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.*

CIGNA Group Insurance
Life · Accident · Disability

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 Whitman College

CLASS 1 & 2 **LOCATION/PAYCODE #** _____ **DATE OF HIRE**_____ **ANNUAL SALARY**_____ **VERIFIED BY** _____

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

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE/DOMESTIC PARTNER
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)

Employee Name _____ Social Security #_____ Birthdate _____

Address_____ City_____ State_____ Zip_____

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

Important: You must complete the medical questions in this application if you apply for life insurance and: (1) as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying more than 31 days after you are eligible to elect benefits; (2) you are currently insured under the prior plan and elect to increase your current insurance amount(s); or (3) you were eligible but did not enroll for insurance under the prior plan.

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

I am currently married and my date of marriage is _____/_____/_____ *–or–* ❑ I currently have an eligible Domestic Partner.*

Spouse/ Domestic Partner Information

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

Birthdate _____/_____/_____ Sex: ❑ M ❑ F

* In order to be eligible for Domestic Partner coverage, you must have a Domestic Partner Affidavit or its equivalent on file with your employer, and accepted by the insurance company. If you do not currently have one on file with your employer, one will be made available through your employer.

TERM LIFE INSURANCE — POLICY NO. FLX-962110

Voluntary Employee-Paid Coverage

Applicant	***Decline***	***Requested Amount***	***Guaranteed Coverage Amount****
Employee	❑	❑ Number of $10,000 units_____	$100,000
Spouse/Domestic Partner	❑	❑ Number of $5,000 units_____	$25,000
Children	❑	❑ Number of $ 2,000 units_____	$10,000

** 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.*

Have you smoked or used any form of tobacco in the last 12 months? Employee: ❑ Yes ❑ No

ACCIDENT INSURANCE — POLICY NO. OK-963713

I select the following insurance amounts

	Benefit Amount
❑ Employee	$_____
❑ Spouse/Domestic Partner	$_____
❑ Child/ren	$_____

BENEFICIARY

To ***specify a beneficiary***, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. 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)*					
Employee *(Accident)*					

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 and Authorization section.**

TL-009320 WA
PM-814990a(app)/ AR-0711-24959(12/07)

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

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 and spouse info in this section if you (i.e., the Employee) or your spouse are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee	Spouse/Domestic Partner
Height ft in	Height ft in
Weight lbs	Weight lbs

PHYSICIAN SECTION

Employee Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Spouse/Domestic Partner Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

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

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

	Employee Yes	Employee No	Spouse Dom. Part. Yes	Spouse Dom. Part. No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	❑	❑	❑	❑
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑	❑	❑
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	❑	❑	❑	❑
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑	❑	❑
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	❑	❑	❑	❑
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	❑	❑	❑	❑
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	❑	❑	❑	❑
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑	❑	❑
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑	❑	❑
J. Alcohol or drug abuse or dependency?	❑	❑	❑	❑

SECTION B

Within the last 5 years has the proposed insured:

A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑	❑	❑
B. Smoked cigarettes:	❑	❑	❑	❑
1. For how many years has the proposed insured smoked?	_____		_____	
2. Approximately how many cigarettes are, or were, smoked on average per day?	_____		_____	
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?	_____		_____	
C. Used any controlled or illegal drug or other substance?	❑	❑	❑	❑
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	❑	❑	❑	❑
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	❑	❑	❑	❑
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	❑	❑	❑	❑

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee/Spouse/Domestic Partner	*Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

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.*

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

Fold and staple this page to conceal health questions.

TL-009320 ***Return application to your employer. Be sure to make a copy for your own records.***

Name _____ **Social Security #**_____

✦✦✦ 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. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. 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 may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) 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 the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me or my children 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.)

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Sign Here _____ *Employee's Signature* _____ *Month/Day/Year* _____ *Spouse/Domestic Partner's Signature (If applying for insurance for your spouse/ domestic partner)* _____ *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.