My City Benefits

Human Resources Management | City of Oakland

Voluntary Life Insurance

Voluntary Life for:

- **Yourself**: You may elect an amount between $25,000 and $500,000, in increments of $25,000.
  - The guaranteed issue amount is $100,000.
  - You must submit evidence of insurability (EOI) to The Hartford when electing coverage that exceeds $100,000:
  - Coverage exceeding $100,000 will be effective after the City receives approval from the Hartford.
- **For your spouse***: You can enroll your spouse or registered domestic partner in supplement life of $20,000.
- **For your eligible children***: You can enroll children under age 26 in voluntary life coverage of $15,000 per child; $250 for a child 15 days old but under 6 months.

Benefits will be reduced by 35% at age 65, by 50% at age 70, and by 70% at age 75. Reductions applied to the original amount.

*Your spouse and children may only be covered if you elect Voluntary employee life coverage.

Enrollment Instructions

Step 1 Complete The Hartford enrollment form

Step 2 Return your completed enrollment form to the **City of Oakland Benefits Unit.**

- FAX to: **(510) 238-6560**
- Email to: **BenefitsAdmin@oaklandca.gov**
- Mail to: **City of Oakland Benefits Unit**
  150 Frank Ogawa Plaza, 3rd Floor
  Oakland, CA 94612

Step 3 If you elect coverage over the guaranteed amount of $100,000, the Benefits Unit will send you an Evidence of Insurability (EOI) form. You must complete and submit your EOI form **directly to The Hartford**.

BASIC and SUPPLEMENTAL GROUP TERM LIFE INSURANCE BENEFIT HIGHLIGHTS

THE HARTFORD

More than half of Americans (53%) expressed a heightened need for life insurance because of COVID-19.[1]

CITY OF OAKLAND

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit **www.thehartford.com/employee-benefits/employees**

COVERAGE INFORMATION

APPLICANT	BASIC COVERAGE	SUPPLEMENTAL COVERAGE
Employee	Benefit[2]: 1x earnings Maximum: $200,000	Benefit[3]: Increments of $25,000 Maximum: $500,000
Spouse	Not Included	Benefit[3]: $20,000 Maximum: 100% of your supplemental coverage
Child(ren)	Not Included	Benefit: $15,000

PREMIUMS

Your employer pays 100% of the premium for your (employee) basic coverage. Your contribution for voluntary coverage is shown on the Premium Worksheet.[4]

ASKED & ANSWERED

WHO IS ELIGIBLE?

You are eligible if you are an active full time non-sworn employee who works at least 18.5 hours per week on a regularly scheduled basis. Your spouse and child(ren) are also eligible for coverage. Any child(ren) must be under age 26.

CAN I INSURE MY DOMESTIC OR CIVIL UNION PARTNER?

Yes. Any reference to "spouse" in this document includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable law.

AM I GUARANTEED COVERAGE?

Basic insurance is guaranteed issue coverage – it is available without having to provide information about your health.

If you elect an amount that exceeds the guaranteed issue amount of $100,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

This coverage is offered without requiring your spouse to provide evidence of insurability.

Supplemental insurance is guaranteed issue coverage – it is available without having to provide information about your child(ren)'s health.

If you are a late entrant, evidence of insurability is required for the full coverage amount.

HOW MUCH DOES IT COST AND HOW DO I PAY FOR THIS INSURANCE?

Your employer pays 100% of the premium for your (employee) basic coverage.

Premiums for supplemental coverage are provided on the Premium Worksheet. You have a choice of coverage amounts. You may elect supplemental insurance for you only, or for you and your dependent(s).

Premiums will be automatically paid through payroll deduction, as authorized by you during the enrollment process. This ensures you don't have to worry about writing a check or missing a payment.

WHEN CAN I ENROLL?

Your employer will automatically enroll you for basic coverage. If you have not already done so, you must designate a beneficiary.

[2]Your benefit will be reduced by 35% at age 65, 50% at age 70, and 70% at age 75. Reductions will be applied to the reduced amount.
[3]Your benefit will be reduced by 35% at age 65, 50% at age 70, and 70% at age 75. Reductions will be applied to the reduced amount.

You may enroll in supplemental coverage from 9/16/2024 to 10/11/2024.

WHEN DOES THIS INSURANCE BEGIN?

Basic insurance will become effective for you on the date you become eligible.

The effective date of supplemental coverage is 1/1/2025.

You must be actively at work with your employer on the day your coverage takes effect. Your spouse and child(ren) must be performing normal activities and not be confined (at home or in a hospital/care facility).

WHEN DOES THIS INSURANCE END?

This insurance will end when you (or your dependent(s)) no longer satisfy the applicable eligibility conditions, premium is unpaid, or the coverage is no longer offered.

CAN I KEEP THIS INSURANCE IF I LEAVE MY EMPLOYER OR AM NO LONGER A MEMBER OF THIS GROUP?

Yes, you can take this life coverage with you. Coverage may be continued for you and your dependent(s) under a group portability certificate or an individual conversion life certificate. Your spouse may also continue insurance in certain circumstances. The specific terms and qualifying events for conversion and portability are described in the certificate.

[1]Source: LIMRA, Facts About Life 2020: https://www.limra.com/globalassets/limra/newsroom/fact-tank/fact-sheets/liam-facts-2020-final.pdf, as viewed on October 14, 2020.
[4]Rates and/or benefits may be changed on a class basis.. Rates are based on the age of the insured person and increase on the policy anniversary date on or following your birthday as you enter each new age category.

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5962a and 5962b NS 07/21

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

GENERAL LIMITATIONS AND EXCLUSIONS

- A supplemental or voluntary life benefit will not be paid if death occurs by suicide within two years (or as allowed by state law) of purchasing this coverage.
- You and your dependent(s) must be citizens or legal residents of the United States, its territories and protectorates.

DEPENDENT LIMITATIONS AND EXCLUSIONS

- Coverage may only be elected for dependents when you elect and are approved for coverage for yourself.
- Coverage may not be elected for a dependent who has employee coverage under this certificate.
- Coverage may not be elected for a dependent who is in active full-time military service.
- Child(ren) may only be covered as a dependent of one employee.
- Infants may receive a reduced benefit prior to the age of six months.

5962a NS 05/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

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Premium Worksheet

Rates and/or benefits may be changed on a class basis. Rates are based on the employee's age and increase as you enter each new age category.

SUPPLEMENTAL TERM LIFE INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$25,000	$1.88	$1.88	$2.38	$3.13	$4.63	$6.63	$11.38	$18.88	$31.88	$65.13	$90.88	$90.88
$50,000	$3.75	$3.75	$4.75	$6.25	$9.25	$13.25	$22.75	$37.75	$63.75	$130.25	$181.75	$181.75
$75,000	$5.63	$5.63	$7.13	$9.38	$13.88	$19.88	$34.13	$56.63	$95.63	$195.38	$272.63	$272.63
$100,000	$7.50	$7.50	$9.50	$12.50	$18.50	$26.50	$45.50	$75.50	$127.50	$260.50	$363.50	$363.50
$125,000	$9.38	$9.38	$11.88	$15.63	$23.13	$33.13	$56.88	$94.38	$159.38	$325.63	$454.38	$454.38
$150,000	$11.25	$11.25	$14.25	$18.75	$27.75	$39.75	$68.25	$113.25	$191.25	$390.75	$545.25	$545.25
$175,000	$13.13	$13.13	$16.63	$21.88	$32.38	$46.38	$79.63	$132.13	$223.13	$455.88	$636.13	$636.13
$200,000	$15.00	$15.00	$19.00	$25.00	$37.00	$53.00	$91.00	$151.00	$255.00	$521.00	$727.00	$727.00
$225,000	$16.88	$16.88	$21.38	$28.13	$41.63	$59.63	$102.38	$169.88	$286.88	$586.13	$817.88	$817.88
$250,000	$18.75	$18.75	$23.75	$31.25	$46.25	$66.25	$113.75	$188.75	$318.75	$651.25	$908.75	$908.75
$275,000	$20.63	$20.63	$26.13	$34.38	$50.88	$72.88	$125.13	$207.63	$350.63	$716.38	$999.63	$999.63
$300,000	$22.50	$22.50	$28.50	$37.50	$55.50	$79.50	$136.50	$226.50	$382.50	$781.50	$1,090.50	$1,090.50
$325,000	$24.38	$24.38	$30.88	$40.63	$60.13	$86.13	$147.88	$245.38	$414.38	$846.63	$1,181.38	$1,181.38
$350,000	$26.25	$26.25	$33.25	$43.75	$64.75	$92.75	$159.25	$264.25	$446.25	$911.75	$1,272.25	$1,272.25
$375,000	$28.13	$28.13	$35.63	$46.88	$69.38	$99.38	$170.63	$283.13	$478.13	$976.88	$1,363.13	$1,363.13
$400,000	$30.00	$30.00	$38.00	$50.00	$74.00	$106.00	$182.00	$302.00	$510.00	$1,042.00	$1,454.00	$1,454.00
$425,000	$31.88	$31.88	$40.38	$53.13	$78.63	$112.63	$193.38	$320.88	$541.88	$1,107.13	$1,544.88	$1,544.88
$450,000	$33.75	$33.75	$42.75	$56.25	$83.25	$119.25	$204.75	$339.75	$573.75	$1,172.25	$1,635.75	$1,635.75
$475,000	$35.63	$35.63	$45.13	$59.38	$87.88	$125.88	$216.13	$358.63	$605.63	$1,237.38	$1,726.63	$1,726.63
$500,000	$37.50	$37.50	$47.50	$62.50	$92.50	$132.50	$227.50	$377.50	$637.50	$1,302.50	$1,817.50	$1,817.50

SPOUSE SUPPLEMENTAL TERM LIFE INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

Benefit	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$20,000	$1.50	$1.50	$1.90	$2.50	$3.70	$5.30	$9.10	$15.10	$25.50	$52.10	$72.70	$72.70

CHILD(REN) SUPPLEMENTAL TERM LIFE INSURANCE

Monthly Premium Amount (Cost per Pay Period – 12/Year)

Benefit Amount	Cost For Each Child	x	Number of Covered Children	=	Cost For All Children
$15,000	$3.00	x		=	

5962a NS 07/21 Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

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CREATION DATE: 9/3/2024

CITY OF OAKLAND/681009/00169815

Benefits Enrollment Form for CITY OF OAKLAND
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

Instructions: 1) Please print clearly with blue or black ink and provide complete information. (Missing information causes delays.) **2)** Please review the applicable benefit highlight/summary information for each product prior to electing coverage. You (employee) and your dependent(s) (if applicable) are only eligible for coverage as allowed by the applicable group policy. **3)** For each coverage, please check the appropriate box(es) to elect or decline coverage and enter amounts where necessary. **4)** Please sign and date the form. **5)** Submit the form as instructed by your benefits administrator by the enrollment deadline. (Do not submit or send the form directly to The Hartford.)

EMPLOYEE INFORMATION

Name (FIRST MI LAST)	**Employee ID**	**Date of Birth** (MM/DD/YYYY)

Date of Hire (MM/DD/YYYY)	**Salary/Earnings**

Group Policy Number
681009

DEPENDENT INFORMATION (ADDITIONAL CHILDREN MAY BE LISTED ON SEPARATE PAPER AND ATTACHED TO/SUBMITTED WITH THIS FORM)

Spouse Name (FIRST MI LAST) ☐ N/A	**Date of Birth**	**Gender** ☐ M ☐ F	**Date Married/Partnered**

Child Name (FIRST MI LAST)	**Date of Birth**	**Gender**	**Child Name** (FIRST MI LAST)	**Date of Birth**	**Gender**
		☐ M ☐ F			☐ M ☐ F
		☐ M ☐ F			☐ M ☐ F

BASIC TERM LIFE INSURANCE

Coverage for Employee Only	**Benefit Amount**	**Monthly Premium Amount** (Cost per Pay Period – 12/Year)	**Elect Coverage**	**Decline Coverage**
Employee	1 x annual earnings, up to $200,000	Paid by Employer	☒	☐

Additional Information:

- The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 65.

SUPPLEMENTAL TERM LIFE INSURANCE

You must enroll for this coverage in order for your dependents to be eligible for this coverage.

Coverage for Employee Only	Benefit Amount – Select One Option	Monthly Premium Amount (Cost per Pay Period – 12/Year)
Employee	☐ $10,000	$_____
	☐ $25,000	$_____
	☐ $50,000	$_____
	☐ $500,000 (Requires EOI*)	$_____
	☐ $_____	$_____
	☐ Decline Employee Coverage	N/A
Spouse	☐ $20,000	$_____
	☐ Decline Spouse Coverage	N/A
Child(ren) • The premium amount(s) shown apply to each child	☐ $15,000	$3.00 for each child
	☐ Decline Child(ren) Coverage	N/A

Additional Information:

- *If you elect an amount that exceeds the guaranteed issue amount of $100,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective.
- The premium amount(s) for you and your spouse are based on your (employee) age; therefore, the premium amount(s) will change as you grow older.
- The benefit amount available to you (employee) under this plan is subject to a reduction schedule beginning at age 70.
- The child benefit amount listed applies to any child age 6 months or older. A different amount may apply to any child under the age of 6 months.
- To determine the premium amount for all child(ren), multiply the premium amount by the number of eligible children you have.

BENEFICIARY DESIGNATION (PLEASE ENSURE YOUR BENEFICIARY DESIGNATION IS CLEAR SO THERE IS NO QUESTION OF YOUR INTENT)

This designation is for **all** group insurance coverage issued by The Hartford for which benefits are payable to a beneficiary or survivor (as indicated by each specific policy) in the event of your death, unless otherwise requested by you in writing. This designation may be changed upon written request. **All** information requested is required, per beneficiary. If more than one beneficiary is named, the beneficiaries shall share benefits equally unless percentages are stated below. The **percentages must total 100%** for all Primary Beneficiaries and 100% for all Contingent Beneficiaries. If you need to designate more beneficiaries than space will allow, please include the additional information on a separate paper and attach it to/submit it with this form, clearly stating your name. Please consult your benefits administrator or legal advisor for assistance or additional information.

Certain states are community property states. If you live in one of these states – AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI – and designate someone other than your spouse as your beneficiary, state law may require that your spouse consent to the designation. Puerto Rico and certain tribal jurisdictions may also require spousal consent. Spousal consent may not apply to ERISA plans. Please consult your benefits administrator or legal advisor for additional information.

Primary Beneficiary(ies) (PRIMARY BENEFICIARIES ARE FIRST IN LINE TO RECEIVE BENEFITS IF LIVING AT THE TIME OF YOUR DEATH)

1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

Contingent Beneficiary(ies) (CONTINGENT(S) WILL RECEIVE BENEFITS IF NO PRIMARY BENEFICIARY IS ALIVE AT THE TIME OF YOUR DEATH)				
1) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	
2) **Name** (FIRST MI LAST)	**Date of Birth**	**SSN**	**Relationship to You**	**Percent** %
Address (STREET, CITY, STATE & ZIP)			**Phone Number**	

CONFIRMATION & SIGNATURE

By signing below:

- I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer.
- I understand and agree that: 1) If I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is complete and be approved for such coverage before it becomes effective; 2) My request for coverage may be denied by The Hartford; 3) Insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy; 4) This enrollment form along with the insurance policy, the insurance certificate, any riders or applications describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage; 5) No insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy(ies) as issued to my employer; and 6) If group participation requirements are required and are not met, the policy(ies) may not be implemented and the coverage I have elected may not be in force.
- I authorize payroll deductions from my wages to cover my cost of coverage where applicable. I understand that any premium amounts indicated on this form are estimates, which are subject to change based on the final terms of the applicable policy, and may be subject to ongoing change based on my age and/or earnings. I also understand that rates and benefits may be changed by the insurer.
- I have read and understand the “Important Notice – Fraud Warning Statements” that applies to my state of residence.

Employee Signature	**Date of Signature**

END OF FORM – PLEASE REVIEW THE “IMPORTANT NOTICE – FRAUD WARNING STATEMENTS” ON THE FOLLOWING PAGE

Benefits Enrollment Form
Important Notice – Fraud Warning Statements
Hartford Life and Accident Insurance Company

One Hartford Plaza, Hartford, Connecticut 06155 (A stock insurance company)
The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries.

THE HARTFORD

Please read the statement that applies to your state of residence prior to signing the enrollment form.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

For residents of Maine, Tennessee, Virginia 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 and denial of insurance benefits.

For residents of 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For residents of New Mexico and North Carolina: 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 submit to civil fines and criminal penalties.

For residents of New York (not applicable to Life Insurance applications in New York): 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.

For residents of Ohio: Any person who, with 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 is guilty of insurance fraud.

For residents of Oregon: 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of 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.

EMPLOYEE NAME:_____