIFE AND ACCIDENTAL DEATH &amp; DISMEMBERMENT</b>	<b>EMPLOYER CONTRIBUTION: 100%</b>
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**AMOUNT OF COVERAGE:** Pays a benefit of \$20,000 without evidence of insurability.

*Benefits reduce, based on your age, to 65% at age 70, and to 50% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.*

**GROUP TERM LIFE** insurance is designed to provide benefits to your designated beneficiary for loss of life.

**ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)** is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

**GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:**

- Beneficiary Assistance Program
- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Portability
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Child Care Center Benefit
- Common Carrier Benefit
- Felonious Assault Benefit
- Special Education Benefit
- Spouse Training Benefit
- Safety Equipment Benefit
- Total Loss of Use Benefit
- Travel Assistance
- Identity Theft Protection
- Dignity Planner

**VOLUNTARY GROUP TERM LIFE****EMPLOYER CONTRIBUTION: 0%**

**Employee:** If you are age 69 or younger, you may purchase coverage in units of \$5,000 to a maximum of \$50,000 through age 69, and \$0 after reaching age 70 without evidence of insurability. Coverage over these amounts to a maximum of \$300,000 is available with evidence of insurability. Coverage cannot exceed 6 times your Basic Annual Earnings.

*Benefits reduce, based on your age, to 65% at age 70, and to 50% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.*

**Spouse:** If you have purchased Voluntary GTL for yourself, you may purchase coverage for your eligible spouse, age 69 or younger, in units of \$5,000 to a maximum of \$20,000 through age 69, and \$0 after reaching age 70 without evidence of insurability. Coverage over these amounts to a maximum of \$300,000 is available with evidence of insurability.

*Benefits reduce, based on spouse's age, to 65% at age 70, and to 50% at age 75, and then terminate when you are no longer eligible or your retirement, whichever occurs first. Reductions occur at the Policy Anniversary.*

**Child:** If you have purchased Voluntary GTL for yourself, you may purchase coverage for your eligible children between the ages of 6 months and 26 years from \$2,000 to \$10,000 in increments of \$2,000.

*Benefits terminate when they are no longer eligible, or at the termination of your eligibility, whichever occurs first.*

**VOLUNTARY GROUP TERM LIFE (VGTL)** If you need additional term life protection for you and your eligible family members, think about USABLE Life's low cost VGTL coverage. You select the benefit amounts to suit your specific situation and premium payments are made through payroll deduction.

**VOLUNTARY GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:**

- Beneficiary Assistance Program
- Accelerated Benefit
- Dignity Planner
- Portability
- Extended Life Insurance Benefit (Waiver of Premium)

**Important Note**

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USABLE Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USABLE Life's policies set forth the rights and obligations of covered persons and USABLE Life. Please be aware that certain participation requirements, limitations, or exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully.

This benefit summary was generated by USABLE Life on 10/2/2023 at 10:22 AM and may not reflect changes recently submitted to USABLE Life.



## Group Enrollment or Change Form

(Please print or type in Black ink.)

<input type="checkbox"/> New Employee	<input type="checkbox"/> Declination	<input type="checkbox"/> Class or Salary Change	<b>Group #</b> _____ <b>Class</b> _____ <b>Dept/Location</b> _____ <b>Eff Date</b> _____
<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Change of Name	<input type="checkbox"/> Termination Date: _____	
<input type="checkbox"/> Dependent Status Change (Indicate reason _____)			
<input type="checkbox"/> Reinstatement (Complete Date of Rehire as Employment Date)			

**SECTION 1 - APPLICANT INFORMATION**

Employee Legal Name (First, M.I., Last)			For Name Change, Give Prior Last Name		
Home Address		City	State	Zip	Telephone No.
Social Security #		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status
Occupation		Hours worked weekly		Date Employed Full-time	
Employer's Name			Salary \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual		

**SECTION 2 - Complete this Section if applying for Optional Coverage(s). Evidence of Insurability (EOI) may be required when applying for these coverage(s).**

Dependent Life	Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Indicate Date of: Marriage/Divorce _____ Birth of Child _____			
Supp Life	<input type="checkbox"/>	<input type="checkbox"/>	Dependents to be Covered	Relationship	Birthdate	SSN
Supp AD&D	<input type="checkbox"/>	<input type="checkbox"/>				
STD	<input type="checkbox"/>	<input type="checkbox"/>				
LTD	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				

**SECTION 3 - BENEFICIARY DESIGNATION /CHANGE**  Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

**PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):**

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
<b>Total must equal 100% =</b>					

**CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):**

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage
<b>Total must equal 100% =</b>					

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For those coverages I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

**Warning** - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Employee

Date Received - Home Office