GROUP BENEFIT SOLUTIONS

Text 1
Text 2
Address 1
City, ST XXXXX-XXXX
Phone 1
Phone 2

CLEAR FORM

INSURANCE ENROLLMENT FORM

Connecticut General Life Insurance Company (CGLIC)
Life Insurance Company of North America (LINA)
New York Life Group Insurance Company of NY (NYLGICNY)

(herein called the Insurance Company(ies))

For info and customer service for Life, Accident and Disability Insurance call 1-800-XXX-XXXX

- *All info must be completed by the applicant.*
- *Applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*
- *The Insurance Company must approve your request for insurance before it becomes effective.*

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

EMPLOYER USE (MANDATORY DATA NEEDED): In order for the insurance company to process this form, the employer must complete this information.

EMPLOYER _____ **POLICY#** _____ **CLASS** _____

OCCUPATION _____ **BILLING LOCATION** _____ **DATE OF HIRE** _____ **BASE ANNUAL SALARY** _____

VERIFIED BY _____ **TITLE** _____ **DATE** _____

Please print (preferably in black ink).

EMPLOYEE INFORMATION

Name (First) _____ (Last) _____ (Middle Initial) ___

Social Security # _____ Date of Birth _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Day Phone _____ Evening Phone _____

Have you smoked or used any form of tobacco in the last 12 months?

Employee: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No

SPOUSE/DOMESTIC PARTNER INFORMATION

Name (First) _____ (Last) _____ (Middle Initial) ___

Social Security # _____ Date of Birth _____

☐ I am currently married and my date of marriage is _____ ☐ I am currently eligible under the insurance as a Domestic Partner

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

GROUP UNIVERSAL LIFE INSURANCE - POLICY NO. _____

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: $40,000 Maximum Amount: $250,000

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

Dependent Children

I currently have dependent children and I elect the following insurance amount (check one):

☐ 2,000 ☐ 4,000 ☐ 6,000 ☐ 8,000 ☐ 10,000 ☐ 12,000 ☐ 14,000 ☐ 16,000 ☐ 18,000 ☐ 20,000

GROUP UNIVERSAL LIFE BENEFICIARY DESIGNATION

To ***specify a beneficiary,*** complete the section below. You will be your spouse's beneficiary 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. The Beneficiary Percentage should not exceed 100%.

Insured	*Beneficiary*	*Percentage*	*Social Security #*	*Date of Birth*	*Relationship*
Employee (Life)					
Spouse/ Domestic Partner					

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE - POLICY NO. _____

☐ I accept the Accidental Death & Dismemberment insurance provided under this Group Insurance Plan.

☐ I do NOT accept the Accidental Death & Dismemberment insurance provided under this Group Insurance Plan.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFICIARY DESIGNATION

To ***specify a beneficiary,*** complete the section below. You will be your spouse's beneficiary 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 (Life)					
Spouse/ Domestic Partner					

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

DISABILITY INSURANCE (EMPLOYEE ONLY) - POLICY NO. _____

☐ I accept the Disability insurance provided under this Group Insurance Plan.

☐ I do NOT accept the Disability insurance provided under this Group Insurance Plan.

ACCEPTANCE / DECLINATION

I accept the insurance coverage(s) chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the needed amounts from my earnings. If I have not chosen coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability/good health at my own expense and that coverage is subject to the insurance company's approval.

In order to confirm your election, you must provide a signature.

Sign Here _____ *Employee Signature* **08/30/2021** *(Month/Day/Year)*

****You should complete the Beneficiary Designation and read and sign the Agreements Section that follows in this form.****

IMPORTANT
Please complete each section that follows if it is needed. Each section states when it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

SECTION A: This section is needed when applying for Life and/or Disability Insurance.

Complete the Employee info in this section if you (i.e., the Employee) are:

- *applying for Life Insurance for yourself that is greater than the guaranteed amount, or*
- *applying for Life and/or Disability Insurance for yourself more than 31 days after you were eligible for the insurance.*

Complete the Spouse/Domestic Partner and child(ren) info in this section if:

- *applying for Life insurance for your Spouse/Domestic Partner that is greater than the guaranteed coverage amount, or*
- *applying for Life insurance for them more than 31 days after the Spouse/Domestic Partner is eligible for the Life insurance.*

Height and Weight Information

Employee	Spouse/Domestic Partner
Height : _____ ft _____ in Weight : _____ lbs	Height : _____ ft _____ in Weight : _____ lbs

Physician Section

Employee Physician

Name _____ Phone No. _____

Street Address _____

City _____ State _____ Zip _____

Spouse/Domestic Partner Physician

Name _____ Phone No. _____

Street Address _____

City _____ State _____ Zip _____

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

SECTION B: This section is needed when applying for Life and/or Disability Insurance.

Please indicate your answers for each question in this section by checking the Yes or No box for the question. The questions in Section C must also be answered.

Within the last 5 years has the proposed insured been: a) diagnosed with any of the conditions shown in this Section, b) told by a medical professional he/she has or may have any of the conditions shown in items A through J below, c) or been treated by a medical professional for any of the conditions shown in items A through J below?	Employee		Spouse/Domestic Partner	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	☐	☐	☐	☐
B. Insulin Dependent, Diabetes, glandular condition, Hepatitis, Cirrhosis of the liver, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	☐	☐	☐	☐
C. Asthma, Chronic Bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other condition affecting the lungs or respiratory tract?	☐	☐	☐	☐
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	☐	☐	☐	☐
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	☐	☐	☐	☐
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's Disease, Paralysis, Epilepsy, fainting, Seizures, headaches, or other condition affecting the nervous system?	☐	☐	☐	☐
G. Anemia or any other condition affecting the blood; Lupus, Arthritis, deformity or loss of limb?	☐	☐	☐	☐
H. Anxiety disorder, Depression, Bipolar Disorder, or any other mental disorder or condition?	☐	☐	☐	☐
I. Cancer (other than Nonmelanoma Skin Cancer), Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	☐	☐	☐	☐
J. Alcohol or drug abuse or dependency?	☐	☐	☐	☐

SECTION C: This section is needed when applying for Life and/or Disability Insurance.

Please indicate your answers for each question in this section by checking the Yes or No box for the question.

Within the last 5 years has the proposed insured been:	Employee		Spouse/Domestic Partner	
	Yes	No	Yes	No
A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	☐	☐	☐	☐
B. Smoked cigarettes:	☐	☐	☐	☐
1. For how many years has the proposed insured smoked?				
2. Approximately how many cigarettes are, or were, smoked on average per day?				
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C. Used any controlled or illegal drug or other substance?	☐	☐	☐	☐
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	☐	☐	☐	☐
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	☐	☐	☐	☐
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	☐	☐	☐	☐

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

SECTION D: This section is needed when applying for Disability Insurance.		
Complete this section if you (i.e., the employee) are applying for Disability Insurance more than 31 days after you are eligible for it. Please indicate your answers for each question in this section by checking the Yes or No box for the question.		
	Employee	
	Yes	No
1. Have you been diagnosed as pregnant within the past 10 months, or are you being treated for pregnancy?	☐	☐
2. Within the last 5 years has the proposed insured been: • diagnosed with any conditions shown in this section, • told by a medical professional he/she has or may have any of the conditions shown in items A through E below? • been treated by a medical professional for any of the conditions shown in items A through E below?		
A. Any condition affecting hearing or vision, including any loss of sight or hearing, or dizziness or Vertigo?	☐	☐
B. Carpal Tunnel Syndrome; neck, back, knee or joint condition, strain, sprain or other type of injury?	☐	☐
C. Any bone, joint or muscle condition persisting for, or having been treated for, 6 months or longer?	☐	☐
D. Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or Temporomandubular Joint (TMJ) Disease?	☐	☐
E. Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?	☐	☐

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	Condition	Date Occurred	Duration/Treatment Received	Current Status

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.*

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

AGREEMENTS

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 my insurance 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.)

Pre-Existing Condition Limitation (applies to Disability Insurance only): I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage. "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 12 months before his or her most recent effective date of insurance.

Sign Here	_____ *Employee Signature*	**08/30/2021** *(Month/Day/Year)*	_____ *Spouse/Domestic Partner's Signature (If applying for insurance for your Spouse/Domestic Partner)*	**08/30/2021** *(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.*

CLICK TO PRINT