Voluntary Term Life & Accident Insurance

NEW YORK LIFE
GROUP BENEFIT SOLUTIONS

Developed for the Employees of
Marion County - Oregon

811761 a 06/12

Voluntary Term Life Insurance (Policy FLX-964730)

Who Needs Life Insurance?

You do. Single or married. Buying your first home or preparing for retirement. Raising children or sending them off to college. No matter where you are in life, insurance should be part of your financial plan.

By purchasing this insurance product through your employer, you benefit from:

- Affordable group rates
- Convenient payroll deduction
- Access to knowledgeable service representatives.

Who Is Eligible For Coverage?

You — If you are an active, full-time employee, including elected officials, and regularly work a minimum of .5 full-time equivalent per week, as defined by your employer, you will be eligible to elect insurance for you and your dependents on the first of the month on or after 30 days of active service. Temporary and seasonal employees are not covered under this plan.

Your Spouse* — Is eligible provided that you apply for and are approved for coverage for yourself.

Your Unmarried, Dependent Children — Under age 23 (or under 25 if a full-time student), as long as you apply for and are approved for coverage for yourself. One low premium will insure all your eligible children, regardless of the number of children you have.

No one may be covered more than once under this plan. If covered as an employee, you can not also be covered as a dependent.

** For purposes of this brochure, wherever the term Spouse appears it shall also include Domestic Partner. Your domestic partner is eligible for insurance if he or she meets specific criteria stated in the Group Policy. Additional information is available from your Benefit Services Representative.*

How Much Coverage Can You Buy?

You — You can select life insurance coverage in units of $10,000. The maximum for any employee is the lesser of 6 times your annual salary or $300,000. The guaranteed coverage amount for you is $50,000.

Your Spouse — You may select coverage for your spouse in units of $10,000 to a maximum of $300,000, not to exceed 100% of your coverage amount. The cost of coverage will be based on your spouse's age. The guaranteed coverage amount for your spouse is $10,000.

Term life coverage elections for you and your spouse are subject to acceptable medical evidence of insurability, as described below under **Guaranteed Coverage**.

You and your spouse will receive the same amount of accident insurance under Policy OK-966319, underwritten by Life Insurance Company of North America. See page 5 for details on accident insurance.

Your Unmarried, Dependent Children — You may select $2,000, $5,000 or $10,000 of coverage for your unmarried, dependent children. The guaranteed coverage amount for your child(ren) is $10,000.

Guaranteed Coverage

If you and your dependents are eligible and you apply during the initial enrollment period, or within 31 days after you are eligible to elect coverage, you are entitled to choose any of the offered amounts of coverage up to the guaranteed coverage amount, as shown on your application, without having to provide evidence of good health.

If you apply for an amount of coverage for yourself or your spouse greater than the guaranteed coverage amount, coverage in *excess* of the guaranteed coverage amount will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement.

If you apply for coverage for yourself or your spouse more than 31 days from the date you become eligible to elect coverage under this plan, the guaranteed coverage amounts will not apply. Coverage will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement.

How Much Your Coverage Will Cost

The monthly cost of insurance for you and your spouse will depend on your ages, whether or not you and/or your spouse smoke, and the amount of insurance you wish to purchase for you, your spouse and children. As shown in the following chart, the cost of insurance increases with the age of the insured. Note that at age 70, benefits for you and your spouse are reduced.

To calculate your monthly cost:

1. Find your age group in the following table and choose the proper smoker or non-smoker rate;
2. Multiply the rate by the number of coverage units you want;
3. Calculate the cost of coverage for your spouse, using your spouse's age and proper smoker/non-smoker rate, then calculate the cost of coverage for your children;
4. Add the premiums for you, your spouse and your children to get your total monthly cost.

Example:

Employee	25 units	x	$1.46 per unit	= $36.50
(age 28, non-smoker) ($250,000)				
Spouse	10 units	x	$1.92 per unit	= $19.20
(age 24, smoker) ($100,000)				
Children	$10,000 of coverage @ $2.00			= $ 2.00
			Total Monthly Cost	$57.70

To calculate your cost, complete this chart:

Employee	____ units	x	$__.__ per unit	= $__.__
Spouse	____ units	x	$__.__ per unit	= $__.__
Children	$_____ of coverage @ $_____			= $__.__
			Total Monthly Cost	$__.__

Employee/ Spouse Age	Employee/Spouse Monthly Cost per $10,000 Unit	
	Non-Smoker	Smoker
Under 30	$ 1.46	$ 1.92
30 to 34	1.51	2.01
35 to 39	1.79	2.46
40 to 44	2.54	3.60
45 to 49	4.00	5.70
50 to 54	5.84	8.46
55 to 59	9.57	13.60
60 to 64	11.30	16.10
65 to 69	21.16	29.38
70 to 74	37.61	50.56
75 to 79	56.05	72.68
80 to 89	103.06	128.67
90 & Over	259.39	324.09

The monthly costs for children are as follows:

$2,000 of life coverage = $ .40 per month
$5,000 of life coverage = $1.00 per month
$10,000 of life coverage = $2.00 per month.

One premium will insure all your eligible children, regardless of the number of children you have.

In addition to your term life coverage, your plan also provides an equal amount of accident coverage for you and your spouse under Policy OK-966319, underwritten by Life Insurance Company of North America. The rates per $10,000 of accident coverage are included in the employee and spouse costs shown above.

A change in rates due to a change in your age will become effective on the January 1 coinciding with or next following your birthday.

You will need to request changes to your existing coverage if, in the future, you no longer have a spouse or children who qualify for coverage. We will refund premium if you do not notify us of this and it is determined at the time of claim that premium has been overpaid.

Costs are subject to change.

When You Reach Age 70

By the time you and your spouse reach age 70, chances are that your children will be grown and your mortgage paid. At age 70, providing you are still employed, coverage for you and your spouse will decrease to 65% of the benefit amount. It will decrease to 50% at age 75.

How Much Life Insurance Do You Need?

We have provided this worksheet to help you calculate how much life insurance you may need for a surviving spouse and dependents. When calculating annual amounts, be sure to multiply the annual income or cost by the number of years you expect to receive that income, or incur that cost.

1. Living Costs

Day-to-day Living Expenses *(Use 75% of current net income)*
$ _____annually x _____ years = $ _____

Child Care Expenses
$ _____annually x _____ years = + _____

Education Funding
$ _____annually x _____ years = + _____

Major Purchases *(cars, home repair)*
$ _____annually x _____ years = + _____

Estate and Funeral Expenses = + _____

TOTAL LIVING COSTS (A) = $ _____

2. Available Resources

Cash and Savings = $ _____

Retirement Savings *(IRA, 401(k), etc.)* = + _____

Stocks and Bonds *(at current market value)* = + _____

Spouse Income *(multiply by 60%)**
$ _____annually x _____ years = + _____

Other Assets = + _____

TOTAL AVAILABLE RESOURCES (B) = $ _____

3. Life Insurance Need

TOTAL LIVING COSTS (A) = $ _____(A)

LESS TOTAL AVAILABLE RESOURCES (B) – $ _____(B)

EQUALS LIFE INSURANCE NEED = $ _____

Naturally a worksheet like the above is only an aid to determining life insurance needs. It cannot predict all of your expenses, economic conditions, inflation, investment performance or other factors which may alter your needs. For a more accurate plan, you should consider consulting an investment advisor.

** Estimate likely spouse income as sole provider. Include your estimate of Social Security benefits to surviving spouse and dependents. The 60% factor above is used to account for taxation so that a net income figure can be derived. Vary this factor if you feel combined federal, state and local taxes, and FICA will be different for your situation.*

Other Benefit Features

Continuation for Disability for Employees Age 60 or Over

If your active service ends due to disability, this plan provides a continuation of coverage feature. If you are disabled at age 60 or over, your coverage will continue while you are disabled. This benefit will remain in force until the earliest of the following dates: the date you are no longer disabled, the date the policy terminates, the date you are disabled for 9 consecutive months, or the day after the last period for which premiums are paid.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If you become Disabled — The extended death benefit ensures that if you become disabled prior to age 60, and die before you qualify for Waiver of Premium, we will pay the life insurance benefit if you remain disabled during that period. If you qualify for this benefit and have insured your spouse or children, their coverage is also extended.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

Waiver of Premium

If you become totally disabled — To make sure you can keep the life insurance protection you need during a difficult period of your life, this plan provides a *waiver of premium* feature. If you are totally disabled prior to age 60 and can't work for at least 6 months, you won't need to pay premiums for your coverage while you are disabled, provided the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until to Age 70, subject to proof of continuing disability each year. If you qualify for this benefit and have insured your spouse or children, the premium for their coverage is also waived.

What Is Not Covered

The plan will not pay benefits if loss of life is the result of suicide that occurs within the first two years of coverage.

Accelerated Death Benefit — Terminal Illness

If you or your spouse is diagnosed by two unaffiliated physicians as terminally ill with a life expectancy of 12 months or less, the accelerated payment benefit for terminal illness provides for up to 75% of the life insurance coverage amount in force or $150,000, whichever is less, to be paid to the insured. This benefit is payable only once in the insured's lifetime, and will reduce the life insurance death benefit.

The terminal illness benefit may be taxable. As with all tax matters, an insured should consult with a personal tax advisor to assess the impact of this benefit.

Note: Benefits paid under an Accelerated Death Benefit may affect an insured's eligibility for Medicaid or other government benefits or entitlements.

When Your Coverage Begins and Ends

The date your coverage begins is called its "effective date." Your employer will let you know the effective date of your coverage. If you are not actively at work on the effective date of coverage, your coverage will not begin until you return to work. For coverage for your spouse and/or children to be effective, they must not be hospitalized or confined at home under the care of a doctor.

Your coverage cannot be terminated as long as you remain eligible, the premium is paid and the group policy remains in force. For your spouse and children, coverage ends when your coverage ends, when their premiums are not paid or when they are no longer eligible.

Increasing Your Coverage

You may enroll in the plan or increase your coverage at any time. We do require evidence of good health for all new coverage elections.

If You Leave Your Employer

To help you keep your life insurance coverage during the years when your family needs financial protection, the plan allows you to continue all of your voluntary coverage if you leave your employer. Premiums may change at this time. Just make arrangements to pay your premiums directly to the insurance company after you leave your current employer. Coverage may be continued for you and your spouse until age 70. Coverage may also be continued for your children. As long as the group policy remains in force, the option of continuing this coverage is available.

Apply Today

In order to apply for coverage, you must complete an application form. Be sure to answer all questions accurately.

Payroll Deduction

You pay your premiums through payroll deduction. The total depends on how much coverage you select, your age, your spouse's age and the amount of coverage you buy for your spouse and children.

Designating Your Beneficiary

Your term life and accident benefit will automatically be paid to the first beneficiary listed below who is living at the time of your death if you do not designate a specific beneficiary:

1) Your Spouse* 2) Your Child(ren) 3) Your Parents
4) Your Siblings 5) Your Estate

If you wish to designate different beneficiaries, or to indicate percentages, you may do so on your application. If the listed beneficiary is a trustee or a trust, you will need to indicate the trustee's name, the name of the trust and the date of the trust agreement. The trust document must be presented in order for the claim to be processed.

** Benefits will not be paid to your Domestic Partner if he or she is not specifically designated.*

Converting Your Coverage to Permanent Life Insurance

If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can convert to an individual policy. No medical certification is needed. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Family members may convert their coverage as well. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed. Premiums may change at this time.

Questions?

CIGNA Group Insurance has courteous, knowledgeable customer service representatives who can assist you with the completion of your enrollment form by calling 1-800-732-1603 toll-free anytime from Monday through Friday, 8 a.m. to 6 p.m. Eastern time. CIGNA does not have your coverage election information on file. For specific benefit/account inquiries on what is available under your plan, please contact your Employee Benefits Staff.

How Your Claims Are Paid

Your employer has all the forms your beneficiary will need and can provide assistance in completing them.

This portion of the plan provides life insurance only.

Who Needs Personal Accident Insurance?

You do. Accident insurance can help you pay expenses if you or your spouse is seriously injured or killed in a covered accident. This insurance can help ensure that tragedy doesn't take both an emotional and a financial toll on your family.

By purchasing this insurance through your employer, you benefit from:

- Affordable group rates
- Convenient payroll deduction

Who Is Eligible For Coverage?

You – If you are an active, full-time employee, including elected officials, and regularly work a minimum of .5 full-time equivalent per week, as defined by your employer, you will be eligible to elect insurance for you and your dependents on the first of the month on or after 30 days of active service. Temporary and seasonal employees are not covered under this plan.

*Your Spouse** – You may elect coverage for a lawful spouse under age 70.

No one may be covered more than once under this plan. If covered as an employee, you cannot also be covered as a spouse.

** For purposes of this brochure, wherever the term Spouse appears it shall also include Domestic Partner. Your domestic partner is eligible for insurance if he or she meets specific criteria stated in the Group Policy. Additional information is available from your Benefit Services Representative.*

How Much Coverage Can You Buy?

You – You will automatically receive an amount that matches your voluntary life insurance benefit in effect under Policy No. FLX-964730, underwritten by Life Insurance Company of North America.

Your Spouse – Your spouse will automatically receive an amount equal to the spouse's voluntary life insurance benefit in effect under Policy No. FLX-964730, underwritten by Life Insurance Company of North America.

You may need to request changes to your existing coverage if, in the future, you no longer have a spouse who qualifies for coverage. We will refund premium if you do not notify us of this and it is determined at the time of a claim that premium has been overpaid.

Your Monthly Cost

The cost of coverage is included in the rates shown under **How Much Your Coverage Will Cost** in the previous section.

A Valuable Combination of Benefits

Personal Accident Insurance helps protect you against losses due to accidents. A covered accident is a sudden, unforeseeable, external event, resulting directly and independently of all other causes, in a covered injury or covered loss that occurs while coverage is in force. To help survivors of severe accidents adjust to new living circumstances, we will pay benefits according to the chart below.

If, within 365 days of a covered accident, bodily injuries result in:	We will pay this % of the benefit amount:
Loss of life, or Total paralysis of upper and lower limbs, or Loss of any combination of two: hands, feet or eyesight, or Loss of speech and hearing in both ears	100%
Total paralysis of both lower or upper limbs	75%
Total paralysis of upper and lower limbs on one side of the body, or Loss of hand, foot or sight in one eye, or Loss of speech, or Loss of hearing in both ears, or Severance and Reattachment of one hand or foot	50%
Total paralysis of one upper or lower limb, or Loss of all four fingers of the same hand, or Loss of thumb and index finger of the same hand	25%
Loss of all toes of the same foot	20%
Coma	1%

If the same accident causes more than one of these losses, we will pay only one amount, but it will be the largest amount that applies.

Loss of a hand or foot *means complete severance through or above the wrist or ankle joint.* ***Loss of sight*** *means the total, permanent loss of all vision in the eye.* ***Loss of speech*** *means total, permanent and irrecoverable loss of audible communication.* ***Loss of hearing*** *means total and permanent loss of the ability to hear any sound in both ears. Loss of sight, speech and hearing must be irrecoverable by natural, surgical or artificial means.* ***Loss of a thumb and index finger or four fingers****, means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).* ***Paralysis*** *means total loss of use, without severance, of a limb. This loss must be determined by a doctor to be complete and not reversible.* ***Loss of Toes*** *means complete severance through the metatarsalphalangeal joint.* ***Severance*** *means complete and permanent separation and dismemberment of the limb from the body.*

Additional Benefits

For Exposure and Disappearance

Benefits are payable if you or an insured spouse suffer a covered loss due to unavoidable exposure to the elements as a result of a covered accident.

If your or your insured spouse's body is not found within one year of the disappearance, wrecking or sinking of the conveyance in which you or your insured spouse were riding, on a trip otherwise covered, it will be presumed that you sustained loss of life as a result of a covered accident.

For Comas

If you or your spouse have been in a coma for one full month as a result of a covered accident, we will pay a coma benefit, as shown in A Valuable Combination of Benefits. We will make 11 monthly payments, provided the person remains in a coma during this period. If the person recovers, the payments will stop.

If the insured person dies while the monthly coma benefit payments are being made, or if the insured person remains in a coma after the 11 monthly payments have been made, he or she will be entitled to a lump sum payment equal to the full benefit amount.

Coma *means a profound state of unconsciousness which resulted directly and independently from all other causes from a covered accident, and from which the insured is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a covered injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that covered accident.*

For Child Care Expenses

Personal Accident Insurance pays an additional benefit to help pay for your children's child care expenses.

If you die as a result of a covered accident and you have a surviving child under 13 who is enrolled in a licensed child care center at the time of the accident or within 90 days afterward, we will pay a child care center benefit. This benefit will be an annual sum for each child of up to 3% of your benefit amount but not more than $3,000 per year for 4 years or until the child turns 13, whichever occurs first.

We will make the payment to the child's surviving custodial parent or legal guardian.

Each payment will be made at the end of a 12-month period in which there were documented child care center expenses.

Child means your unmarried dependent children who are under age 26.

For Wearing a Seatbelt and Protection by an Airbag

This benefit is payable if an insured employee or spouse dies as a direct result of injuries sustained in a covered accident while driving or riding in an automobile*, while wearing a properly fastened seatbelt. That person's death benefit will be increased by 100% but not more than $50,000. If the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System ** (Airbag), we will increase that person's death benefit by an additional 5% but not by more than $10,000.

Verification of the actual use of the seatbelt and that the supplemental restraint system inflated properly on impact at the time of the accident, must be part of an official report of the accident, or be certified, in writing, by the investigating officer(s) and submitted with the claim.

If it is unclear whether the insured had been wearing a seatbelt or that the person was positioned in a seat protected by a properly functioning and properly deployed airbag, the plan will pay a benefit of $1,000.

**Automobile* *means a self-propelled, private passenger motor vehicle with four or more wheels which is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes but is not limited to a sedan, station wagon, sport utility vehicle or a motor vehicle of the pickup, van, motor home or camper type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.*

***Supplemental Restraint System** means an airbag that inflates upon impact for added protection to the head and chest areas.*

For Furthering Education

The education benefit can give employees extra peace of mind if their children enroll in a school of higher learning.

If you die in a covered accident, we will pay an extra benefit for each child who is enrolled in a school of higher learning or is in the 12th grade and enrolls within one year of the accident. To help pay expenses, we will increase your benefit amount by 3% (up to $3,000) for each qualifying child. This benefit is payable each year for 4 consecutive years as long as your children continue their education.

If there is no qualifying child, we will pay an additional $1,000 to your beneficiary.

Child means your unmarried dependent children who are under age 26.

For Training for Your Spouse

If you have elected spouse coverage, your spouse will receive educational reimbursement if he or she enrolls, within three years of your death in a covered accident, in an accredited school to gain skills needed for employment. We will pay the actual cost of this education or training program up to 3% of your benefit amount, not to exceed $3,000.

What Is Not Covered

Plan benefits are not payable if an injury or a loss results, directly or indirectly, from or is caused by, self-inflicted injuries or suicide while sane or insane; commission or attempt to commit a felony or an assault; any act of war, declared or undeclared; any active participation in a riot or insurrection; bungee jumping; parachuting; skydiving; parasailing; hang-gliding; sickness, disease, physical or mental impairment, or surgical or medical treatment thereof, or bacterial or viral infection, regardless of how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental external cut or wound or accidental food poisoning.)

Benefits are also not payable if the loss occurs while the covered person is voluntarily using any drug, narcotic, poison, gas or fumes except one prescribed by a licensed physician and taken as prescribed; while operating any type of vehicle while under the influence of alcohol (intoxicated is defined by the law of the state in which the covered accident occurred) or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it; while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days); traveling in an aircraft that is owned, leased or controlled by the sponsoring organization or any of its subsidiaries or affiliates (an aircraft will be deemed to be ''controlled'' by the sponsoring organization if the aircraft may be used as the sponsoring organization wishes for more than 10 straight days, or more than 15 days in any year); flying in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface, except as a passenger on a regularly scheduled commercial airline; that is: an ultra-light or glider, designed to be used in outerspace; being used by any military authority, except the Air Mobility Command or its foreign equivalent; being flown by the covered person or in which the covered person is a member of the crew; being used for parachuting, hang-gliding, crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, skydiving, pipeline or power line inspection, aerial photography or exploration, racing or endurance tests, stunts or acrobatic flying, or any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

In addition, benefits will not be paid for services or treatment rendered by a physician, nurse or any other person who is employed or retained by the subscriber or who is providing homeopathic, aroma-therapeutic or herbal therapeutic services, living in the covered person's household or a parent, sibling, spouse or child of the insured.

When Your Coverage Begins and Ends

Your accident insurance begins when your voluntary life insurance coverage begins. Accident insurance for your spouse begins when the person's voluntary life insurance coverage under Policy No. FLX-964730, begins.

A person's accident coverage ends at the earlier of (1) the date their voluntary life insurance under Policy No. FLX-964730, ends, (2) the date the person is no longer eligible for accident insurance or (3) the date accident policy OK-966319, ends.

Changing from the Group Plan to Individual Coverage

If this group coverage is reduced or ends for any reason except non-payment of premium or age, you can convert to an individual policy. No medical certification is needed. To continue coverage, you must apply for the conversion policy and pay the first premium in effect for your age and occupation within 31 days after your group coverage ends. Your spouse may convert his/her coverage as long as he/she has not reached the maximum age limitation. Converted policies are subject to certain benefits and limits as outlined in your certificate, should you become insured under the plan.

This portion of the plan provides ACCIDENT insurance only. It pays benefits for bodily injury. It does not provide coverage for sickness.

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life insurance coverage are set forth in Group Policy No. FLX-964730, on Policy Form TL-004700, issued in Delaware to the . Terms and conditions of accident insurance coverage are set forth in Group Policy No. OK 966319 on Policy Form No. GA-00-1000.00, issued in Oregon. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Coverage is underwritten by
Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192

08/2012

INSURANCE APPLICATION

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603.
- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

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

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

EMPLOYER Marion County - Oregon

CLASS _____ **LOCATION/PAYCODE#** _____ **DATE OF HIRE** _____ **ANNUAL SALARY** _____ **VERIFIED BY** _____

REASON FOR REQUEST: ☐ **NEW HIRE** ☐ **INITIAL ENROLLMENT EVENT** ☐ **ONGOING ENROLLMENT EVENT** ☐ **Llate ENTRANT**

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE/DOMESTIC PARTNER
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

Please print (preferably in black ink).

EMPLOYEE SECTION

☐ Mr. ☐ Mrs. ☐ Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Sex: ☐ M ☐ F

Have you smoked cigarettes in the last 12 months? Employee: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No

Important: You must complete the medical questions in this application if you apply for life insurance: (1) as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying more than 31 days after you are eligible to elect benefits; (2) you were eligible under the prior plan and enroll or increase your insurance amount(s) above the Guaranteed Coverage Amount.

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 or Domestic Partner Info

Name (First) _____ (Last) _____ Social Security # _____

Birthdate _____ Sex: ☐ M ☐ F

TERM LIFE INSURANCE — POLICY NO. FLX-964730

Voluntary Employee-Paid Coverage

Applicant	***Decline***	***Requested Amount***	***Guaranteed Coverage Amount****
Employee	☐	☒ Number of $10,000 units _____	$50,000
Spouse/Domestic Partner	☐	☐ Number of $10,000 units _____	$10,000
Child(ren)	☐	☐ $2,000 ☐ $5,000 ☐ $10,000	$10,000

** Guaranteed Coverage Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.*

ACCIDENT INSURANCE — POLICY NO. OK-966319

Benefit Amount — *Employee and Spouse/Domestic Partner* – An amount equal to the Voluntary Life Insurance Benefit in effect under Policy Number FLX-964730, underwritten by Life Insurance Company of North America.

BENEFICIARY

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

Insured	*Beneficiary*	*Percentage*	*Social Security #*	*Date of Birth*	*Relationship*
Employee *(Life)*					
Employee *(Accident)*					

ACCEPTANCE/DECLINATION

I accept the insurance coverages 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.

Signature _____ Date _____

Please Sign Here

Important: **You must also sign and date the Agreements and Authorization section.**

Return application to your employer. Be sure to make a copy for your own records.

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

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

Complete the employee and spouse/domestic partner info in this section if you (i.e., the Employee) or your spouse are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee	**Spouse/Domestic Partner**
Height ft in	Height ft in
Weight lbs	Weight lbs

PHYSICIAN SECTION

Employee Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Spouse/Partner Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

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

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

		Employee		Spouse/DP	
		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.	Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑	❑	❑
C.	Asthma, Chronic Bronchitis, Emphysema, 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, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑	❑	❑
I.	Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑	❑	❑
J.	Alcohol or drug abuse or dependency?	❑	❑	❑	❑

SECTION B

Within the last 5 years has the proposed insured:

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?	❑	❑	❑	❑

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	*Medical 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.*

***Important:* You must also sign and date the Agreements and Authorization section.**

Fold and staple this page to conceal health questions.
Return application to your employer. Be sure to make a copy for your own records.

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

♦ ♦ ♦ AGREEMENTS AND AUTHORIZATION ♦ ♦ ♦

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 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.)

Sign Here

_____ _____ _____ _____

Employee's Signature *Month/Day/Year* *Spouse/Domestic Partner's Signature* *Month/Day/Year*

(If applying for insurance for your spouse/domestic partner)

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.

TL-009320 (**OR**)

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