VOLUNTARY INSURANCE APPLICATION

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

For information and customer service, call or write
Cigna Customer Service Center:
Administered by Infosys McCamish Systems, LLC
P.O. Box 14577
Des Moines, IA 50306
Phone: 1.800.231.1193, 8:00 a.m. to 5:00 p.m., CT
Fax: 1.877.435.7181

Cigna.

Please print (preferably in black ink)

EMPLOYER USE

EMPLOYER Insperity Holdings, Inc. **WORKSITE**_____ **BILLING LOCATION** _____

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 ( ) _____
Date of Hire ____/____/____ Covered Annual Earnings * _____

Important: You must complete the medical questions in this application if you apply: (1) for life insurance exceeding the Guaranteed Coverage Amount, or (2) as a newly hired employee more than 30 days after you are eligible to elect benefits (for Life and Disability Insurance only). Such insurance will not take effect unless and until the insurance company has approved this medical questionnaire as satisfactory.

**Covered Annual Earnings as paid by Insperity*

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 ___/___/___ Height: _____ft. _____ in. Weight: _____ (lbs.) Sex: ❑ M ❑ F
Spouse's Primary Physician Name _____ Address_____ Phone ( )_____
*See Affidavit of Domestic Partnership requirement

VOLUNTARY GROUP UNIVERSAL LIFE INSURANCE — POLICY NO. 2433712 (CG) (02-L104500)

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 *(check one):*
❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x Covered Annual Earnings *
I elect to contribute $_____ each month to my Cash Accumulation Fund (*ex. $5.00, $10.00, $25.00, etc.)*
**Covered Annual Earnings as paid by Insperity*

Spouse/Domestic Partner

❑ I select the following insurance amount for my Spouse/Domestic Partner *(check one):*
❑ $10,000 ❑ $20,000 ❑ $30,000 ❑ $40,000
❑ $50,000 ❑ $100,000 ❑ $150,000 ❑ $200,000

I elect to contribute $_____ each month to my Spouse's Cash Accumulation Fund (*ex. $5.00, $10.00, $25.00, etc.)*

Dependent Children: I wish to enroll for my dependent children and elect the following insurance amount: ❑ $5,000 ❑ $10,000

VOLUNTARY PERSONAL ACCIDENT INSURANCE — POLICY NO. OK 823223 (LINA)

I select the following insurance coverage: ❑ Myself only ❑ Myself and my family
If spouse only — 60% of my benefit amount. If spouse and child(ren) — 50%/10% of my benefit amount. If child(ren) only — 15% of my benefit amount
I select the following amount of PAI coverage: ❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x Covered Annual Earnings*
**Covered Annual Earnings as paid by Insperity*

VOLUNTARY DISABILITY INSURANCE — POLICY NO. SLK 030024 (LINA)

NOTE: Eligibility for Voluntary Disability Insurance is determined by the Insperity benefits package available to you and may be affected by your participation in other benefit programs. Please confirm that Voluntary Disability is available to you by checking with your Insperity orientation representative or by calling Insperity toll-free at 866-715-3552 weekdays between 7 a.m. and 7 p.m. Central time.

❑ Yes, I am eligible and select Disability Coverage ❑ No, I do not select Disability Coverage

Pre-Existing Conditions Limitation (applicable to Long-Term Disability Insurance only): A pre-existing condition is any injury or illness for which you have consulted a Physician, received medical treatment, taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become totally disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 months after the effective date of your coverage.

ACCEPT	DECLINE
❑ I accept the insurance coverage elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings.	❑ 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.

Employee Signature _____ Date ____/____/____

Please Sign Here

Important: You must also sign and date the Agreements Section on the last page
This plan is administered by Infosys McCamish Systems, LLC.

Applicant's Name _____ **Social Security #** _____

BENEFICIARY

To ***specify a beneficiary***, once you are enrolled, visit Benefits on Insperity Premier at portal.insperity.com. Click the "Apply Now" button on the Voluntary Benefits page to go directly to the Cigna Trusted Advisor® site to designate a beneficiary; or 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					
Spouse/Domestic Partner					
Child(ren)					

COMPLETE QUESTIONS A-G IF APPLYING FOR LIFE INSURANCE ABOVE THE GUARANTEED COVERAGE AMOUNT.
COMPLETE QUESTIONS A-K IF APPLYING FOR LIFE OR DISABILITY INSURANCE MORE THAN 30 DAYS AFTER YOU ARE ELIGIBLE.

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/ Dom. Partner Yes	Spouse/ Dom. Partner 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/Domestic Partner	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

Important: You must also sign and date the Agreements Section on the following page
This plan is administered by Infosys McCamish Systems, LLC.

Applicant's Name _____ **Social Security #** _____

♦ 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/Domestic Partner:* A spouse/domestic partner 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.

Sign Here

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