ENROLLMENT FORM

Policyholder: Smithsonian Institution — Policy Number: PAI 8035033A

Name of Employee _____ S.S.# _____

Date of Birth _____ Gender _____

Primary Beneficiary _____ Relationship _____

Contingent Beneficiary _____

_____ Relationship _____

To apply for coverage, please check Employee Plan, Employee and Children, Employee and Spouse, or Family Plan in the space provided and check Principal Sum amount below.

☐ Employee Plan ☐ Employee and Children ☐ Employee and Spouse ☐ Family Plan

PRINCIPAL SUM AMOUNTS AND BI-WEEKLY COSTS

	Principal Sum	Employee	Employee & Children	Employee & Spouse	Family
☐	$ 50,000	$ .50	$ .60	$ .70	$ .85
☐	$100,000	$1.00	$1.20	$1.40	$1.70
☐	$150,000	$1.50	$1.80	$2.10	$2.55
☐	$200,000	$2.00	$2.40	$2.80	$3.40
☐	$250,000	$2.50	$3.00	$3.50	$4.25
☐	$300,000	$3.00	$3.60	$4.20	$5.10
☐	$350,000	$3.50	$4.20	$4.90	$5.95
☐	$400,000	$4.00	$4.80	$5.60	$6.80
☐	$450,000	$4.50	$5.40	$6.30	$7.65
☐	$500,000	$5.00	$6.00	$7.00	$8.50

☐ I authorize the premium for this insurance to be deducted from my salary. I understand if I apply for an amount over $250,000 it cannot exceed 10x my salary. All excess premiums will be returned.

☐ I do not wish to participate in the insurance program offered through Smithsonian Institution.

Date signed: _____

Signature: _____

FOR COMPANY USE ONLY

Effective Date of Coverage _____