The effective date of coverage is January 1, 2026. If you want to enroll in Voluntary Dependent Life Insurance, just complete the enclosed forms and return it to the Benefits Department by **Friday, October 31, 2025**.

What is Voluntary Dependent Life Insurance? Voluntary Dependent Life Insurance is additional Life Insurance for dependent(s), spouse &/or child(ren), payable to you, the employee, upon the death of your dependent(s), spouse &/or child(ren). Child(ren) are under the age of 26. You, the employee, pay for this additional coverage through payroll deduction. You can purchase this life insurance in three options:

Option	Spouse Coverage	Child(ren) Coverage	Cost per Month	Cost per Weekly Pay Period
Option 1	$10,000	$2,500	$3.46	$0.80
Option 2	$20,000	$5,000	$6.93	$1.60
Option 3	$25,000	$7,000	$8.82	$2.04

If you are an employee with a spouse but no children or an employee with child(ren) but without a spouse, the cost for coverage is same for the option. The coverage is the same cost for multiple children, under the age of 26. *An employee may NOT be covered as an employee and as a Dependent. Child(ren) cannot be covered by more than one employee.*

If you are currently enrolled in Voluntary Dependent Life Insurance and you do not wish to make any changes, your current elections will roll over from 2025 to 2026 without making any elections or changes.

If you wish to elect Voluntary Dependent Life Insurance,

- Complete the enclosed Enrollment Form
- Complete the enclosed Dependent Verification Form
- Complete the Beneficiary Designation Form
- Return the completed forms to the Benefits Department, by **Friday, October 31, 2025**:

  Mail: Bi-State Development
  211 N. Broadway, Suite 700
  Attn: Benefits – MS 125
  St. Louis, MO 63102, or
  Fax: 314-335-3431
  Email: Benefits@BiStateDev.org

If you have any additional questions, contact the Benefits Department at Benefits@BiStateDev.org or 314-982-1400 x 3006.

Thank you,

Bi-State Benefits Department
**Read full Policy for complete Terms & Conditions.

Life Insurance Company of North America (LINA)

GROUP TERM LIFE INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any requested information below. Don't forget to include your Social Security Number, herein shown as SSN, Birthdate, sign your name and enter today's date.

Return completed form to: Benefits Department

EMPLOYER: Bi-State Development Agency

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ SSN _____ Date of birth _____

Home Address _____ City _____ State _____ Zip _____

Email _____ Home/Cell Phone _____ Employee ID # _____ Gender: _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is _____

Spouse Name _____ SSN _____ Date of birth _____ Gender _____

YOUR COVERAGE ELECTIONS

View the Summary of Benefits for costs and instructions for how to calculate premium.

Employee-Paid Term Life Insurance – Policy # FLX0970854 Underwritten by LINA		
Choose your desired coverage amount below and who you would like to cover. See the Summary of Benefits for costs.		
Who You Want to Cover	**Coverage Amount**	**Accept your desired coverage amount or decline coverage below.**
❑ Spouse (Spouse Option must correlate with Child Option)	❑ Option 1 - $10,000 ❑ Option 2 - $20,000 ❑ Option 3 - $25,000**** Guaranteed Issue Amount***: $25,000	❑ Decline Coverage
❑ Children (Child Option must correlate with Spouse Option)	❑ Option 1 - $2,500 ❑ Option 2 - $5,000 ❑ Option 3 - $7,000**** Guaranteed Issue Amount***: All amounts	❑ Decline Coverage

If Children are elected, all eligible dependent children will be covered.

*** Guaranteed Issue Amount is only available if enrolling within the first 31 days of eligibility. Amounts of insurance may be limited by state law.

****This is the maximum coverage amount that you can choose under this plan. Coverage elected during this enrollment period will take effect on the later of 01/01/2026, or the date your election form is received by your Employer.

SIGN TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. I understand that coverage is subject to the insurance company's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Please Sign Here Signature _____ Date _____

Created on 09/2025.

BI·STATE DEVELOPMENT

Dependent Life Eligibility Verification

Employee Name _____ Badge Id Number _____

Address of Employee _____
Street City Zip

Phone Number _____ Email Address _____
(Optional)

*Eligible Dependent Name	Date of Birth	Relationship to Employee	Social Security Number

Employee Signature _____ Date _____

Please be sure to include dependent eligibility documentation (marriage license, birth certificate, adoption certificate, etc.)

*Eligible Dependent

- *Your legal spouse—must provide a copy of marriage license or certificate for enrollment*
- *Your children from birth up to the date the child attains age 26, including biological children (provided the child has not been legally adopted by another person), Adopted Children, stepchildren living with the Employee, and Foster Children.*
- *Spouse or child must not be full-time member(s) of the armed forces.*
- *Cannot be insured as both an individual (employee) and a dependent (spouse or child).*

Completed form and verification documentation should be returned to the Bi-State Benefits Department, Mail-Stop 125, Benefits@bistatedev.org, or fax 314-335-3431

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America
New York Life Group Insurance Company of NY
Connecticut General Life Insurance Company

Beneficiary Designation Form

Employer Name: Bi-State Development Agency

Employee Name:_____ **Employee Social Security Number:** _____

Current Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Home Phone:_____ **Work Phone:** _____

Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Basic Life Insurance — Policy No. FLX0970854

Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Voluntary Life Insurance — Policy No. FLX0970854

☐ Check here if you want to use the same designations here that you used for Basic Life Insurance, and do not complete the rest of this section.

Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Employee's Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse as beneficiary, payments of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse's Signature:_____ Date: _____

Owner's Signature:_____ Date: _____

Note: This form is not complete without your signature. Please sign the form on the next page where indicated.

Guidelines for Designation of Beneficiaries

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation(s).

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e. one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate because it is lost, contested, or superseded by a later will. Claim payment delays can result if the beneficiary designation does not provide for this situation.

Domestic Partner - If you wish to designate your domestic partner as your beneficiary, you must complete a beneficiary form. Otherwise, your death benefit will be paid according to the provisions of the policy.

Life Status Changes - We recommend that you review your beneficiary designation(s) when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation(s). A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Voluntary benefit costs.

Prepared for the employees of Bi-State Development Agency.

Instructions: The below table(s) contain cost information for your available product options. To find your cost, view the box where your age and selected coverage amount cross.

Family coverage amounts

Spouse guarantee issue amount is $25,000. Dependent child(ren) coverage amounts are always available without having to answer any medical questions.

Weekly costs per elected amount for Family Benefit					
Spouse	Child	Cost	Spouse	Child	Cost
$10,000	$2,500	$0.80	$20,000	$5,000	$1.60
$25,000	$7,000	$2.04			

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

*If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply. Coverage will not be issued until the insurance company approves acceptable proof of good health.

Costs shown are for illustrative purposes only; actual per pay period deductions may differ due to rounding and individual tax situations. Costs are subject to change based on age and program experience. Terms and conditions of coverage are set forth in your group policy. Refer to your Certificate of Insurance or Summary Plan Description for more information.

New York Life Group Benefit Solutions products and services are provided by Life Insurance Company of North America, New York Life Group Insurance Company of NY, and New York Life Insurance and Annuity Corporation, subsidiaries of New York Life Insurance Company. Policy forms: Term Life: TL-004700 et al.. Life Insurance Company of North America is not authorized in NY and does not conduct business in NY.

New York Life Insurance Company

51 Madison Avenue
New York, NY 10010

911126 d 0524 SMRU 5018415.3 Exp. Date 06.17.2027