INSURANCE APPLICATION
Connecticut General Life Insurance Company (CG)
Life Insurance Company of North America (LINA)

Please print (preferably in black ink)

For information and customer service:
Call 1.800.231.1193, or write to the
Cigna Customer Service Center
Administered by Infosys McCamish Systems, LLC
P.O. Box 14577, Des Moines, IA 50306-3577
Or fax toll-free 1.877.435.7181

Cigna.

EMPLOYER ARTHUR J. GALLAGHER & CO.

Mr. ❑ Mrs. ❑ Ms. ❑ (check one) Employee ID#_____

Employee Name (First) _____ (Last) _____ Social Security #_____-_____-_____ Birthdate ____/____/____

Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____Home Phone ( ) _____ Email Address _____

Height: _____ft. _____ in. Weight: _____ (lbs.) Sex: ❑ M ❑ F

Primary Physician Name_____ Address_____ Phone ( ) _____

Original Date of Hire ___/___/___ Annual Earnings_____

Important: You must complete the medical questions in this application if you apply for life insurance: (1) exceeding the Guaranteed Coverage Amount, or (2) after the completion of any open enrollment period (as agreed upon by your employer and the insurance company), or (3) as a newly hired employee 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 Information* Name (First) _____ (Last) _____ Social Security # _____ - _____ - _____

Birthdate ___/___/___ Height: _____ft. _____ in. Weight: _____ (lbs.) Sex: ❑ M ❑ F

Spouse's Primary Physician Name_____ Address_____ Phone ( ) _____

***Domestic Partner and Civil Union Partner are defined in the Group Policy. For the purposes of this application, wherever the term Spouse appears, it shall include Domestic Partner and Civil Union Partner. For specific information regarding eligibility requirements for Domestic Partners and Civil Union Partners, please contact Gallagher HR support.*

GROUP UNIVERSAL LIFE INSURANCE — POLICY NO. 242673(L104400)

See the brochure for Guaranteed Coverage, and amounts of insurance you may purchase. Amounts of insurance may be limited by state law.

Employee
I select the following insurance amount:
❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x ❑ 7x ❑ 8x Annual Earnings, rounded to the next higher $1,000 if not already an even multiple of $1,000, or $2,500,000, whichever is less
**Maximum guaranteed coverage amount available during your Benefit Eligibility Period is the less of 3x your Annual Earnings rounded to the next higher $1,000, or $600,000.*
I elect to contribute $_____ each month to my Cash Accumulation Fund *(ex. $5.00, $10.00, $25.00, etc.)*

Spouse
I select the following insurance amount for my Spouse:
$_____ *(in increments of $10,000, up to $250,000 or 100% of the Employee Coverage Amount, whichever is less)*
**Maximum guaranteed coverage amount available during your Benefit Eligibility Period is $30,000.*
I elect to contribute $_____ each month to my Spouse Cash Accumulation Fund (*ex. $5.00, $10.00, $25.00, etc.)*

Dependent Children: I currently have eligible dependent children and elect the following insurance amounts: ☐ $5,000 -or- ☐ $10,000

Please Note: *1) If you meet the eligibility requirements and Cigna receives your enrollment application within 31 days of your eligibility date, the coverage amount that can be offered on a guaranteed issue basis will take effect on the later of the date you become eligible or the date Cigna receives the completed and signed enrollment application. Coverage amounts above that which can be offered on a guaranteed issue basis will take effect on the date Cigna agrees in writing to cover you or your spouse. You may need to have a medical exam or provide a physician's statement before additional coverage can be approved. 2) If you or your spouse apply for any amount of life insurance coverage more than 31 days after becoming eligible, coverage will take effect on the date Cigna agrees in writing to cover you or your spouse. You may need to have a medical exam or provide a physician's statement for coverage to be approved.*

ACCEPT

❑ 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.

Employee Signature _____ Date _____

Please Sign Here

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

BENEFICIARY

Once you have enrolled, visit http://www.cignatrustedadvisor.com/ajg to designate a beneficiary on-line or to download a paper copy to be completed and returned to Cigna at the address on the form.

Be sure to make a copy of your application for your own records. This plan is administered by Infosys McCamish Systems, LLC

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 IF APPLYING AFTER YOUR OPEN ENROLLMENT PERIOD.

During the last five years, has the proposed insured been diagnosed with, or treated by/from a member of the medical profession for any of the conditions listed in questions below?	Employee Yes	Employee No	Spouse Yes	Spouse 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 provide details for "Yes" answers given above and/or medical impairments listed in questions A-K. Complete and attach a separate sheet of paper if additional space is required. Please sign and date the attachment.

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

♦ AGREEMENTS ♦

To the best of my knowledge and belief, all information I provided is true and complete. I also understand that the insurance I have selected for myself will begin on the effective date provided I am actively at work on that date. If I am not, the effective date of my personal coverage, as well as dependent coverage, will be delayed until I am actively at work. For Group Universal Life Insurance, if I am not actively at work within 90 days of the date the insurance company receives the application, a new application and medical questionnaire will be required. Also, if any one of my dependents to be insured is not performing normal daily activities* on the effective date, that coverage will be delayed until the date the dependent resumes normal daily activities. For Group Universal Life Insurance, if a dependent is not performing normal daily activities within 90 days of the date the insurance company receives the application, a new application and medical questionnaire will be required. I understand that I am responsible to report to the insurance company any change in my health prior to my coverage effective date, and that no coverage will be effective unless I meet the insurance company's underwriting requirements on the effective date.

Authorization: If proposed for insurance, I authorize the following parties with any records or knowledge of personal information, medical history, mental or physical condition, diagnosis or treatment of me, to give such information to the Insurer, its authorized representatives or reinsurers. The authorized parties include any licensed physician, medical practitioner, hospital, clinic, Veterans Administration or other medically related facility, insurance company, employer, the Medical Information Bureau, or other organization, institution or person. For the purposes of collection and use of information to evaluate my application for insurance, I agree that my authorization is valid for thirty (30) months from the date of my signature below. I understand that disclosures may be made without my consent as permitted by law. I also understand that the Insurer, its authorized representatives or reinsurers may make a brief report about my health or medical information listed above to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If I apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request will supply such company with the information in its file. Upon receipt of my request, the Bureau will arrange disclosure of any information it may have in my file. If I question the accuracy of information in the file, I may contact the Bureau and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. A copy of this authorization will be valid as the original. I understand that my authorized representative or I have the right to receive a copy of this authorization upon my request. My authorized representative or I can revoke this authorization at any time, subject to the rights of an individual who acted in reliance on this authorization at any time, subject to the rights of an individual who acted in reliance on this authorization prior to notice of revocation. The revocation must be in writing, signed and dated by my authorized representative or myself.

Electronic/Telephonic Authorization: I authorize the insurance company to accept my telephonic and electronic elections and change requests, as allowed by law. The insurance company will not be legally responsible for any liability if acting in good faith upon any instructions given by telephonic or electronic means, or for the authenticity of such instructions.

***Normal Daily Activities:** Normal daily activities for a spouse and child are defined as follows. *Spouse:* A spouse will not be deemed able to do normal tasks if he or she: (a) is hospitalized; and/or (b) is confined at home under the care of a medical doctor for sickness or injury; and/or (c) has had his or her level of activity significantly reduced so that he or she requires human supervision or assistance to perform any of the following Activities of Daily Living: mobility, transferring, feeding, dressing or toileting – which another person of the same age and sex could normally perform; and/or (d)is receiving any disability benefits from any source due to any sickness or injury. *Child:* A child will not be deemed able to do normal tasks if he or she: (a) is hospitalized; and/or (b) is confined at home under the care of a medical doctor for sickness or injury.

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.

☛

Employee's Signature	*Month/Day/Year*	*Spouse's Signature (If applying for insurance for your spouse)*	*Month/Day/Year*

Sign Here