Everyone has the need for financial security, but the needs of each member can vary. To help meet these needs, State Employees Association of North Carolina is proud to offer Group Voluntary Life Insurance to you and your family through the convenience of monthly payroll deductions, where available.

Who Is Eligible?

You, as an active member of the association working more than 30 hours per week in the employment of the State of North Carolina, your spouse under the age of 70, your unmarried children ages 14 days to 19 years *(to age 25 if full-time student),* and handicapped children over the age of 19. *Dependents may not be insured if they are confined in a medical facility.*

What About Coverage For My Family?

If you are covered as a member, you may insure your spouse for $25,000 *(if spouse is not an insured member).* Dependent children age one year to 19 years *(to age 25 if full-time student)* are eligible for Life Insurance in the amount of $10,000, and children 14 days to one year for $500. *A Spouse or Child who is an insured member cannot be insured as a Dependent.* If both spouses are insured, their Children can only be insured as Dependents of one Spouse.

How Much Does Family Coverage Cost?

The monthly cost to insure your spouse and all eligible dependent children for Life Insurance is only $6.75 per family. The monthly cost to insure all eligible children *(without spouse)* is only $2.20 per family.

How Much Insurance May I Select?

You have the flexibility to choose coverage in units of $10,000 to a maximum of $300,000.

What is Accelerated Death Benefit?

The Accelerated Death Benefit provision enables a member diagnosed with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary at time of death.

Are There Reductions Or Exclusions?

Yes, they are stated in the master policy and your certificate. Members' Life Insurance is reduced according to the following schedule:

to 65% of original benefit at age 70
to 50% of original benefit at age 75
to 35% of original benefit at age 80
to 25% of original benefit at age 85
to 20% of original benefit at age 90
to 15% of original benefit at age 95

Upon retirement the original amount of life insurance shall be reduced to the lesser of the insured's inforce benefit or $50,000 subject to the Age Reduction formula noted above.

How Do I Apply?

Complete the enrollment form. When you sign it, you are giving your employer authorization to dedect the premiums from your pay if available. Coverage in excess of the Guaranteed Issue amount will become effective after Boston Mutual approves your application and the first full premium payment is paid.

Completed enrollment forms should be mailed directly to:

SEANC Insurance Department
State Employees Association of North Carolina
Post Office Drawer 27727
Raleigh, NC 27611
Telephone: (800) 222-2758 or (919) 833-6436

WWW.SEANC.ORG

Our Pledge To You...

For over 100 years Boston Mutual has been a recognized leader in providing affordable coverage to working people. We are committed to the promises we have made to you, our customers.

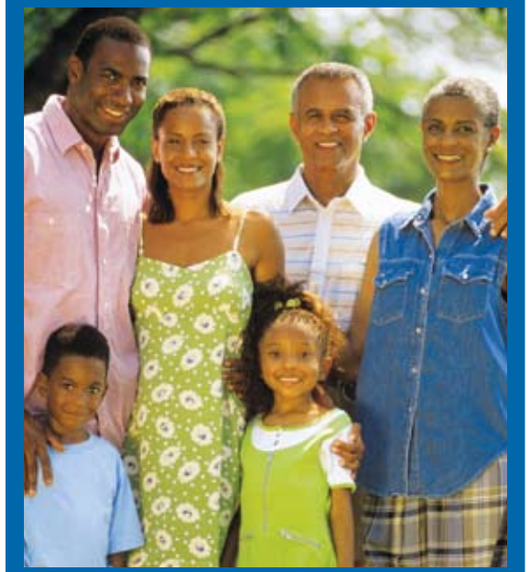
Underwritten By:

Boston Mutual Life Insurance Company
120 Royall Street
Canton, Massachusetts 02021

This brochure is intended only to provide a summary of available coverage.

Policy Series GRTP (4/99) *241-083 4/12*

Group Voluntary Life Insurance



Added Insurance Protection for You and Your Family!

Sponsored by

State Employees Association of North Carolina
Post Office Drawer 27727 • Raleigh, NC 27611
Telephone: (800) 222-2758 or (919) 833-6436

WWW.SEANC.ORG

How Much Does Voluntary Life Insurance Cost For Each Member of the Association?

Because of group purchasing power this term life insurance is affordable. Monthly payroll deductions for members are shown below:

Rate table effective April 1, 2010.

Monthly Member Rates and Sample Monthly Premium Costs

Age	Rate per $1,000	Volume of Insurance			
		10,000	20,000	50,000	100,000
< 24	0.045	0.45	0.90	2.25	4.50
25-29	0.055	0.55	1.10	2.75	5.50
30-34	0.07	0.70	1.40	3.50	7.00
35-39	0.11	1.10	2.20	5.50	11.00
40-44	0.17	1.70	3.40	8.50	17.00
45-49	0.26	2.60	5.20	13.00	26.00
50-54	0.44	4.40	8.80	22.00	44.00
55-59	0.76	7.60	15.20	38.00	76.00
60-64	1.10	11.00	22.00	55.00	110.00
65-69	1.85	18.50	37.00	92.50	185.00
70-74	5.27	52.70	105.40	263.50	527.00
75-79	5.56	55.60	111.20	278.00	556.00

Premiums and Rates are based on attained age and change as you move to a higher age bracket.

Premiums and Rates for members age 80 and over are available. Please call SEANC Insurance Department for details.

What About Medical Questions?

If you and your dependent enroll within 180 days of membership initiating, provided that the new member has not been a member at any time during the immediate preceding two years, you and your family may purchase a specific amount of Life Insurance on a guaranteed issue basis. Medical questions will not be required for coverage at or under the Guaranteed Issue Amounts. You, the member, may also apply for coverage that exceeds the Guaranteed Issue Amount but, you will be subject to medical underwriting for any amount in excess of the Guaranteed Issue Amount.

Guaranteed Issue for Members:

Age	Amount
Under 60	$100,000
60-69	40,000
70 and Over	-0-

Coverage will become effective on the first of the month following receipt of the first full premium payment, and provided membership dues are paid current.

What If I Leave State Government?

If you leave State Government, the coverage is "portable". You may continue life insurance coverage for you and your family by making payments directly to Boston Mutual. 1) You must apply and pay premium within 31 days after the date employment ends. 2) You must be under age 60 and you have not converted your group life insurance.

Is There A Conversion Privilege For All Or Part of My Insurance Benefit?

Yes, you may convert your Voluntary Life coverage for yourself, spouse, and children to a whole life policy without medical underwriting, if you apply within 31 days of the date coverage terminated, and it did not terminate due to non-payment of premium. The premium will be based on our usual rate for the insured's age on the date of conversion.

GROUP VOLUNTARY LIFE INSURANCE ENROLLMENT FORM

G# 40138

SEANC INSURANCE DEPARTMENT
P.O. Drawer 27727
Raleigh, NC 27611-7727

For SEANC Use Only:

Premium _____

Effective Date _____

MEMBER:

Information – Amounts in excess of the guaranteed issue limit are avaiable. Please contact SEANC Insurance Office at 800-222-2758 or 919-833-6436. Amounts in excess of the guaranteed issue or enrollment forms submitted after you first become eligible are subject to medical evidence of insurability satisfactory to Boston Mutual.

Member Name *(Last, First, Middle Initial)* _____

Social Security # ___ - ___ - ___ Department/Agency _____

Member Address _____

Date of Birth _____ Age ____ Sex (M or F) ____ Date of Hire _____ Occupation _____ Avg. Hours Worked ____

Insurance Selection *(complete appropriate section)*

New Life Insurance ❑

Member Life Insurance $ _____

OR

Increase in Life Insurance ❑

Current Insurance $ _____

Additional Insurance Requested $ _____

Total Requested Insurance $ _____

Beneficiary Information Name of Beneficiary Relationship Benefit %

Primary _____

Primary _____

Contingent Beneficiary _____

Contingent Beneficiary _____

If more than one beneficiary is designated, the proceeds will be split equally unless otherwise indicated.

SPOUSE/DEPENDENT CHILDREN:

Information: Spouse/Dependent Child(ren)

Spouse Life Insurance YES ❑ NO ❑

Spouse Name _____

Spouse Date of Birth _____

Dependent Child(ren) Life Insurance YES ❑ NO ❑

Dependent(s) _____

Dependent Dates of Birth _____

The beneficiary for the spouse and dependent children is the member.

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the group policy of group policies issued to **SEANC** by the Boston Mutual Life Insurnace Company and authorize deductions from my earnings of the required premium contribution toward the cost of the insurance.

I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.

I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurnace Company.

Signature of Member _____ Date _____

Tear at perforation and mail to: SEANC P.O. Drawer 27727 Raleigh, NC 27611-7727

BOSTON MUTUAL LIFE INSURANCE COMPANY

120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473

EVIDENCE OF INSURABILITY FORM FOR GROUP INSURANCE

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance

PLEASE COMPLETE IN FULL

IMPORTANT
Submit with completed Enrollment form.

EMPLOYER SECTION

Group #	Div. #	Employer/Group Name
Social Security #		Employee Name *(Last, First, Middle Initial)*
Telephone #		Address

PROPOSED INSURED(S)

Name	Relationship	Date of Birth	Height	Weight

REASON

NEW

- ❑ Late Applicant
- ❑ Applying for Coverage in Excess of the Guaranteed Amount
- ❑ Applying for Supplemental Coverage
- ❑ Other _____

CHANGE

- ❑ Increase in Coverage
- ❑ Adding Spouse
- ❑ Increasing Spouse
- ❑ Adding Dependent Child(ren)
- ❑ Other _____

APPLYING FOR . . .

YOU	LIFE	AD&D	VOLUNTARY LIFE	VOLUNTARY AD&D
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ❑ Short Term Disability $ _____ *Weekly Benefit*
- ❑ Long Term Disability $ _____ *Monthly Benefit*
- ❑ Other $ _____

YOUR SPOUSE	LIFE	AD&D	VOLUNTARY LIFE	VOLUNTARY AD&D
Current Insurance				
Additional Insurance Requested				
Total New Coverage				

- ❑ Other $ _____

EVIDENCE OF INSURABILITY

1A. Existing Coverage

Please list all life insurance and/or annuity contacts now in-force or pending on your life

Name of Company *(if replacement include Policy No.)*	Life Amount	AD&D Amount	Year Issued or Pending	Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?
				❑ YES ❑ NO
				❑ YES ❑ NO

1B. To be Completed for ALL Proposed Insured(s) if Required by the Group Insurance Contract

Have you used any form of tobacco products (cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches) within the past 12 months? ** **Employee** ❑ YES ❑ NO **Spouse** ❑ YES ❑ NO

** ***I understand and agree that if I have not answered these questions correctly 1) the coverage may be rescinded during the first two years from the certificate effective date, and 2) after that time, the sum payable and every other benefit will be adjusted to the amount which the premiums would have purchased if the questions had been answered correctly.***

2. Have ANY of the proposed insureds ever had or been told by a member of the medical profession that they had:
   - A. 1) asthma or emphysema; 2) high blood pressure, stroke, heart or circulatory disease or disorder; 3) intestinal disease or disorder or ulcer; 4) diabetes; 5) leukemia, cancer, tumor or malignancy; 6) epilepsy, mental or nervous disease or disorder; 7) kidney or genito-urinary disease or disorder; or 8) disorder of the back, muscles, bones or joints? ❑ YES ❑ NO
   - B. Have any of the proposed insureds been treated for or been diagnosed by a member of the medical profession as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? ❑ YES ❑ NO
   - C. In the past 5 years, have any of the proposed insureds; 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? ❑ YES ❑ NO
   - D. Do you or your spouse: 1) fly, or intend to fly, as pilot or crew member; 2) race or test any form of vehicle; 3) scuba dive; 4) hang glide or sky dive? ❑ YES ❑ NO
   - E. Has any proposed insured used on a regular basis or are they currently using or ever received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ❑ YES ❑ NO

3. Details for questions 2 - A, B, C, D, E answered "YES". Include question number.

Name	Disease or Injury	Date (s)	Details/Treatment	Names & Address of Attending Phy's & Hospitals

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we represent that the statements and answers in this Evidence of Insurability form are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

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.

Signature of Applicant *(Employee/Member)* | Date | Signed & Dated at *(City, State)*

Signature of Applicant *(Other than Employee/Member)* *(Employee/Member if the proposed insured is under 15)* | Date | Signed & Dated at *(City, State)*

Thank you for considering Boston Mutual Life Insurance Company as your insurance carrier.
Your application will receive our immediate and full consideration.