Utah State University
Voluntary Accident Insurance Plan Enrollment Form

Underwritten by Zurich American Insurance Company, Policy Number GTU 4379833

Your Name (Please Print) Last First Middle

Date of Birth Your Social Security Number

Your Monthly Cost:

- The monthly cost for Employee Only coverage is $.012 for each $1,000 Principal Sum.
- The monthly cost for Employee and Covered Child(ren) Only is $.015 for each $1,000 Principal Sum.
- The monthly cost for Employee and Covered Spouse Only is $.015 for each $1,000 Principal Sum.
- The monthly cost for the Family Plan is $.015 for each $1,000 Principal Sum.

Principal Sum Amounts You May Purchase:

Under this coverage you may elect to purchase an amount of Principal Sums in multiples of $25,000 to a maximum of $1,000,000.

Optional Family Plan Coverage for Your Eligible Spouse and Dependent Children:

Employee: You are insured for the Principal Sum you purchased above.

Spouse: Your Spouse is insured for 60% of your Principal Sum if at the time of the injury you do not have any Covered Children or 50% of your Principal Sum if at the time of the injury you have Covered Children.

Covered Children: Each Covered Child is insured for 20% of your Principal Sum if at the time of the injury you did not have a Covered Spouse or 15% of your Principal Sum if at the time of the injury you have a Covered Spouse.

Benefit Amount	PLAN I Monthly Cost Yourself Only	PLAN II & III Monthly Cost You &: Your Covered Spouse Only; or Your Covered Child(ren) Only	PLAN IV Monthly Cost You & Your Family
$ 25,000	$ .30	$ .38	$ .38
50,000	.60	.75	.75
100,000	1.20	1.50	1.50
150,000	1.80	2.25	2.25
200,000	2.40	3.00	3.00
275,000	3.30	4.13	4.13
350,000	4.20	5.25	5.25
450,000	5.40	6.75	6.75
500,000	6.00	7.50	7.50
600,000	7.20	9.00	9.00
700,000	8.40	10.50	10.50
800,000	9.60	12.00	12.00
900,000	10.80	13.50	13.50
1,000,000	12.00	15.00	15.00

The cost of benefits for you and your dependents (if they are enrolled) is paid by payroll deduction.

Check One:

☐ **PLAN I – Employee Only**

☐ **PLAN II – Employee & Covered Children** ***Principal Sum Selected*** ***Monthly Cost***

☐ **PLAN III – Employee & Spouse**

☐ **PLAN IV – Employee & Family** $_____ $_____

Beneficiary Designation & Relationship: _____

The beneficiary for Spouse and dependent children is the employee named in the enrollment form.

☐ I authorize the deduction from my salary of the premiums for the insurance applied for as shown above.

☐ I have been given the opportunity to apply for this insurance but I do not desire to participate.

Your Signature Date

For Company Use Only (Effective Date)