MEMBER APPLICATION FOR TERM LIFE INSURANCE

Life Insurance Company of North America (LINA)
a CIGNA Company (herein called the Insurance Company)

CIGNA

ENROLLMENT

❒ Initial Enrollment
❒ Late Applicant

CHANGE

❒ Increase Coverage
❒ Terminate Coverage
❒ Add Dependant
❒ Reduce Coverage
❒ Address Change
❒ Name Change

ASSOCIATION NAME: _____

MEMBER SECTION

❒ Mr. ❒ Mrs. ❒ Ms. *(select one)*

Member Name: _____ Social Security # _____

Age: _____ Birthdate: ____/____/____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex *(select one)*: ❒ M ❒ F

VOLUNTARY LIFE INSURANCE

❒ MEMBER
Amount of Coverage Applied for (multiples of $10,000 to a max of $250,000): $_____

❒ INCREASE/DECREASE
Increase/Decrease Coverage to (multiples of $10,000 to a max of $250,000): $_____

❒ SPOUSE
Amount of Coverage Applied for (multiples of $10,000 to a max of $100,000, not to exceed 50% of Member's amount): $_____

❒ INCREASE/DECREASE
Increase/Decrease Coverage to (multiples of $10,000 to a max of $100,000, not to exceed 50% of Member's amount): $_____

DEPENDENT CHILDREN:
❒ $2,500 ❒ $5,000
❒ $10,000

COMPLETE THIS SECTION IF ELECTING SPOUSE COVERAGE

I am currently married and my date of marriage is: ____/____/_____

Spouse Name (Last, First): _____

Social Security # _____ Birthdate: ____/____/_____ Sex *(select one)*: ❒ M ❒ F

BENEFICIARY

To specify a beneficiary, complete 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, please attach, sign, and date a separate sheet of paper using the format below:

BENEFICIARY	BIRTHDATE	SSN	RELATIONSHIP	% OF BENEFIT

ACCEPTANCE/DECLINATION

I accept the insurance coverages elected above. If I have not elected coverage, I understand that if I wish to participate at a later day, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

Signature: _____ Date: _____

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

Mandatory Data Needed – In order to process this application, this information must be complete.

Date of Employment: _____ Annual Salary: _____ Association Membership Date: _____

MEMBER NAME: _____ SOCIAL SECURITY # _____

Important: You must complete the medical questions in this application if: (1) as a new member you apply for life insurance exceeding the Guaranteed Coverage Amount, or life insurance more than 31 days after you are eligible to elect benefits; or (2) you are currently insured under the prior life insurance plan and elect to increase your current insurance amount(s); or (3) you were eligible but did not enroll for insurance under the prior life insurance plan.

HEIGHT, WEIGHT, AND OTHER INFORMATION

Member Height: _____ft. _____in. Weight: _____lbs

Spouse *(if applicable)* Height: _____ft. _____in. Weight: _____lbs

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

1. Within the last 5 years, has the proposed insured been **a)** diagnosed with any of the conditions shown in items A though F or **b)** told by a medical professional that he/she has or may have any of the conditions shown in items A though F:

	Member	Spouse
A. A heart attack or stroke?	❒Y ❒N	❒Y ❒N
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	❒Y ❒N	❒Y ❒N
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	❒Y ❒N	❒Y ❒N
D. HIV infection or AIDS?	❒Y ❒N	❒Y ❒N
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	❒Y ❒N	❒Y ❒N
F. Alcohol or drug abuse or dependency?	❒Y ❒N	❒Y ❒N

2. Within the last five years, has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction? ❒Y ❒N ❒Y ❒N

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files for an insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of information concerning any fact material thereto, commits a fraudulent insurance act.

AGREEMENTS AND AUTHORIZATIONS

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 coverage for each of my dependents 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 the 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 or my children to disclose to the Insurance Company or its authorized agents, 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.)

Member Signature: _____ Date (M/D/YY): _____

Spouse Signature *(If applying for insurance)*: _____ Date (M/D/YY): _____