CHRISTIAN SCHOOLS INTERNATIONAL

OPTIONAL LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

•Participants in the CSI Insurance Plan have the opportunity to purchase additional term life insurance coverage for themselves, their spouses and their children at affordable group rates.

•Coverage is available in increments of $10,000, with a maximum of $250,000. Effective January 1, 2008, the maximum is the lower of $250,000 or five times your annual salary.

•The amount elected for the spouse cannot exceed the employee's insurance amount.

•Coverage levels of $5,000 and $10,000 are available for children.

•Benefits will be reduced by 35% on the first day of the calendar month after attainment of age 70, another 20% on the first day of the calendar month after attainment of age 75, another 15% on the first day of the calendar month after attainment of age 80.

•This coverage terminates upon the retirement of the employee. If you would like to know about rates for conversion and/or portability, please visit the CSI web site at www.CSIonline.org. Go to Employee Benefits/United States/CSI Insurance/Forms/Optional Life.

•Premium billing begins the first of the month following the effective date given. All premium payments are made through the school by payroll deduction and sent to the Plan Administrator.

OPTIONAL LIFE INSURANCE:

•Premium cost for employee and spouse is based on age as follows:

Monthly Rate per $10,000 of Benefit

Age	Non-Tobacco User	Tobacco User	Age	Non-Tobacco User	Tobacco User
0-29	$0.50	$1.00	55-59	$ 7.65	$15.30
30-34	$0.80	$1.55	60-64	$ 8.75	$17.50
35-39	$1.05	$2.10	65 69	$11.95	$23.90
40-44	$1.65	$3.20	70-74	$29.65	$59.30
45-49	$2.75	$5.40	75-79	$47.50	$94.95
50-54	$4.75	$9.45			

•The monthly premium cost for children is $2.00 for coverage of $5,000 and $3.50 for $10,000. This rate covers each of your children regardless of the number of children you have.

•Apply for coverage by completing the application and Evidence of Insurability (enclosed) for the employee and/or spouse, and return the forms to the CSI Insurance Office. Employees within 30 days of employment do not need to complete the Evidence of Insurability form.

•Participants covered by at least $10,000 in optional life may increase coverage at any September 1 without completing an Evidence of Insurability form. Spouse coverage over $50,000 is available pending approval of an Evidence of Insurability form.

OPTIONAL AD&D:

•The monthly premium cost for employee/spouse is $0.50 for each $10,000 in coverage.

•The monthly premium cost for children is $0.30 for $5,000 of coverage and $0.50 for $10,000 of coverage.

LIMITATIONS AND EXCLUSIONS

LATE ENROLLMENT

If approved, I understand any such change will be effective as of my first day of active work on or after such approval. Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer disabled. This delay does not apply to newborn children while dependent insurance is in effect. “Totally disabled” means that, as a result of an injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

EXCLUSION FOR SUICIDE

Where the cause of death is suicide: 1) No benefits will be payable for a loss within 24 months after the individual’s initial effective date of insurance; and 2) No increased or additional insurance will be payable for a loss occurring with 24 months after the day of such increased or additional insurance is effective.

(More)

APPLICATION

OPTIONAL LIFE

AND

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Employee	Social Security Number	Birthdate	Sex	School	
Address	City	State	Zip Code	Effective Date	Employment Date
Employee's Beneficiary (First Name - Middle Initial - Last Name)	Relationship	Spouse's Beneficiary			Relationship
Spouse	Social Security Number	Birthdate	Sex		

OPTIONAL LIFE

Complete this section if electing Optional Life

I have ( ) have not ( ) used tobacco products during the 12 month period immediately preceding the date noted below.

Employee Signature_____________________________ Date_________________, 20________

I have ( ) have not ( ) used tobacco products during the 12 month period immediately preceding the date noted below.

Spouse Signature_____________________________ Date_________________, 20________

NOTE: If you are eligible for non-smoker rates at this time and you start smoking in the future, you must advise the CSI Insurance Plan office and your premium rate will be adjusted accordingly. If you fail to do so, the Insurance Company may terminate your life insurance benefits, deny your claim for life insurance benefits and return your group insurance contributions under the group policy.

Current Optional Life Coverage (Do not include $20,000 Basic Life) Employee $____________ Spouse $____________ Child $____________

Additional amount requested (Elect coverage in increments of $10,000)
(For Child Optional Life elect either $5,000 or $10,000) Employee $____________ Spouse $____________ Child $____________

Total Coverage Desired Employee $____________ Spouse $____________ Child $____________

OPTIONAL AD&D

Current Optional AD&D Coverage (Do not include $20,000 Basic AD&D) Employee $____________ Spouse $____________ Child $____________

Additional amount requested (Elect coverage in increments of $10,000)
(For Child Optional AD&D elect either $5,000 or $10,000) Employee $____________ Spouse $____________ Child $____________

Total Coverage Desired Employee $____________ Spouse $____________ Child $____________

I request my employer to arrange for the Group Coverage for which I elect and authorize my employer to deduct from my earnings the required contributions.

I have been given the opportunity to participate in the Optional Life and Dependent Life Insurance Programs with UNUM/Provident. I understand that if I elect to participate more than 31 days after first eligible; or, if I later elect to increase the amounts of insurance elected on a date other than September 1, I will be considered a late subscriber and will need to provide medical evidence of good health satisfactory to UNUM/Provident. If approved, I understand any such change will be effective as of my first day of active work on or after such approval. If I elect to increase the amounts of insurance elected now or on any September 1, I can do so without having to provide medical evidence of good health.

Employee's Signature:_____________________________Date Signed:_____________________

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