INSURANCE APPLICATION

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 to process this application, the employer must complete this information.

EMPLOYER Yosemite Community College District

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

REASON FOR REQUEST: ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **ONGOING ENROLLMENT EVENT** ❑ **LATE ENTRANT**

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

Please print (preferably in black ink).

EMPLOYEE SECTION

☐ Mr. ☐ Mrs. ☐ Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

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

Important: You must complete the medical questions in this application if you apply for life insurance: (1) as a newly hired employee you are applying more than 31 days after you are eligible to elect benefits; (2) you were eligible under the prior plan and enroll or increase your insurance amount(s) after the completion of the Initial Enrollment period.

TERM LIFE INSURANCE — POLICY NO. FLX-966111

	Applicant	***Decline***	***Requested Amount***	***Guaranteed Coverage Amount****
Voluntary Employee-Paid Coverage	Employee	☐	☐ Number of $10,000 units _____	$200,000

**Guaranteed Coverage Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.*

BENEFICIARY

To ***specify a beneficiary***, complete the section below. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

Insured	*Beneficiary*	*Percentage*	*Social Security #*	*Date of Birth*	*Relationship*
Employee *(Life)*					

ACCEPTANCE/DECLINATION

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

Signature _____ Date _____

Please Sign Here

Important: **You must also sign and date the Agreements section on the back of this form.**

Be sure to make a copy of your application for your own records.

TL-009320

Print Reset Form

Applicant's 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 information in this section if you (i.e., the Employee) are applying for Life Insurance more than 31 days after you were eligible for the insurance.

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.

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