Voluntary Term Life Insurance Program
for

RIO HONDO COMMUNITY COLLEGE

Certificate Number: 05372801

If you are eligible, Voluntary Term Life Insurance is available to you, your eligible spouse, and your eligible dependent children. This insurance option provides low cost, pure life insurance protection—it is an ideal way to help provide financial protection during your working years.

ELIGIBILITY FOR THIS PROGRAM

Employee: (1) if your employer requires that you must be continuously employed by them for a minimum number of days, you must be continuously employed for at least that number of days; and (2) you must be actively performing the regular duties of your job for at least the required number of hours as defined in the Group Contract and work in the usual manner and at the usual place of employment or business (if you are not working due to illness or injury, you will *not* be eligible until you return to work); and (3) you must provide evidence of insurability satisfactory to MetLife, if we ask for it. If you are not working due to illness or injury, you will not be eligible until you return to work.

Spouse: Your spouse who is legally married (as determined by the laws of the state in which you live) to you is eligible to participate in this program. Spouse also means your registered domestic partner* as defined in the Group Contract. A spouse does not include anyone who is personally eligible as an employee. You must be covered in order for your spouse to be eligible for coverage.

*Your registered domestic partner means a person whose domestic partnership with you has been validly registered by the California Secretary of State; or a person with whom you have established a union other than marriage, recognized under California law as the equivalent of a registered domestic partner.

Dependent Children: Dependent children are your children from live birth to 26 years old. Your children include your legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren, Registered Domestic Partner's children, and foster children. A child placed with you for adoption prior to legal adoption is considered your qualified dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you.

A dependent child does not include anyone who is personally eligible as an employee. If you and your spouse are both eligible as an employee, your children may be insured as dependent children of either you or your spouse, but not both of you. You must be covered in order for your dependent children to be eligible for coverage.

A qualified dependent may be confined for medical care or treatment, at home or elsewhere. If a qualified dependent is so confined on the day that your dependent's insurance under a coverage for that qualified dependent, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the qualified dependent's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

BENEFITS

Employee Coverage:

Classification	Maximum Benefit	Non-Medical Limit*
Superintendent, Management, Certificated, and Classified Employees.	$10,000 increments to a maximum of $500,000 not to exceed five (5) times annual earnings (rounded to the next highest $10,000).	Two (2) times annual earnings, rounded to the next highest $10,000 not to exceed $100,000.
All Members of the Board of Education	$10,000 increments to a maximum of $500,000.	$100,000.
Evidence of Insurability will be required on all employee amounts over the non-medical limit amount. *To be eligible for non-medical limit, you must be an active employee and apply within 31 days of first becoming eligible for this coverage. Annual earnings are defined as the gross amount of money paid to you by the employer in cash for performing the duties required of your job. Bonuses, overtime pay, earnings for more than 40 hours per week, and all other benefits are not included.		

Dependent(s) Coverage*:

Spouse: Your spouse's amount must be in **$10,000** increments, not to exceed **$500,000**. Non-Medical Limit of up to **$20,000** is available. The spouse can only select coverage if the employee enrolls.

Dependent Children: You may select from the following coverage amounts: **$2,500, $5,000, $10,000**.

Your spouse and dependent children can only participate if you have NOT been denied coverage.
***Dependents' coverage may not exceed 100% of your approved coverage amount.**

HIGHLIGHTS

Premium will be waived for you, your spouse, and your children if **you**, the employee, are insured and become totally disabled for at least six consecutive months. Your total disability must occur while coverage is in force and prior to your attaining age 70. During the six-month waiting period, premiums for all coverage must be paid. Limitations and exclusions apply. Refer to the Group Contract for details.

Accelerated Death Benefit
The Accelerated Death Benefit for Terminal Illness allows individuals to "tap into" life insurance proceeds early. You can receive up to **80%** of the applicable Voluntary Term Life Insurance amount in the event of an insured's terminal illness. The maximum benefit payable under this option is **$500,000**. The balance of the coverage will be paid to the beneficiary at the death of the insured. Limitations and exclusions apply. Refer to the Group Contract for details.

Accelerated Death Benefit option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered "terminally ill" You may wish to seek professional tax advice before exercising this option.

Continuation of Coverage
If your employment terminates for any reason or you become ineligible, you and your covered family may continue your Voluntary Group Term Life Insurance coverage on a direct payment basis at the same rate as long as the Group Contract remains in effect. YOU MUST CONTINUE your coverage in order to continue dependent coverage. If you elect this option, you will be billed on a semiannual or annual basis. A fee per billing will apply, and your premium cost is subject to change. You must sign an application for continuation within 31 days following the termination of your employment or eligibility. An insured on continued coverage may apply for conversion to permanent coverage at any time, but in no event more than 31 days after the termination of the Group Contract.

EXCLUSIONS

Suicide Exclusion
If you or your covered dependent's death results from or is caused by suicide, while sane or insane: (1) A death benefit is not payable if you or your covered dependent dies within two years of the date you or your covered dependent became a covered person. But, MetLife will refund any premiums paid for your Voluntary Term Life Insurance or Voluntary Dependent Term Life Insurance under this coverage. (2) The amount of any increase in your or your dependent's death benefit is not payable if you or your covered dependent dies within two years of the date of the increase. But, Prudential will refund any premiums paid for that increase.

Beneficiary
You designate your own beneficiary. You, as the employee, will be the beneficiary of your spouse's and/or children's insurance.

How to Apply

Select the amount of coverage that best meets your needs and those of your family. Calculate your premium, then complete and sign the enclosed application and its payroll deduction authorization. Be sure to complete all questions accurately. Your spouse must sign if he/she is requesting insurance coverage. All applications are subject to the underwriting review and approval by MetLife. If you do not want coverage, simply sign and date the appropriate line at the top of the application. Whether you apply for coverage or choose not to participate, all applications and waivers must be returned to your employer.

PREMIUM COST

Premium per $1,000 of Coverage for Employees and Spouses		
AGE	TENTHLY	MONTHLY
Under 30	.05	.04
30-34	.05	.04
35-39	.07	.06
40-44	.11	.09
45-49	.19	.16
50-54	.29	.24
55-59	.47	.39
60-64	.78	.65
65-69	1.31	1.09
70+	2.22	1.85

Children Coverage Options	TENTHLY COST	MONTHLY
$2,500	.60	.50
$5,000	1.20	1.00
$10,000	2.40	2.00

Employee/Spouse rates are based on the age of the covered individual. Your rates will automatically increase on the Contract Anniversary following the date you advance into the next higher age-bracket listed above. During the employee's or spouse's lifetime, a premium adjustment will be made immediately if any discrepancy is found in either the employee's or spouse's age or cost.

Effective Date
Your coverage will be effective on the first day of the month following the date that MetLife or its administrator approves your application. As an eligible employee if you qualify for the non-medical limit, the first two times annual earnings, rounded to the next highest $10,000 not to exceed **$100,000** will be effective on the first day of the month following the date you enroll. As an eligible Board Member if you qualify for the non-medical limit, the first **$100,000** will be effective on the first day of the month following the date you enroll. Your spouse's coverage will be effective on the first day of the month following the date he/she is approved for coverage. If your spouse qualifies for a non-medical limit, up to the first **$20,000** will be effective on the first day of the month following the date you enroll your spouse. Children coverage is effective when your coverage becomes effective. Spouse and dependent children coverage will not become effective unless you apply for and are approved for coverage.

Delay of Effective Date
Your Employee Insurance under a Coverage will be delayed if you do not meet the Active Work Requirement on the day your insurance would otherwise begin. Instead, it will begin on the first day you meet the Active Work Requirement and the other requirements for the insurance. The same delay rule will apply to any change in your insurance that is subject to this section. For Dependents Term Life coverage, if a Qualified Dependent is so confined on the day that your Dependents Insurance under a Coverage for that Qualified Dependent, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the Qualified Dependent's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

LIMITATIONS AND EXCLUSIONS
This booklet highlights the features of your Voluntary Group Term Life Insurance coverage. Only the provisions, definitions, limitations, and exclusions of the Group Contract, Certificate, Riders, Endorsements, Applications and/or Enrollment Form, which together constitute the formal legal contract, will apply. A copy of the Group Contract is held by your employer and can be viewed upon request during your employer's normal business hours.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Division	Class	Dept Code
RIO HONDO COMMUNITY COLLEGE	05372801	0001		
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee in blue or black ink)

Name (First, Middle, Last)	Social Security # – –	☐Male ☐Female	☐Single ☐Married
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
☐Employee ☐Retiree	Job Title:	Basic Annual Earnings: $	☐Salaried ☐Hourly	Hours Worked Per Week:

☐New Enrollment ☐Change in Enrollment If due to a Qualifying Event, enter date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand the amounts of insurance I request must comply with and are limited by the plan design described in my enrollment materials.

► If you are enrolling during the initial enrollment period, you must complete this Hospitalization question for Supplemental/Optional Life, Supplemental/Optional Dependent Spouse Life and Supplemental/Optional Dependent Child Life.

Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?

Employee	Spouse	Child(ren)
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

If a Proposed Insured has been Hospitalized within the last 90 days a Statement of Health must be completed for the person to whom the "yes" applies. **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance

☐Supplemental/Optional Life [1] (Buy up)
Enter amount requested $________________

☐Supplemental/Optional Dependent Spouse [2] Life [1,3] (Buy up)
Enter amount requested $________________

☐Supplemental/Optional Dependent Child Life [3] (Buy up)
Enter amount requested $________________

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

[3] Amounts will be subject to state limits, if applicable.

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
____________________	____________	☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
____________________	____________	☐ Male ☐ Female
____________________	____________	☐ Male ☐ Female
____________________	____________	☐ Male ☐ Female
____________________	____________	☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

GEF02-1
ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: 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.

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

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

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Maine, Tennessee 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 or a denial of insurance benefits.

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.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): 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.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

GEF09-1a

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.

Pennsylvania and all other states: 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 subjects such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%
If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):				
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.
6. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
7. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
8. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

PAYMENT AUTHORIZATION

By signing below, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)