4 EVER LIFE INSURANCE COMPANY

2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181
(888) 923-4227

Return to: Mercer Voluntary Benefits
P.O. Box 9122
Des Moines, IA 50306-9122
1-800-621-2358
FAX 1-515-365-1520

# Group Universal Life - Enrollment and Statement of Health

☐ New Hire or Initial Open Enrollment ☐ Late Enrollment or Increase in Coverage Amount ☐ Re-Enrollment

***Complete SECTIONS 1-5, and 8 regardless of coverage amount.***

| ***SECTION I - EMPLOYER*** | | | | | |
|---|---|---|---|---|---|
| Name | | | | | |
| Address | | City | | State | Zip |

| ***EMPLOYEE COVERAGE*** | | | | | |
|---|---|---|---|---|---|
| Last Name | First Name | M.I. | Social Security No. | | Sex ☐ M ☐ F |
| Address | City | State | Zip | Email Address | |
| Birth Date (mm/dd/yyyy) | Hire Date (mm/dd/yyyy) | | Title Preference ☐ Mr. ☐ Mrs. ☐ Ms. | | |
| Daytime Phone | Annual Base Pay $ _____ | Employee No. (if Used) | Pay Frequency ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly | | |

1. Select your total coverage amount based on the following multiple of your current base pay:
   ☐ 1X (or $10,000, whichever is greater) ☐ 1 ½ X ☐ 2X ☐ 2 ½ X ☐ 3X ☐ 3 ½ X ☐ 4X ☐ 4 ½ X ☐ 5X ☐ 5 ½ X ☐ 6X
   (Round up coverage to the next higher $1,000 increment if not an even $1,000.)
2. In addition to life insurance coverage, I elect the accidental death benefit option equal to my life insurance coverage amount: ☐ Yes ☐ No
3. I have smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 12 months: ☐ Yes ☐ No
4. In addition to the coverage premium, I elect to contribute a monthly dollar amount to my cash accumulation account:
   $ _____

| ***SECTION 2 – SPOUSE* COVERAGE*** ***Employee must enroll for Spouse to be eligible*** | | | | |
|---|---|---|---|---|
| Last Name | First Name | M.I. | Social Security No. | Sex ☐ M ☐ F |
| Birth Date (mm/dd/yyyy) | Title Preference ☐ Mr. ☐ Mrs. ☐ Ms. | | Email Address | |

1. Select total Spouse* coverage amount in increments of $1,000. Spouse* coverage must be a minimum of $10,000 and may not exceed the lesser of $100,000 or 2 times Employee's annual base pay rounded up to the next higher increment of $1,000 (if not already an even $1,000).
   $_____
2. In addition to life insurance coverage, I elect the accidental death benefit for my Spouse* equal to my Spouse* life insurance coverage amount: ☐ Yes ☐ No
3. Spouse* has smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 12 months: ☐ Yes ☐ No
4. In addition to the coverage premium, I elect to contribute a monthly dollar amount to my Spouse's* cash accumulation account:
   $_____

| ***SECTION 3 – CHILD(REN) COVERAGE*** | | | | |
|---|---|---|---|---|
| Check box if coverage is desired: □ $10,000. Note: List each child age 14 days to 26 years of age. Each child is covered for the same amount regardless of how many children are covered. | | | | |
| Last Name | First Name | Birth Date (mm/dd/yyyy) | Age | Social Security No. |
| Last Name | First Name | Birth Date (mm/dd/yyyy) | Age | Social Security No. |
| Last Name | First Name | Birth Date (mm/dd/yyyy) | Age | Social Security No. |
| Last Name | First Name | Birth Date (mm/dd/yyyy) | Age | Social Security No. |

| ***SECTION 4 – BENEFICIARY*** | | | | | |
|---|---|---|---|---|---|
| Percentages must total 100%. No white outs or cross outs allowed in this section. | | | | | |
| **Employee Beneficiary** | | | | | |
| **First Name** | **Last Name** | **Social Security No.** | **Date of Birth** | **Relationship** | **% Share** |
| | | | | | |
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| | | | | | |
| **Spouse Beneficiary** | | | | | |
| **First Name** | **Last Name** | **Social Security No.** | **Date of Birth** | **Relationship** | **% Share** |
| | | | | | |
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| The beneficiary for Spouse* and Children coverages is the Employee unless otherwise designated. If the beneficiary format is not sufficient for your needs, contact Mercer Voluntary Benefits. | | | | | |

**ANSWER QUESTIONS IN *SECTION 5* REGARDLESS OF COVERAGE AMOUNT:**

| ***SECTION 5 – ELIGIBILITY INFORMATION*** | **Employee** | **Spouse*** | **Children** |
|---|---|---|---|
| 1. Are you (Employee) actively at work on the date of your signature on page 5? | □ Yes □ No | | |
| 2. Has anyone to be insured been hospitalized during the past 90 days? | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 3. Is anyone to be insured **unable** to perform normal activities? | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 4. If you answered "**Yes**" to questions 2. or 3. above for any children, please indicate child(ren)'s name(s): 1. _____ 2._____ | | | |

— ***Please continue to Page 3*** —

## ANSWER QUESTIONS IN *SECTION 6* IF:

1. You answered "No" to question 1. in *SECTION 5*; or
2. You answered "Yes" to questions 2. or 3. in *SECTION 5* for anyone to be insured; or
3. You are a late entrant; or
4. You would like to increase your coverage; or
5. Your coverage amount exceeds 3X annual base pay or $500,000; or
6. Spouse* is under age 65 and coverage amount exceeds $20,000; or
7. Spouse* is age 65 or older; or
8. Re-Enrollment:
   a. You are <u>not</u> currently enrolled and your elected coverage amount exceeds 2X annual base pay or $100,000; or
   b. You are currently enrolled and your coverage amount exceeds 1X annual base pay or $500,000.

| ***SECTION 6 – UNDERWRITING INFORMATION*** | **Employee** | **Spouse** |
|---|---|---|
| a. Have you been absent from work or unable to perform normal activities due to illness or injury more than 15 days during either of the past two years? | □ Yes □ No | □ Yes □ No |
| b. Have you received consultation or treatment during the past 5 years for: 1) Malignant tumor, including cancer, leukemia, or Hodgkin's Disease? | □ Yes □ No | □ Yes □ No |
| 2) Circulatory impairment including heart disease, angina, coronary artery disease or stroke? | □ Yes □ No | □ Yes □ No |
| 3) Drug or alcohol abuse? | □ Yes □ No | □ Yes □ No |
| 4) Acquired Immune Deficiency Syndrome, AIDS related complex, or AIDS related condition? | □ Yes □ No | □ Yes □ No |

## ANSWER QUESTIONS IN *SECTION 7* IF:

1. You answered "No" to question 1 in *SECTION 5;* or
2. You answered "Yes" to questions 2. or 3. in *SECTION 5* for anyone to be insured; or
3. You are a late entrant; or
4. You would like to increase your coverage; or
5. You answered "Yes" to questions a. or b. in *SECTION 6* above for you or your Spouse*; or
6. Your elected coverage exceeds 3 times your annual base pay or $500,000; or
7. Spouse* is under age 65 and elected coverage amount exceeds $50,000; or
8. Spouse* is age 65 or older and would like to elect coverage; or
9. Re-Enrollment:
   a. You are <u>not</u> currently enrolled and your coverage amount exceeds $500,000; or
   b. You are currently enrolled and your coverage amount exceeds $500,000; or
   c. Spouse* is under age 65 and elected coverage amount exceeds $20,000.

| ***SECTION 7 – STATEMENT OF HEALTH GENERAL INFORMATION*** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Give Full Name | Relationship To Employee | Date of Birth | Sex M/F | Weight | Height | Last Physician Contacted | Last Date Consulted | Reason Consulted Physician |
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— ***You must continue to Page 4 to complete SECTION 7 —***

***SECTION 7 (Continued)***

| **Answer all questions by checking the "Yes" or "No" box in the appropriate places.** | | | | | | | |
|---|---|---|---|---|---|---|---|
| To the best of your knowledge and belief, has any person on whom insurance is applied for in this application: | | | | | | | |
| **Question Number** | | **Insert Applicant Name Below** | | | | | |
| | | | | | | | |
| 1. | Ever had any deformity, amputation or physical disability? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 2. | Ever been advised by a physician or other practitioner to have treatment, hospitalization, or surgery? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 3. | Ever been in a hospital or clinic or other institution for observation, diagnosis, surgery or treatment? | □ Yes□ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes□ No |
| 4. | Ever had or been told by a physician or practitioner that he/she had dizziness, fainting spells, epilepsy, nervous breakdown, or mental disorder? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 5. | Ever had or been told by a physician or other practitioner that he/she had high blood pressure, chest pain, tuberculosis, asthma, or any disease or disorder of lungs or respiratory system, diabetes, syphilis, cancer or ulcer of any kind, hernia or varicose veins? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes□ No |
| 6. | Ever had arthritis, rheumatism, or disease or disorder of eye, ear, nose or throat or circulatory system, brain or nervous system, stomach, gall bladder, liver, or digestive system, intestines, kidney, bladder, or prostate, back, bones, joints or muscles? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 7. | Ever had or been told by a physician or other practitioner that he/she had any tumor or disease of the breast or other female organs, or complications of pregnancy? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 8. | Is any female now pregnant? If Yes, how long? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 9. | Receiving any treatment or taking any medication at this time? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 10. | Ever been treated by or consulted a physician or psychiatrist for any condition not mentioned above? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |
| 11. | Ever had or been told by a physician or other practitioner that he/she had a problem of alcoholism or drug abuse? | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No | □ Yes □ No |

***— You must continue to Page 5 to complete SECTION 7 —***

***SECTION 7 (Continued)***

**If any of the answers to Questions 1 – 11 are Yes, give full details below. Use additional paper, if necessary.**

| Question Number | Applicant Name | Disease or Injury | Date | Details | Name and Address of Physician and Hospital |
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***SECTION 8 – AUTHORIZATION - READ AND SIGN***

I understand and agree that the insurance herein applied for shall not become effective unless and until such insurance has been approved for issuance by 4 EVER LIFE INSURANCE COMPANY ("the Company") at its Home Office during the lifetime of the person proposed for coverage and while the health and physical condition of such person remains as represented herein.

I represent that all of the information on the Enrollment Form is true and complete to the best of my knowledge and belief and that I am actively at work and performing normal activities on the date of my signature specified below. I understand that the insurance I have selected for myself will begin on the effective date provided I am actively at work and performing normal activities on that date. I understand that if I am not actively at work and performing normal activities on the effective date of coverage, coverage will not go into effect until my return to work. I understand that if I am not actively at work and performing normal activities on the effective date of coverage, coverage for my dependents will not go into effect until my return to work. Further, if any member of my family to be insured has been hospitalized during the 90-day period prior to the date of my signature below and/or is unable to perform normal activity on the date of my signature below, that individual's effective date of coverage will be delayed until approved by the Company.

My failure to completely and correctly disclose my medical history will result in my coverage being voided as of the approval date of said coverage.

Has any company or association ever declined to grant insurance on the person(s) considered for insurance or offered a modified policy? □ Yes □ No

| | |
|---|---|
| **If yes, give date, reason and name of company:** | |

By this form I authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or other medically related facility, insurance company, employer, or the MIB, Inc. that has any health related records or knowledge of me or my Spouse* or children for whom insurance application is made, to give to the Company, its representatives, or its reinsurers, any such information to determine eligibility for insurance. I authorize the Company, its representatives or its reinsurers to make a brief report of my personal health information and that of my Spouse* or children for whom insurance application is made to MIB, Inc. This Authorization shall be valid for 24 months and a copy shall be as valid as the original. I may revoke this Authorization at any time, but such revocation will have no effect on actions taken by the Company prior to receipt of the revocation. I or my authorized representative may receive a copy of this form upon request.

I also acknowledge that I have received the Investigative Consumer Reports notification and Important Notice attached to this Statement of Health.

**Check Here**

| | |
|---|---|
| □ Yes □ No | I hereby authorize my Employer to make appropriate payroll deductions for the above specified coverage. |
| | |
| □ Yes □ No | I agree to accept my Certificate of coverage under the Policy electronically. Please provide email address below: |

**Employee Signature (Required) X**_____ **Date Completed**_____

**Spouse* Signature (Required if Electing Spouse* Coverage)**_____

**Child Signature****_____

*The definition of Spouse will be interpreted according to the laws of your state of residence. Some employers may choose to go beyond state law and take a broader view of the term Spouse. Be sure to check with your employer for the definition of "Spouse" based upon your specific state of residence and to learn of any broader views taken by your employer. The Company will always follow state law as well as the broader interpretation of your employer.

**If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, and indicate the legal relationship between the Personal Representative and the proposed insured. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

***SECTION 9 – Retained by Employee***

**INVESTIGATIVE CONSUMER REPORTS**

Under Public Law 91-508, 4 Ever Life Insurance Company ("the Company") is required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Company at the address shown on page 1, further information on the nature and scope of the report will be provided.

**IMPORTANT NOTICE**

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your Enrollment and Statement of Health Form, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities.

Information regarding your insurability will be treated as confidential. The Company, its representatives, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc. ("MIB") a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the MIB, will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Please contact the MIB at 866 692-6901 (TTY 866 346-3642 for hearing impaired). The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Company, its representatives, or its reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**EMPLOYEE SHOULD RETAIN THIS PORTION.**

4 EVER LIFE INSURANCE COMPANY

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# Fraud Notices

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, confinement in prison or any combination thereof.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regarding to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Arkansas, Louisiana, Massachusetts & Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and concealment in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, subjects an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false incomplete or misleading information is guilty of a felony.

Pennsylvania: 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.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Maine, Tennessee, & Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.