INSURANCE APPLICATION

[Life Insurance Company of North America (LINA)]
a CIGNA Company (herein called the Insurance Company)
For info and customer service call 1-866-486-1943.

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

Return Completed Forms To:
CIGNA Customer Service Center
P.O. Box 9279
Des Moines, IA 50306-9279
Fax: 1-515-365-1520

CIGNA®

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

EMPLOYER [SAMPLE FULL ADMINISTRATION APP] 358

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 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].

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 or Domestic Partner Information

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

Birthdate _____ Sex: ❑ M ❑ F Height: _____ft ___in Weight: _____lbs

*In order to be eligible for Domestic Partner coverage, you must have any required 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-000000]

Voluntary Employee-Paid Coverage

Applicant	***Decline***	***Requested Amount***	***Guaranteed Coverage Amount****
Employee	❑	❑ Number of [$10,000] units _____	[The lesser of 3 times salary or $500,000
Spouse[/Domestic Partner]	❑	❑ Number of [$5,000] units _____	$50,000
Child(ren)	❑	❑ Number of [$2,00]0 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.*

BENEFICIARY

To ***specify a beneficiary***, you can do so online by going to http://www.cignatrustedadvisor.com/CLIENT.

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.**

Be sure to make a copy for your own records.

TL-006069 (5/97)

IMPORTANT: Complete questions A-G if applying for Life Insurance above the Guaranteed Coverage Amount. Complete questions A-K if applying for Life Insurance more than [31] days after you are eligible or after your Open Enrollment Period. Please indicate your answers for each question by checking the Yes or No box for the question.

During the last 5 years has the proposed insured been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in questions below?

	Employee		Spouse[/ Dom. Part.]	
	Yes	No	Yes	No
A. Cysts, moles, warts, polyps, cancer or tumor?	❑	❑	❑	❑
B. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins, or any other disease or disorder of the heart or circulatory system?	❑	❑	❑	❑
C. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract?	❑	❑	❑	❑
D. Any alcohol and/or drug addiction and/or substance abuse; mental, emotional or any other nervous disorders?	❑	❑	❑	❑
E. Is there a current use of prescribed medications by the proposed insured?	❑	❑	❑	❑
F. Ever been diagnosed with or been treated for AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	❑	❑	❑	❑
G. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions A through F?	❑	❑	❑	❑
H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease/disorder of the nervous system?	❑	❑	❑	❑
I. Gout, arthritis, rheumatism, neck or back strain/ sprain/ injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	❑	❑	❑	❑
J. Any surgical operation performed or been advised to have any performed?	❑	❑	❑	❑
K. Ever been in a hospital or sanitarium for rest, treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions A through J?	❑	❑	❑	❑

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]	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

♦ ♦ 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 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.)

***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.*

Please 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.