VOLUNTARY AD&D INSURANCE BENEFITS SUMMARY

For Employees of: STATE BOARD FOR COMMUNITY COLLEGES AND OCCUPATIONAL EDUCATION

ELIGIBILITY

Employee Eligibility Requirement	You must be an active benefit eligible employee of the Policyholder domiciled in the United States. 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.
Dependent Eligibility Requirement	You must elect insurance for your dependent(s) to be eligible. Eligible dependent(s) include your spouse (to include domestic partners as defined by the Benefits Advisory Committee) and any unmarried dependent child(ren) or foster child(ren) until the end of the month of their 25th birthday (any age if incapacitated).
Premium Payment	You pay 100% of the premium for this insurance.

BENEFIT AMOUNT GUIDELINES

	Employee	**Family Plans**		
		+ Spouse & Child(ren)	**+ Spouse Only**	**+ Child(ren) Only**
Minimum Benefit	$10,000	Spouse Benefit: 50% of Employee's benefit Child Benefit: 20% of Employee's benefit	60% of Employee's benefit	25% of Employee's benefit
Maximum Benefit	$500,000 (amounts over $250,000 are subject to 10 times your annual salary)			
Increment(s)	$10,000			

BENEFITS

About This Insurance	This accidental death and dismemberment (AD&D) insurance plan offers protection on a worldwide basis against any covered accident in the course of business or pleasure, whether on or off the job, or in or away from home. This protection is available 24 hours a day, everyday.
Benefit Amount (The Principal Sum)	Within the coverage guidelines defined above, you select the amount of AD&D insurance coverage you want. This plan also includes the option to select coverage for your spouse and dependent child(ren). The AD&D benefit amount is also known as the Principal Sum.
Basic Benefits	Benefits are payable if you (or your dependent, if covered) are injured as a result of an accident, the injury is independent of sickness and all other causes, and a loss occurs within 365 days after the date of the accident. Benefits are paid as indicated below:

Loss	**Benefit**
▪ Life ▪ Both hands, both feet or entire sight of both eyes ▪ One hand and one foot ▪ One hand and entire sight of one eye ▪ One foot and entire sight of one eye ▪ Speech and hearing (both ears)	Principal Sum
▪ One hand, one foot or entire sight of one eye ▪ Speech or hearing (both ears)	50% of the Principal Sum
▪ Loss of thumb and index finger of same hand	25% of the Principal Sum

FEATURES

Additional AD&D Benefits	In addition to basic AD&D Benefits, you and your dependents (if applicable) are protected by the following:	
	▪ Air Bag Usage ▪ Children's Education Benefit ▪ Coma ▪ Day Care Benefit	▪ Paralysis Benefit ▪ Premium Waiver/Extension of Coverage ▪ Seat Belt Usage ▪ Surviving Spouse Training Benefit

Note: *Additional information about the benefits and features of this plan will be included in the certificate on file with the Policyholder. Please contact your employer if you have questions.*

AGE REDUCTIONS

Your AD&D Principal Sum is subject to age reductions. At age 70, amounts reduce to 65%. At age 75, amounts reduce to 45%. At age 80, amounts reduce to 30%. At age 85, amounts reduce to 15%.

EXCLUSIONS

This plan does not cover:

- suicide or any attempt thereat while sane or insane;
- loss caused by act of declared or undeclared war;
- injuries received while participating in training exercises or maneuvers of an armed service while a member of an armed service;
- injuries received while traveling by air, except as provided by the policy;
- injuries received because the insured person was under the influence of any controlled substance, unless administered on the advice of a physician;
- injuries received because the insured person was intoxicated;
- injuries received while traveling in any aircraft which is owned or leased by: (a) the Policyholder, subsidiary or affiliate of the Policyholder; or (b) a director, officer or employee of the Policyholder, subsidiary or affiliate of the Policyholder.

Information about additional exclusions for this plan will be included in the certificate on file with the Policyholder.

Please contact your employer or benefits administrator if you have questions prior to enrolling.

AD&D BENEFIT AMOUNT SELECTION AND PREMIUM AMOUNTS

To select your benefit amount and determine your monthly premium, do the following:

1) Determine whether you are electing coverage for yourself only or for yourself and your dependents (Employee & Family Coverage).
2) Locate the benefit amount you want to select from the top row of the appropriate premium table. Your benefit amount must be in an increment of $10,000 (ex. $10,000, $50,000 or $150,000).
3) Locate the corresponding monthly premium amount in the row below.
4) Enter your benefit amount and monthly premium amount into their respective areas in the AD&D section of your enrollment form.

If the benefit amount you want to select is not presented in the table, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want $220,000 in coverage, you obtain your premium amount by multiplying the monthly premium amount for $10,000 times 22.

Employee Only Coverage Premium Table

Benefit Amount	$10,000	$50,000	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000
Monthly Premium	$0.22	$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90

Employee & Family Coverage Premium Table

Benefit Amount	$10,000	$50,000	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000
Monthly Premium	$0.45	$2.25	$4.50	$6.75	$9.00	$11.25	$13.50	$15.75	$18.00	$20.25

This information describes some of the features of the benefits plan. Certain benefits within the insurance may not be available in all states. Please refer to the certificate for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the policy/certificate and this outline, the policy/certificate will prevail. Benefits availability is subject to final acceptance and approval by Mutual of Omaha. Accidental death & dismemberment insurance is underwritten by Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175.

COMMUNITY COLLEGES OF COLORADO

Voluntary Accidental Death & Dismemberment - Mutual of Omaha

Employee Principal Sum	Employee Only	Employee and Family
$10,000.00	$0.22	$0.45
$20,000.00	$0.44	$0.90
$30,000.00	$0.66	$1.35
$40,000.00	$0.88	$1.80
$50,000.00	$1.10	$2.25
$60,000.00	$1.32	$2.70
$70,000.00	$1.54	$3.15
$80,000.00	$1.76	$3.60
$90,000.00	$1.98	$4.05
$100,000.00	$2.20	$4.50
$110,000.00	$2.42	$4.95
$120,000.00	$2.64	$5.40
$130,000.00	$2.86	$5.85
$140,000.00	$3.08	$6.30
$150,000.00	$3.30	$6.75
$160,000.00	$3.52	$7.20
$170,000.00	$3.74	$7.65
$180,000.00	$3.96	$8.10
$190,000.00	$4.18	$8.55
$200,000.00	$4.40	$9.00
$210,000.00	$4.62	$9.45
$220,000.00	$4.84	$9.90
$230,000.00	$5.06	$10.35
$240,000.00	$5.28	$10.80
$250,000.00	$5.50	$11.25
$260,000.00	$5.72	$11.70
$270,000.00	$5.94	$12.15
$280,000.00	$6.16	$12.60
$290,000.00	$6.38	$13.05
$300,000.00	$6.60	$13.50
$310,000.00	$6.82	$13.95
$320,000.00	$7.04	$14.40
$330,000.00	$7.26	$14.85
$340,000.00	$7.48	$15.30
$350,000.00	$7.70	$15.75
$360,000.00	$7.92	$16.20
$370,000.00	$8.14	$16.65
$380,000.00	$8.36	$17.10
$390,000.00	$8.58	$17.55
$400,000.00	$8.80	$18.00
$410,000.00	$9.02	$18.45
$420,000.00	$9.24	$18.90
$430,000.00	$9.46	$19.35
$440,000.00	$9.68	$19.80
$450,000.00	$9.90	$20.25
$460,000.00	$10.12	$20.70
$470,000.00	$10.34	$21.15
$480,000.00	$10.56	$21.60
$490,000.00	$10.78	$22.05
$500,000.00	$11.00	$22.50

Monthly rates per $1,000 Principal Sum

Employee Only	$0.022
Employee & Family	$0.045

Voluntary Enrollment Form

Underwritten by: Mutual of Omaha Insurance Company

Employer Section

Company Name:

STATE BOARD FOR COMMUNITY COLLEGES AND OCCUPATIONAL EDUCATION

City:	State:	Zip Code:
Sub Group Name:	Location Code:	
Group I.D.: **T66BA-P-51585** / Sub-group I.D.: / Class:	Effective Date:	Hours worked per week:
Current Base Pay $ ☐ Hourly ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Semimonthly ☐ Annually	Full-Time Employment Date:	Occupation:

Employee Section (Please Print)

Social Security:	Name: Last First M.I.	
Birth Date: Mo. Day Yr.	Gender: ☐ Male ☐ Female	Marital Status:
Street Address:		
City:	State:	Zip Code:

Voluntary AD&D Coverage Election — Review & Check As Applicable

		Yes	No	Benefit Amount	Premium Amount
Voluntary AD&D	Employee Only	☐	☐	$_____	$_____
Voluntary AD&D	Employee & Family	☐	☐	$_____	$_____

Dependent Information (Please Print)

Name of Dependent(s)	Gender	Relationship	Birth Date Mo. Day Yr.	Social Security Number
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 Last Name	First	M.I.	Relationship to Insured	**Secondary Beneficiary** 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. **Should you decline coverage(s) for either yourself or your eligible dependent(s), you MUST complete the Waiver of Group Voluntary Insurance on the back of this form**.

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**_____/_____/_____

Waiver of Group Voluntary Insurance

I have been given the opportunity to apply for Group Voluntary AD&D Insurance as offered by the Policyholder, and after careful consideration have decided not to enroll:

For:
- ☐ Myself (and all eligible dependents, if applicable)
- ☐ My eligible dependent spouse only
- ☐ My eligible dependent spouse and children only
- ☐ My eligible dependent children only

I understand and accept the Waiver of Group Insurance provisions.

Signature of Employee_____**Date**_____/_____/_____

Insurance Company Use Only

Acknowledgement_____Date Recorded _____/_____/_____