KEEP THIS PAGE FOR YOUR RECORDS

YMCA of Greater Louisville

National YMCA Employee Benefits Plan

Group Life and Accidental Death & Dismemberment Insurance

SCHEDULE OF BENEFITS

Non-Contributory Insurance for Employees

Basic Term Life Insurance.....$5000

Contributory Insurance for Employees

Term Life Insurance

An amount equal to 2 times your basic annual earnings, reduced by your Basic Term Life amount, adjusted to the next higher multiple of $1000 if not already a multiple thereof.

Maximum Insurance..... $250,000

*The total amount of Term Life Insurance for employees age 65 and over will be $5000 And will terminate when they retire. Contributions will be adjusted accordingly.

**Based on earnings for a normal work week not exceeding 40 hours, exclusive of bonus and overtime pay, and other special compensation.

Accidental Death and Dismemberment Insurance

An amount equal to your Term Life Insurance

Cost of the Insurance

You will be informed of the amount of your contribution upon enrollment. .33 per $1,000

Change in Amount of Insurance

Adjustments in the amounts of Term Life Insurance due to an increase in earnings will become affective on the date of change, provided you are working full-time on that date. Otherwise, the adjustment will be delayed until you return to full-time work.

In no event will the amount of your insurance be reduced due to a decrease in your earnings.

Eligible Employees

All full-time employees of *The National Board of YMCAs and YMCA Affiliates.*

Date of Eligibility/Employment Waiting Period

You will be eligible on the 1st of the month following the date you complete the employment waiting period of 60 days of continuous full-time employment.

BENEFIT ENROLLMENT / CHANGE FORM

Please press firmly.

*Must Return

☐ New Coverage	☐ Request For Change	☐ Waive All Coverage	☐ COBRA Application Former EE SSN_____	☐ Address Change (Indicate in Sec. 2)	☐ Open Enrollment

1 TYPE OF LIFE EVENT OR CHANGE (Please mark all that apply)

☐ Add Dependents: Marriage ☐ Birth ☐ Adoption ☐ Other ☐ _____ ☐ Salary Change ☐ Name Change (Complete Sec. 2) Eff. Date_____ ☐ Full Time to Part Time ☐ Part Time to Full Time

☐ Drop Dependents: Death ☐ Divorce/Legal Separation ☐ Limiting Age ☐ Dependent Gain Employment ☐ Other ☐ _____ ☐ Surviving Spouse – Former Employee SSN_____

☐ Terminate All Benefits Reason: _____ ☐ Terminate Medical/Dental Reason: _____ ☐ Other_____

IST COMPLETE
IS SECTION

2 PERSONAL INFORMATION Status: ☐ Active ☐ COBRA ☐ Terminated ☐ Retired (Date_____)

Employee Name (LAST / FIRST / MI)

Address (STREET / CITY / STATE / ZIP CODE) ☐ Male ☐ Female Gender: ☐ Single ☐ Married ☐ Other Marital Status:

Home Phone No. ( ) Work Phone No. ( ) E-Mail

YMCA Corp Association Name Date of Birth / / Social Security No. | | | |-| | |-| | | | |

IS SECTION
T NEEDED

3 MEDICAL COVERAGE

☐ I decline coverage Reason: Name of NYEBP Plan

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T NEEDED

4 DENTAL COVERAGE

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T NEEDED

5 EMPLOYEE/DEPENDENT INFO

(C) CHG	SHIP	DATE OF BIRTH (MM/DD/YY)	FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	MED	DEN	DISABLED	FULL-TIME STUDENT?
	Spouse	/ /			- -			☐Y ☐N	☐Y ☐N
	Son ☐ Daughter ☐	/ /			- -			☐Y ☐N	☐Y ☐N
	Son ☐ Daughter ☐	/ /			- -			☐Y ☐N	☐Y ☐N
	Son ☐ Daughter ☐	/ /			- -			☐Y ☐N	☐Y ☐N
	Son ☐ Daughter ☐	/ /			- -			☐Y ☐N	☐Y ☐N

$5000 2 X's SALARY - 33¢ per #1,000

IST COMPLETE
IS SECTION

6 LIFE INSURANCE ☐ Basic Life ☐ Optional Life ☐ Dependent Life Tobacco User: ☐ Yes ☐ No

7 OTHER HEALTH COVERAGE

☐ Medicare Part B Effective Date / / Reason (if under 65)

IST COMPLETE
IS SECTION

8 BENEFICIARY DESIGNATION AND CHANGE ☐ Life and AD&D ☐ Dependent Life ☐ Original ☐ Beneficiary Change ☐ Name Change

Beneficiary Name(s)	Address	Relationship	Date of Birth
Beneficiary Change–Effective Date (Life and AD&D) / / Change to	Address (STREET / CITY / STATE / ZIP)	Relationship	Date of Birth (BENEFICIARY)
Name Change – Effective Date / /	Reason for Change (MARRIAGE OR COURT ORDER)	Change From	To (BENEFICIARY)

* If more than one beneficiary is designated, settlement will be made in equal shares to such of the beneficiaries as survived the insured unless otherwise provided therein.
* If no designated beneficiary survives the insured, settlement will be made to the estate of the insured unless otherwise provided in the group policy.

EASE SIGN
D DATE THIS
CTION

9 EMPLOYEE SIGNATURE

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give the YMCA's Administrator and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Plan Administrator after it has been approved by the Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

If my employer's plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.

NOTICE Of Enrollment Rights

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

X Signature _____ Date_____

10 TO BE COMPLETED BY YMCA

Full Time Date of Hire____/____/____	Health/Change Effective Date____/____/____	Salary $ _____	Salary Effective Date____/____/____	☐ Exempt ☐ Non-Exempt
Basic Life Amount ☐ $5,000 ☐ $10,000 ☐ 1 x pay ☐ 1-1/2 x pay ☐ 2 x pay ☐ 3 x pay		Optional Life ☐ 1 x pay ☐ 1-1/2 x pay ☐ 2 x pay		
Association Number 2 3 8 5 LTD ☐ Yes ☐ No	LTD Effective Date ____/____/____	Transfer from other YMCA ☐ Yes ☐ No If yes, YMCA Name_____	Telephone No._____	
COBRA Eff. Date____/____/____	Employer Name Print_____ Employer Name Sign_____		Date_____	

ORIGINAL–NATIONAL YELLOW – ASSOCIATION PINK–EMPLOYEE