Application for
Employee Term Life Insurance

MESTMAKER & ASSOC.
A division of Morgan White Group

Cigna

Life Insurance Company of North America (LINA), Cigna Life Insurance Company of New York a Cigna Company (herein called the Insurance Company)

Enrollment	Change		
❑ Initial enrollment ❑ Late applicant	❑ Increase coverage ❑ Terminate coverage	❑ Add dependant ❑ Reduce coverage	❑ Address change ❑ Name change

Policy name	Policy #	Employer name
North American Insurance Trust (NAIT)	FLX964061	East MS State Hospital

Employee Information

Prefix *(choose one)* ❑ Mr. ❑ Mrs. ❑ Ms.	Employee		
SSN	Age	Date of birth	Occupation
Address	City	State	Zip
Work phone	Home phone	Sex *(choose one)* ❑ M ❑ F	

Voluntary Life Insurance

❑ **Employee** *Amount of Coverage Applied for (multiples of $10,000 to a max of $250,000)*

Current voluntary life amount		Additional amount requested		Total amount requested
$	+	$	=	$

❑ **Spouse/Domestic Partner** *Amount of Coverage Applied for (multiples of $10,000 to a max of $100,000, not to exceed 50% of employee's amount)*

Current dependents voluntary life amount		Additional amount requested		Total amount requested
$	+	$	=	$

Spouse name	Marriage date	
Date of birth	SSN	Sex *(choose one)* ❑ M ❑ F

❑ **Dependent Children Voluntary Life** *(please select one)* ❑ $2,500 ❑ $5,000 ❑ $10,000

Beneficiary Name	Birthdate	SSN	Relationship	% of Benefit

Acceptance/Declination

I accept the insurance coverages elected above. If premium is 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.

Signature _____ Date _____ /_____ /_____
(Important: You must also sign and date the Agreements and Authorizations section) Month Day Year

Employer Use (Mandatory Data Needed): In order to process this application, the employer must complete all requested information.

Date of hire	Annual salary	Group insurance eligibility date	Verified by

Important: you must complete the medical questions in this application if, (1) as a newly enrolled 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.

Employee		*Spouse (if applicable)*	
Height *(ft/in)*	Weight *(lbs)*	Height *(ft/in)*	Weight *(lbs)*

Questions

Please indicate your answer for each question in this section by checking the yes or no box.		*Member*		*Spouse*	
		Yes	*No*	*Yes*	*No*
1. Within the last 5 years, has the proposed insured been (a) diagnosed with any of the conditions in items A through F, or (b) told by a medical professional that he/she has or may have any of the conditions in items A through F:					
A	A heart attack or stroke?	❑	❑	❑	❑
B	Cancer (other than nonmelanoma skin cancer), Hodgkin's disease, or leukemia?	❑	❑	❑	❑
C	Emphysema or chronic obstructive pulmonary disease (COPD)?	❑	❑	❑	❑
D	HIV infection or AIDS?	❑	❑	❑	❑
E	Diabetes, hepatitis C or cirrhosis of the liver?	❑	❑	❑	❑
F	Alcohol or drug abuse or dependency?	❑	❑	❑	❑
2. Within the last five years, has the proposed insured had a driving while intoxicated (DWI) or a driving under the influence (DUI) conviction?		❑	❑	❑	❑

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 provided the insurance.
2. I may need to provide more medical info.
3. I must report any change in my health that happens before the insurance is effective.
4. 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.

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 information 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 agent, any such information, 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 information 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 context of a claim or policy in accordance with applicable law.

I understand that information 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 _____ /_____ /_____
Month Day Year

Spouse signature (*if applying for insurance*) _____ Date _____ /_____ /_____
Month Day Year

Email, mail, or fax completed, signed form to:

MWG Mestmaker & Assoc. • P.O. Box 2303 • Bakersfield, CA 93303
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