

Metropolitan Life Insurance Company Statement of Health Form Instructions

Based on your enrollment, a Statement of Health is required to complete your request for group insurance coverage. Below are instructions for Completing the Statement of Health Form.

A separate Statement of Health form is required for each Proposed Insured / Applicant requesting insurance.

PLEASE USE THE CHECKBOXES TO ENSURE PROPER COMPLETION OF THE FORM.

Information to be Completed by Employer

- Enter Employer Name
- Enter Customer Number
- Enter SOH Reporting Location (if applicable)
- Enter Employer Address
- Select type of Insurance
 - If Life Insurance, enter the additional amount of insurance
- Enter Enrollment Year or year of requested increase (usually current year) for reporting purposes only

Information to be Completed by Proposed Insured / Applicant

The Proposed Insured / Applicant must complete all information located in the boxes at the top:

- Enter Employee Name and Social Security Number**
- Enter Relationship of Proposed Insured / Applicant to Employee
- Enter Proposed Insured / Applicant's
 - Name
 - Sex
 - Date of Birth
 - Mailing Address
 - Business Telephone Number
 - Home Telephone Number
 - Email Address
 - State of Birth
 - Country of Birth

****NOTE: The Employee's Name and Social Security Number must appear on the form.**

Medical Information — must be completed.

- Complete Question 1.
- Check "Yes" or "No" for Questions 2-6 (all parts).
- Complete Question 7.
- Complete the details section if ANY of the questions 2 through 6 were answered "Yes."

Signatures

- The Employee must always sign and date the **Statement of Health** form.
- The Proposed Insured / Applicant (if over the age of 18) must sign and date the **Statement of Health and Authorization** forms. If the Proposed Insured / Applicant is under the age of 18, his/her personal representative must sign and date the Authorization.

Upon completion, make a copy of the completed form for your records and FAX or MAIL the completed 3-pages to the Statement of Health (SOH) Unit at MetLife.

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

Note: Additional medical information may be required after initial review of completed forms. This information may be in the form of a physical examination, paramedical exam, or Attending Physician Report, in which correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned for completion. For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com.

STATEMENT OF HEALTH FORM

To be Completed by the Employer

-PLEASE PRINT CLEARLY-

Employer Name	Customer Number	Reporting Location Number	
Employer's Street Address	City	State	Zip Code
Insurance Requested (To be completed for each Proposed Insured / Applicant)			
<input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental/Optional Life <input type="checkbox"/> Group Universal Life <input type="checkbox"/> Group Variable Universal Life <input type="checkbox"/> Dependent Life			
Additional Amount of Life Insurance Subject to Medical Underwriting \$ _____			
<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability			
Enrollment Year: _____			

To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)

Employee Name (Must Complete)			First	MI	Last	Employee Social Security Number (Must Complete)				
Insurance is for			Proposed Insured Name			First	MI	Last	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Mo Day Yr)
<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child										
Mailing Address					City			State	Zip Code	
Business Phone Number () ()		Home Phone Number () ()		E-mail Address			State of Birth		Country of Birth	

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Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

- Height ___ feet ___ inches Weight ___ lbs
- Are you now:

	Yes	No
a. pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b. taking prescribed medications or on a prescribed diet? If "yes," list: _____	<input type="checkbox"/>	<input type="checkbox"/>
c. receiving or applying for any disability benefits including workers' compensation?	<input type="checkbox"/>	<input type="checkbox"/>
- In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? Yes No
- In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.) _____ Yes No
- Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

	Yes	No		Yes	No
a. chest pain or heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	h. colitis, Crohn's or any intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. high blood pressure, stroke or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	i. Epilepsy, paralysis or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
c. cancer or tumors?	<input type="checkbox"/>	<input type="checkbox"/>	j. mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. anemia, leukemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lyme disease, Epstein-Barr or chronic fatigue syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
e. diabetes? insulin treated?	<input type="checkbox"/>	<input type="checkbox"/>	l. arthritis, carpal tunnel, or any muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>
f. asthma, tuberculosis, pneumonia, or other lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	m. kidney or urinary tract disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g. ulcers, stomach or liver disorder?	<input type="checkbox"/>	<input type="checkbox"/>	n. thyroid or other gland disorder?	<input type="checkbox"/>	<input type="checkbox"/>
			o. back, neck or spinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
- Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? Yes No
- Personal Physician: _____ Date and reason for last visit: _____
Address: _____ Phone Number: _____

Give full details for "Yes" answers on the next page.

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SOH/NW

(08/08)

Give full details for "Yes" answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code

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Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

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

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.



Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

	(Employee must always sign) Signed		Date Signed (Mo./Day/Yr.)
	(Proposed Insured if other than Employee and at least 18 years of age) Signed		Date Signed (Mo./Day/Yr.)

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DEC

SOH/NW

(08/08)

Make A Copy For Your Records & FAX or MAIL Completed Forms to
the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, the proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

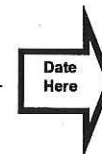
By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Each proposed insured has a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.



Signature of Proposed Insured or
Signature & Relationship of Personal Representative*



Date Signed (Mo./Day/Yr.)

Print Name of Proposed Insured

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, and indicate the legal relationship between the Personal Representative and the proposed insured. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Understanding Your Life Insurance Plan (continued)

If something happened to you, would your family be protected?

Get an idea of how much life insurance you might need through these examples:

	John and Susan	Tom and Debbie	Robert and Helen
Profile	Married with two children	Married with no children	Pre-retirees with no children at home
Goals	Since John and Susan have young children and Susan isn't employed, they want life insurance that will cover their expenses for 10 years as well as have an additional \$100,000 to help pay for their children's education.	If something were to happen to either Tom or Debbie, they want life insurance to cover expenses for five years. Tom also has older parents who depend on his support so they want to set aside \$50,000 for adult care.	Even though Robert and Helen have no dependents living at home, Robert would like to set aside \$45,000 and cover expenses for one year to make sure Helen has enough money to maintain a comfortable life if something happens to him. He also wants to set aside \$10,000 for funeral expenses.
Ages	John: 40 Susan: 38 Children: 4 and 6	Tom: 28 Debbie: 30	Robert: 58 Helen: 56
Monthly Expenses	\$3,000	\$1,600	\$1,500
Additional Expenses To Plan For	\$100,000	\$50,000	\$55,000
Outstanding Debt	\$200,000	\$100,000	\$70,000
Assets/Savings	\$20,000	\$50,000	\$40,000
Recommended Coverage	\$640,000	\$196,000	\$103,000

We recommend that you review your coverage periodically — even annually — to ensure that your family's needs will be met now and in the future.

Take advantage of this important coverage.

If you have any questions about the options that are available to you, contact your benefits administrator or MetLife.

The examples shown are hypothetical and are used for informational purposes only. Your particular needs may vary. You may utilize the Life Insurance Calculator at www.metlife.com/mybenefits to assist you in determining the amount that is best for you and your specific needs.

If you determine you need more coverage than is offered under your employer's program, consider enrolling for the available group coverage and supplementing it with individual insurance.

Like most group insurance policies, MetLife group insurance policies contain certain exceptions, reductions, limitations and terms for keeping them in force. Please contact your benefits administrator or MetLife for costs and complete details.

Old Dominion University Research Foundation Plan Benefits

Explore the coverage that makes it easy to give yourself and your loved ones more security today...and in the future.

Basic Term Life and Accidental Death and Dismemberment Insurance (AD&D)

Your employer provides you with Basic Term Life and Accidental Death and Dismemberment insurance coverage in the amount of 2 times your base annual earnings up to a maximum of \$300,000 at no cost to you.

Supplemental Term Life Insurance Coverage Options

For You	Your choice of \$10,000 increments, up to 5 times your basic annual earnings or \$500,000.
For Your Spouse	Minimum \$5,000 up to \$250,000 in \$5,000 increments, up to 100% of your coverage amount
For Your Dependent Children*	15 days to 6 months old: \$1,000 6 months and older: \$10,000

*Child(ren)'s Eligibility: Dependent children ages from 15 days old, under age 26, if a child is an unmarried, are eligible for coverage.

Monthly Costs for Supplemental Term Life Insurance and Accidental Death and Dismemberment Insurance

You have the option to purchase Supplemental Term Life Insurance. Listed below are your monthly rates as well as those for your spouse (based on your age and the amount of coverage you want). Rates to cover your child(ren) are also shown.

Age	Your Monthly Cost Per \$1,000 of Coverage	Spouse Monthly Cost Per \$1,000 of Coverage
Under 25	\$0.065	\$0.065
25 - 29	\$0.065	\$0.065
30 - 34	\$0.084	\$0.084
35 - 39	\$0.102	\$0.102
40 - 44	\$0.132	\$0.132
45 - 49	\$0.205	\$0.205
50 - 54	\$0.336	\$0.336
55 - 59	\$0.566	\$0.566
60 - 64	\$0.872	\$0.872
65 - 69	\$1.648	\$1.648
70 +	\$2.670	\$2.670
Cost for your Child(ren)[†]	\$01.10 per employee	

[†] Covers all eligible children

Use the table below to calculate your premium based on the amount of life insurance you will need.

Example: \$100,000 Supplemental Life Coverage

1. Enter the rate from the table (example age 36)	\$0.102	\$ _____
2. Enter the amount of insurance in thousands of dollars (Example: for \$100,000 of coverage enter \$100)	100	_____
3. Monthly premium (1) x (2)	\$10.20	\$ _____

Repeat the three easy steps above to determine the cost for each coverage selected.

Features

This insurance offering from your employer and MetLife comes with a variety of added features that can provide assistance to you and your family members today and during a difficult time.

Accelerated Benefits Option¹

For access to funds during a difficult time

You can receive up to 80% of your Basic and Supplemental Term Life insurance proceeds to a maximum of \$400,000 in the event that you become terminally ill and are diagnosed with less than 12 months to live.

This can go a long way toward helping your family meet medical and other related expenses at this difficult time. The Accelerated Benefit Option is also available to spouses insured under Dependent Life insurance plans. This option is not available for dependent child coverage.

Conversion

For protection after your coverage terminates

You can generally convert your Group Term Life insurance benefits to an **Individual Whole Life** insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or, a change in your employee class. Conversion is available on all Group Life insurance coverages. Please note that conversion is **not** available on AD&D coverage. If you experience an event that makes you eligible to convert your coverage, you can speak with a MetLife representative by calling: 1-877-275-6387 or contact your employer for more information.

Waiver of Premiums for Total Disability (Continued Protection)

Offering continued coverage when you need it most

You may be eligible for waiver of your Basic and Supplemental Term Life insurance premium until you reach age 65, die or recover from your disability, whichever is sooner, should you become unable to work due to total disability. Total disability or totally disabled means your inability to do your job and any other job for which you are fit by education, training or experience, due to injury or sickness. The total disability must begin before age 60, and your waiver will begin after you have satisfied a 90 days waiting period. The Waiver of Premium will end on the earliest of your turning age 65, death or recovery. Please note that this benefit is available after you have participated in the Supplemental Term Life Plan for one year and it is only available to you. This one-year requirement applies to new participants in the plan.

Portability

So you can keep your coverage even if you leave your current employer

Should you leave Old Dominion University Research Foundation for any reason, and your Supplemental, Dependent Term Life, and Voluntary Accidental Death and Dismemberment insurance under this plan terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Rates will be based on the experience of the ported group and MetLife will bill you directly. Rates may be higher than your current rates. To take advantage of this feature, you must have coverage of at least \$10,000 up to a maximum of \$2,000,000.

Portability is also available on coverage you've selected for your spouse and dependent child(ren). The maximum amount of coverage for spouses is \$250,000; the maximum amount of dependent child coverage is \$25,000. Increases, decreases and maximums are subject to state availability.

Generally, there is no minimum time for you to be covered by the plan before you can take advantage of the portability feature. Please see your certificate for specific details. Please note that if you experience an event that makes you eligible for portable coverage, please call a MetLife representative at 1-888-252-3607 or contact your employer for more information.

Will Preparation Service²

To help ensure your decisions are carried out

Like life insurance, a carefully prepared Will (Simple, Complex or Living) along with a Power of Attorney are important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property.

Living Will:

- Ensures your wishes are carried out, and protects your loved ones from making these very difficult and personal medical decisions by themselves.
- Also called an "advanced directive," it is a document authorized by statutes in all states. A person appoints someone as his/her proxy or representative to make decisions on maintaining extraordinary life-support if the person becomes incapacitated so that he or she cannot communicate his or her wishes

Power of Attorney:

- Allows you to plan ahead by designating someone you know and trust to act on your behalf in the event of unexpected occurrences or if you become incapacitated. It is a written document that grants an individual the power to act on the grantor's behalf.

By electing Supplemental Term Life coverage, you will have access to Hyatt Legal Plans' network of 11,500+ participating attorneys. When you enroll in this plan, you may take advantage of this benefit with a participating plan attorney.* When you use a participating plan attorney there will be no charge for the services. To obtain the legal plan's toll-free number and your company's group access number, contact your employer or your plan administrator for this information.

* You also have the flexibility of using an attorney who is not participating in the Hyatt Legal Plans' network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney's fees that exceed the reimbursed amount.

MetLife Estate Resolution Services—ERS³

Personal service and compassion to help your beneficiaries and others manage your estate during their time of need

MetLife Estate Resolution Services—is a valuable service offered under the plan. When your estate representative uses a participating plan attorney there will be no charge for the services. A Hyatt Legal Plan attorney will consult your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator. This can help alleviate the financial and administrative burden upon your loved ones in their time of need.

Total Control Account^{®7}

For immediate access to death proceeds

The Total Control Account[®] settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life or accident policy for claim payments of \$5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. They'll have the convenience of immediate access to any or all of their proceeds, through an interest bearing account with unlimited draft-writing privileges. The Total Control Account gives beneficiaries time to decide what to do with their proceeds, which can be very helpful to them during a difficult time.

What's Not Covered?

Like most insurance plans, this plan has exclusions. Supplemental and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage.

Please note that a reduction schedule may apply. Please see your certificate for specific details.

Accidental Death & Dismemberment (AD&D) coverage complements your Basic and Supplemental Life coverage insurance and helps protect you 24 hours a day, 365 days a year.

Accidental Death & Dismemberment Coverage Options

This valuable coverage is available to you even if you already have accident insurance. It provides benefits beyond your disability or life insurance for losses due to covered accidents — while commuting, traveling by public or private transportation and during business trips. MetLife's AD&D insurance pays you benefits if you suffer a covered accident that results in paralysis or the loss of a limb, speech, hearing or sight, or brain damage or coma. If you suffer a covered fatal accident, benefits will be paid to your beneficiary.

Voluntary AD&D Coverage Amounts for You:

You also have the option to enroll for Voluntary AD&D insurance.

You can choose the Voluntary AD&D option that meets your needs:

- \$10,000 to \$500,000 coverage in increments of \$10,000

The maximum amount of coverage you can receive is the lesser of 10 times your Basic Annual Earnings rather than pay or \$500,000.

Voluntary AD&D Coverage Amounts for Spouse and Child(ren):

You can choose to cover your dependent spouse and child(ren) with AD&D coverage under the Family Protection Plan Plus. Your dependents will be eligible for the following coverage:

Dependent Spouse and Child(ren):

- **Spouse**— 40% of your coverage amount
- **Child(ren)** — 10% of your coverage amount

Dependent Spouse only:

- 50% of your coverage amount

Dependent Child(ren) only:

- 15% of your coverage amount

Monthly Cost for Accidental Death & Dismemberment (AD&D) Insurance

Voluntary Coverage	Monthly Cost Per \$1,000 of Coverage
Employee	\$0.020
Employee & Family	\$0.030

Note: Costs for any coverages you select will be automatically payroll deducted.