Term Life Insurance Change Form

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603.

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Important: *Please enter all dates in mm/dd/yyyy format.*

EMPLOYER USE (MANDATORY DATA NEEDED): In order for the insurance company to process this form, the employer must complete this information.

EMPLOYER Yosemite Community College District **Policy** FLX-966111

CLASS _____ **LOCATION/PAYCODE #** _____ **DATE OF HIRE** _____ **ANNUAL SALARY** _____ **VERIFIED BY** _____

REASON FOR REQUEST: ❑ **LIFE STATUS CHANGE** ❑ **ONGOING ENROLLMENT EVENT** ❑ **REINSTATEMENT** ❑ **LATE ENTRANT**

	VOLUNTARY EMPLOYEE
NEW COVERAGE (TOTAL)	
CURRENT COVERAGE	
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE	
AMOUNT SUBJECT TO MEDICAL EVIDENCE	

Please print (preferably in black ink).

EMPLOYEE SECTION

❑ Mr. ❑ Mrs. ❑ Ms. (Check One)

Name (First) _____ (Last) _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Sex: ❑ M ❑ F

I WISH TO MAKE THE FOLLOWING CHANGES TO MY LIFE INSURANCE COVERAGE

See your life insurance brochure/application for the coverage election options for your plan. When selecting new coverage amounts, please ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application.

CHECK THE APPROPRIATE BOXES:

❑ ***Increase, decrease or begin coverage on the following individuals as indicated below:***
(Complete the medical questions on the next page if you are electing or increasing coverage for yourself)

	Current Voluntary Coverage	***New*** Voluntary Coverage	***Total*** Voluntary Coverage
❑ Employee			

❑ ***Life Status Change***

If this change is being made due to a Life Status Change, please check one of the following, and provide date of change.

❑ Marriage ❑ Divorce ❑ Annulment ❑ Legal Separation ❑ Birth or Adoption of a Child ❑ Death of a Spouse or Child ❑ Leave of Absence

❑ Change in Spouse's Employment ❑ Return to or from Military Duty ❑ Change from full to part-time (or vice-versa)

Date of Life Status Change _____

❑ ***Cancel coverage on the following individuals:***

Effective Date of Cancellation _____

❑ ***Name Change: (Current / New Name)***

Employee _____/_____

Reminder: If you'd like to designate new beneficiaries, please complete a Beneficiary Form

ACCEPTANCE / DECLINATION

I accept the insurance coverage(s) chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the needed amounts from my earnings

Sign Here Signature _____ Date _____
Month/Day/Year

Important: You must also sign and date the Agreements and Authorization section.

Return to your employer. Be sure to make a copy for your own records

TL-009320
3/2015

Print Reset Form

Name _____ Social Security #_____

IMPORTANT
Please complete each section that follows if it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee info in this section if you (i.e., the Employee) are applying for/increasing Life Insurance: (1) exceeding the guaranteed amount, or (2) due to a reinstatement

Height and Weight Information

Employee
Height _____ ft _____in
Weight _____ lbs

Please indicate your answers for each question in this section by checking the Yes or No box for the question.

1. Within the last 5 years has the proposed insured been:
   - diagnosed with any of the conditions shown below,
   - told by a medical professional he/she has or may have any of the conditions shown below,
   - or been treated by a medical professional for any of the conditions shown below?

		Employee Yes	Employee No
A.	A heart attack or stroke?	❑	❑
B.	Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	❑	❑
C.	Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	❑	❑
D.	HIV infection or AIDS?	❑	❑
E.	Diabetes, Hepatitis C or Cirrhosis of the liver?	❑	❑
F.	Alcohol or drug abuse or dependency?	❑	❑
2.	Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	❑	❑

***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 fact material thereto, commits a fraudulent insurance act.*

♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:
(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I must report any change in my health that happens before the insurance is effective.
(4) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about my health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Sign Here _____ _____
Employee's Signature *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

Important: **You must also sign and date the Agreements and Authorization section.**

Fold and staple this page to conceal health questions.
Return application to your employer. Be sure to make a copy for your own records.