Agilent Technologies, Inc. REF#56909 Group Universal Life Enrollment Form

096184010202

NAME Last First Middle SOCIAL SECURITY NO. SEX (M/F)

ADDRESS No. Street City State Zip

ANNUAL BASE PAY DAYTIME PHONE EMAIL ADDRESS

HIRE DATE (Mo./Day/Yr.) BIRTH DATE (Mo./Day/Yr.) Country of citizenship: ❑ United States ❑ Other (specify): _____

1 *EMPLOYEE COVERAGE*

A. Select the total annual base pay multiple that you desire. Your choice is from 1 to 7 times your annual base pay to a maximum of $5,000,000. Plan minimum is $10,000 or 1 times your annual base pay. Coverage will be rounded to the next higher $10,000 increment if not an even $10,000.

❑ 1X ❑ 2X ❑ 3X ❑ 4X ❑ 5X ❑ 6X ❑ 7X

B. In addition wto life insurance coverage, I elect the Accidental Death Benefit ..... ❑ Yes ❑ No

C. I have smoked or used a form of tobacco in the last 12 months. ..... ❑ Yes ❑ No

D. In addition to the coverage premium, I elect to contribute a monthly dollar amount to my Cash Accumulation Fund. $_____ .00

2 *SPOUSE/DOMESTIC PARTNER COVERAGE*

A. Select the total amount of coverage that you desire in $10,000 increments. Your choice is from $10,000 to $200,000 (not to exceed 3 times your annual base pay).

$ _____

B. My spouse/domestic partner has smoked or used a form of tobacco in that last 12 months ..... ❑ Yes ❑ No

C. In addition to life insurance coverage, I elect the Accidental Death Benefit for my spouse/domestic partner. ..... ❑ Yes ❑ No

D. In addition to the coverage premium, I elect to contribute a monthly dollar amount to my Cash Accumulation Fund. $_____ .00

SPOUSE/DOMESTIC PARTNER NAME Last First Middle SOCIAL SECURITY NO. SEX (M/F)

BIRTH DATE (Mo./Day/Yr.)

Maximum issue age is 99. Spouse/Domestic Partner must be age 64 or younger to enroll.

3 *CHILD(REN) COVERAGE*

A. Select the amount of coverage that you desire. ❑ $10,000 ❑ $20,000

Note: Each child is covered for the same amount regardless of how many children are covered. Eligible children must be at least 14 days old but less than age 23 (special circumstances may apply - see plan details).

CHILD NAME Last First M.I. BIRTH DATE (Mo./Day/Yr.) SOCIAL SECURITY NO.

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Note: Mercer Voluntary Benefits must be notified by you within 90 days when a child ceases to be eligible for the dependent children's rider so that the child may be given the opportunity to take advantage of the Children's Portability Privilege.

4 *UNDERWRITING INFORMATION*

***SIMPLIFIED EVIDENCE OF GOOD HEALTH* - Please fill in the Height and Weight Information and answer questions 1 and 2 if: a) your employee coverage amount exceeds the lesser of $80,000 or 1x salary; b) your spouse/domestic partner is applying for coverage.**

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

1. Within the last 5 years, has the proposed insured been:
   - diagnosed with any of the conditions shown in item A through F below.
   - told by a medical professional he/she has or may have any of the conditions shown in items A through F below,
   - or been treated by a medical professional for any of the conditions shown in items A through F below?

	Employee	Spouse/Domestic Partner
A. A heart attack or stroke?	❑ Yes ❑ No	❑ Yes ❑ No
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or leukemia?	❑ Yes ❑ No	❑ Yes ❑ No
C. Emphysema or Chronic Obsructive Pulmonary Disease (COPD)?	❑ Yes ❑ No	❑ Yes ❑ No
D. HIV infection or AIDS?	❑ Yes ❑ No	❑ Yes ❑ No
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	❑ Yes ❑ No	❑ Yes ❑ No
F. Alcohol or drug abuse or dependency?	❑ Yes ❑ No	❑ Yes ❑ No

2. Within the last 5 years, has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction? ❑ Yes ❑ No ❑ Yes ❑ No

You may be required to provide additional evidence of health if: 1) you answered "Yes" to any of the above questions for you or your spouse/domestic partner; 2) your coverage exceeds 3 times your annual base pay or $300,000; 3) your spouse/domestic partner coverage exceeds $100,000 (not to exceed 3 times employee's annual base pay); 4) if your height and weight information are determined not to be within the underwriting guidelines; 5) you are enrolling after your initial eligibility period. Mercer Voluntary Benefits will mail a Evidence of Insurability Form to the address listed on this form for your completion.

CONTINUE ON REVERSE SIDE OF FORM.

5 *BENEFICIARY* *No white outs or cross outs allowed in this section.*

Please designate beneficiaries for the coverage you are electing. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. Percentages for each type of beneficiary must total 100%.

Employee Primary Beneficiary:

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

Employee Contingent Beneficiary - If my primary beneficiary dies before me, I designate as contingent beneficiary:

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

Spouse/Domestic Partner Primary Beneficiary:

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

Spouse/DP Contingent Beneficiary - If the primary beneficiary dies before my spouse/domestic partner, I designate as the contingent beneficiary:

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

NAME/ADDRESS/PHONE NUMBER *(Address/Phone Number are optional)* | BIRTH DATE (Mo./Day/Yr.) | RELATIONSHIP TO INSURED | % SHARE

- The beneficiary for my dependent's coverages is the employee unless otherwise designated.
- If the beneficiary format is not sufficient for your needs, contact Mercer Voluntary Benefits.
- Each owner may change the beneficiary at any time, unless the beneficiary designation is irrevocable. Please see the ownership and assignment section of your certificate for details.

6 AGREEMENTS AND AUTHORIZATION

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, 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. 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 I. I understand that this information will be used to evaluate my application for insurance.

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** for a spouse/domestic partner and child are defined as follows: A spouse/domestic partner will not be deemed able to do normal tasks if he or she: a) is a patient in a hospital; or b) is confined at home under the care of a doctor for sickness or injury; 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 could normally perform. A child will not be deemed able to do normal tasks if he or she: a) is a patient in a hospital; or b) is confined at home under the care of a 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 SIGNATURE X_____ **DATE** _____

SPOUSE/DOMESTIC PARTNER SIGNATURE X_____ **DATE** _____

RETURN THE COMPLETED ENROLLMENT FORM TO MERCER VOLUNTARY BENEFITS

Program Offered and Administered by Mercer Health & Benefits Administration LLC

AR Insurance License #100102691 CA Insurance License #0G39709 In CA d/b/a Mercer Health & Benefits Insurance Services LLC