AIRES, LLC. APPLICATION FOR BENEFITS

Employer use only:

Date of hire			
OR Date of change			
OR Termination date			

Employee name (Last, First, MI)												
Home address												
	Address						*City*			*State*		*Zip code*
Primary Phone	( )						Email					
Date of birth				Gender	M	F	Social Security Number (SSN)					
Health plan			PPO Dental plan			*OR*	HMO Dental plan			Vision plan		
	Yes	*No*		*Yes*	*No*			*Yes*	*No*		*Yes*	*No*

You may choose one dental plan. If you choose the Dental HMO a Primary Care Dentist will be assigned to you based on your home zip code. Once enrolled you may change your Primary Care Dentist online at mycigna.com or by calling the phone number on your ID Card. If you sign your family up for benefits they are enrolled in the same product as you. You must provide SSN or Social Security Number for yourself and your family members in order to enroll in any plans.

Did you check NO above for medical, dental or vision? If so, please tell us why. (select which apply)

Reason for declining: (select which apply)			
	Covered by spouse's plan	Covered by parent's plan	Too expensive
	Covered by Medicare	Covered by other state plan	Other:

If enrolling for health, dental or vision, indicate your family members you wish to cover:

Dependent or spouse name (Last, First, MI)								SP or CH	
Home address									
	Address (if different than yours)					*City*		*State*	*Zip code*
Primary Phone	( )					Email			
Date of birth				Gender	M	F	Social Security Number (SSN)		
Health	*Yes*	*No*	Dental	*Yes*	*No*	Vision	*Yes*	*No*	

Dependent or spouse name (Last, First, MI)								SP or CH	
Home address									
	Address (if different than yours)					*City*		*State*	*Zip code*
Primary Phone	( )					Email			
Date of birth				Gender	M	F	Social Security Number (SSN)		
Health	*Yes*	*No*	Dental	*Yes*	*No*	Vision	*Yes*	*No*	

Dependent or spouse name (Last, First, MI)								SP or CH	
Home address									
	Address (if different than yours)					*City*		*State*	*Zip code*
Primary Phone	( )					Email			
Date of birth				Gender	M	F	Social Security Number (SSN)		
Health	*Yes*	*No*	Dental	*Yes*	*No*	Vision	*Yes*	*No*	

For additional family members please use an additional sheet of paper

EMPLOYER PAID LIFE INSURANCE (You may not decline)

Basic term life and accidental death and dismemberment is provided by your employer at no cost to you.

Death benefit: $20,000 Accidental death benefit: $20,000

Benefits may reduce after age 65. Refer to your policy for specific details.

You must name a beneficiary for your life insurance. Without this information, your family may not receive your benefit. You may name a separate beneficiary for life and for accidental death.

Beneficiary #1		
	Name & relationship to you	*Social Security Number (SSN) or FEIN*
	Address, City, ST, zip	*% of benefit allocated (must = 100%)*

Beneficiary #2		
	Name & relationship to you	*Social Security Number (SSN) or FEIN*
	Address, City, ST, zip	*% of benefit allocated (must = 100%)*

Check here if you wish to have the beneficiaries named above for ALL life and accidental death policies. ☐

IMPORTANT: USE A SEPARATE SHEET OF PAPER IF YOU REQUIRE ADDITIONAL SPACE FOR BENEFICIARIES.

I hereby apply for the requested group medical, dental, vision or life insurance coverage for which I and my dependents, if any, are eligible and available under AIRES, LLC. policies. I authorize AIRES, LLC. to deduct from my wages the amount of premium required for the amount of coverage approved by AIRES, LLC. insurance providers including any premium increases due to age bracket or salary changes when applicable. I affirm that the facts and other matters contained in the application are true and accurate to the best of my knowledge and belief. 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 may be guilty of a crime and may be subject to fines and confinement in prison.

If you are only applying for medical, dental and/or vision, you are finished! If you would like to apply for additional life insurance at a low cost please complete and sign page 3.

Sign below to apply for coverage. Your application cannot be processed without your signature.

Signature: _____ **Date:** _____

OPTIONAL LIFE INSURANCE FOR YOU AND YOUR FAMILY

For you: Purchase any benefit amount in $1,000 increments (minimum $10,000, maximum $500,000)

Your maximum benefit may not exceed 5x your base annual salary

First time applying: Apply for up to $175,000 with NO health questions or amounts over $175,000 with health questions

Previously waived: Must fill out health questions

The cost for insurance will be deducted from your paycheck

Spouse: Purchase any benefit amount in $500 increments (minimum $5,000, maximum 50% of your benefit amount

First time applying: Apply for up to $30,000 for your spouse with NO health questions or more than $30,000 with health qu

Previously waived: Must fill out health questions

Your spouse must be less than age 70 in order to be eligible for coverage

Child or Children: Purchase any benefit amount in $2,500 increments (minimum $2,500, maximum $10,000)

No health questions apply to children.

BELOW ARE COMMON BENEFIT AMOUNTS. REFER TO THE COST SHEET TO FIND A COMPLETE TABLE OF ALL BENEFIT AMOUNTS.

Payroll Deduction Illustration: 2 Times Per Month

Employee Options

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$.30	$.30	$.33	$.38	$.48	$.66	$.98	$1.48	$2.16	$2.90	$4.49	$7.52	$22.07
$25,000	$.75	$.75	$.81	$.94	$1.20	$1.65	$2.44	$3.69	$5.40	$7.24	$11.21	$18.79	$55.16
$50,000	$1.48	$1.48	$1.61	$1.86	$2.38	$3.28	$4.86	$7.36	$10.78	$14.46	$22.41	$37.56	$110.31
$100,000	$2.95	$2.95	$3.20	$3.70	$4.75	$6.55	$9.70	$14.70	$21.55	$28.90	$44.80	$75.10	$220.60

Spouse Options

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$5,000	$.16	$.16	$.17	$.20	$.25	$.34	$.50	$.75	$1.09	$1.46	$2.25
$10,000	$.30	$.30	$.33	$.38	$.48	$.66	$.98	$1.48	$2.16	$2.90	$4.49
$15,000	$.45	$.45	$.49	$.56	$.72	$.99	$1.46	$2.21	$3.24	$4.34	$6.73
$20,000	$.59	$.59	$.64	$.74	$.95	$1.31	$1.94	$2.94	$4.31	$5.78	$8.96
$25,000	$.75	$.75	$.81	$.94	$1.20	$1.65	$2.44	$3.69	$5.40	$7.24	$11.21

Child Options

Life & AD&D	Child(ren) 6 months to age 19, or 25 if full-time student	Child(ren) live birth to 6 months	Deduction amount Child(ren)
Option 1:	$2,500	$1,000	$0.32
Option 2:	$5,000	$1,000	$0.63
Option 3:	$7,500	$1,000	$0.95
Option 4:	$10,000	$1,000	$1.27

SPOUSE RATES ABOVE ARE TO BE CALCULATED BASED ON YOUR AGE (NOT YOUR SPOUSE'S AGE).

I would like to apply for the following coverages for myself and my family:

Employee Life and Accidental Death Benefit Amount: _____ (maximum $500,000 or 5x annual salary)

Spouse Life and Accidental Death Benefit Amount: _____ (maximum $250,000 or 50% of EE amount)

Child Life and Accidental Death Benefit Amount: _____ (maximum $10,000)

I understand that certain coverage may require evidence of insurability. All coverages require approval.

Beneficiary #1

Name & relationship to you | *Social Security Number (SSN) or FEIN*

Address, City, ST, Zip | *% of benefit allocated (must = 100%)*

Beneficiary #2

Name & relationship to you | *Social Security Number (SSN) or FEIN*

Address, City, ST, Zip | *% of benefit allocated (must = 100%)*

Beneficiary #3

Name & relationship to you | *Social Security Number (SSN) or FEIN*

Address, City, ST, Zip | *% of benefit allocated (must = 100%)*

Beneficiary #4

Name & relationship to you | *Social Security Number (SSN) or FEIN*

Address, City, ST, Zip | *% of benefit allocated (must = 100%)*

Signature: _____ **Date:** _____