INSURANCE APPLICATION
Connecticut General Life Insurance Company (CG)
CIGNA Life Insurance Company of New York

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
Or fax toll-free 1.877.435.7181

Cigna.

Please print (preferably in black ink).

EMPLOYER Cornell University

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

Address _____ City _____ State _____ Zip _____

Work Phone ( ) _____ Home Phone ( ) _____ Email Address _____

Height ___ Ft. ___ In. Weight: ___Lbs. Sex: ❑ M ❑ F Birthdate ___/___/____

Primary Physician Name _____ Address _____ Phone No. ( ) _____

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 60 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/ Domestic Partner Information

Name (First) _____ (Last) _____ Social Security # ___ - ___ - ____

Birthdate ___/___/____ Sex: ❑ M ❑ F Height ____ft. ____in. Weight: _____ lbs.

Primary Physician Name _____ Phone No. ( ) _____

Primary Physician Address _____

**See your Employer for more information about eligibility requirements for Domestic Partners, including whether an Affidavit must be on file with your Employer if you are not in a state-registered Domestic Partnership or in a Civil Union.*

GROUP UNIVERSAL LIFE INSURANCE — POLICY NO. 02–L104410

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

Employee:

❑ I would like my insurance amount to match the following *(check one):*

❑1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x ❑ 7x ❑ 8x ❑ 9x ❑ 10x Annual Salary.

Guaranteed Amount: The lesser of 5 times Annual Salary or $1,000,000.

Maximum Amount: The lesser of 10 times Annual Salary or $2,000,000.

❑ I elect to contribute $_____ each month to my Cash Accumulation Fund. *(ex. $5, $10, $25. etc.)*

Spouse/Domestic Partner:

❑ I select the following insurance amount for my Spouse/Domestic Partner:

$_____ (in units of $10,000)

Guaranteed Amount: $50,000 Maximum Amount: $250,000

❑ I elect to contribute $_____each month to my Spouse's/ Domestic Partner's Cash Accumulation Fund. *(ex. $5, $10, $25. etc.)*

Dependent Children: I currently have eligible dependent children, and:

❑ I elect the following insurance amount: ❑$2,000 ❑$4,000 ❑$6,000 ❑$8,000 ❑$10,000 ❑$12,000 ❑$14,000 ❑$16,000 ❑$18,000 ❑ $20,000

PERSONAL ACCIDENT INSURANCE — POLICY NO. YOK-008416

I select the following insurance amount:

Employee Benefit Amount $ _____ (units of $10,000, up to $500,000)

Spouse/Domestic Partner ❑ 100% of my benefit - or - ❑ 50% of my benefit Maximum Amount: $250,000

❑ Children at 10% of my benefit Maximum Amount: $25,000

BENEFICIARY

To ***specify a beneficiary***, go to http://workday.cornell.edu (You should land on All About Me). Click the Benefits icon, then click on either the Life Insurance or Personal Accident Insurance link. Once on Cigna Trusted Advisor, click on the "My Accounts" link.

ACCEPTANCE/DECLINATION

❑ 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. 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.

☛ Employee Signature _____ Date ____/____/____

Please Sign Here

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

TL-006069 (5/97)

Be sure to make a copy for your own records.

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 MORE THAN 60 DAYS AFTER YOU ARE ELIGIBLE.

During the last five 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 Yes	Employee No	Spouse/DP Yes	Spouse/DP 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. Completed and attach a separate sheet of paper if additional space is required. Please sign and date the attachment.

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

♦ AGREEMENTS ♦

To the best of my knowledge and belief, all written, telephonic and electronic 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 insurance subject to medical questions requires insurance company approval, and additional medical information, including blood work, may be required to approve such insurance. 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. The Bureau's information office address is P.O. Box 105, Essex Station, Boston, MA 02112. Telephone: 617.426.3660. 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 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 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 telephone or electronic means, or for the authenticity of such instructions.

**** Normal Daily Activities:*** Normal daily activities for a spouse/domestic partner 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. ***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's/Domestic Partner's Signature (If applying for insurance for your spouse)*	*Month/Day/Year*