Term Life Insurance Change Form

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

Company) For info and customer service call 1-866-607-2360.



• All info must be completed by the applicant.

• He/she must sign and date this form.

TL-009320

• 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 POLICY # CLASS LOCATION/PAYCODE # DATE OF HIRE ANNIAL SALANY VEHIFLED BY REASON FOR REQUESTE LIFE STATIS CHANGE ONCOMOR GENELILENT FUENT REINSTATEMENT LATE ENTRANT NEW COVERAGE VOLUNTARY EMPLOYEE VOLUNTARY SPOUSE VOLUNTARY CHILD NEW COVERAGE COLONTARY EMPLOYEE VOLUNTARY CHILD CURRENT COVERAGE COLONTARY EMPLOYEE VOLUNTARY CHILD PORTON OF REQUESTED INCREASE COMPLETE FOR COVERAGE PORTON OF REQUESTED INCREASE AMOUNT SUBJECT TO EMPLOYEE SECTION Mine Coverence PRover print (projenshy in black tak). Employee Name (Erst) (Last) Social Security # Birthdate Address (Last) Social Security # Birthdate More Phone Home Phone Employee ID Number Social Security # Social Social Security # Birthdate Social Security # Social Name (First) (Last) Social Security # Birthdate Social Security # Birthdate Social Security # Social Social Security # Social Security # Social Security #	this information.			this form, the employer must complete
CLASSLOCATION/PAYCODE #DATE OF HIREANNUAL SALARYVERIFIED BY REASON FOR REQUEST:HIPE STUTUS CHANGEONCOING ENROLLMENT FUENTREINSTATEMENTARITER ENTRANT 	EMPLOYER			POLICY#
REASON FOR REQUESE: LIFE STATUS CHANGE ONGOING ENROLLMENT EVENT REINSTATEMENT LATE ENTRANT VOLUNTARY EMPLOYEE VOLUNTARY SPOUSE VOLUNTARY CHILD NEW COVERAGE COURTARY COVERAGE COURTARY EMPLOYEE VOLUNTARY CHILD COURT COVERAGE COURTARY EMPLOYEE VOLUNTARY SPOUSE VOLUNTARY CHILD COURTAGE FORT COVERAGE FORTON OF REQUESTED INCREASE AMOUNT SUBJECT TO MEDICAL EVIDENCE BUPLOYEE SECTION EMPLOYEE SECTION BUPLOYEE SECTION COMPLETE IF ELECTING SPOUSE COVERAGE Mance first) Last Mance first) COMPLETE IF ELECTING SPOUSE COVERAGE Social Security # Birthdate Border COMPLETE IF ELECTING SPOUSE COVERAGE Social Security # Birthdate Social Security # Birthdate Birthdate Social Security # Birthdate Social Security # Birthdate Social Security # Birthdate Social Security # Birthdate Soc				
NEW COVERAGE (TOTAL)				
NEW COVERAGE (TOTAL)		VOLUNTARY EMPLO	YEE VOLUNTARY SPO	DUSE VOLUNTARY CHILD
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE PORTION OF REQUESTED INCREASE Image: Control (preferably in black ink). Place print (preferably in black ink). EMPLOYEE SECTION Image: Control (preferably in black ink). EMPLOYEE SECTION Image: Control (preferably in black ink). Social Security #	NEW COVERAGE (TOTAL)			
FORTION OF REQUESTED INCREASE	CURRENT COVERAGE			
Image: Second State Sta				
EMPLOYEE SECTION Mr. Mrs. Mrs. Mrs. Check One) Employee Name (First) (flast) Social Security # Birthdate Address Giy State Zip Work Phone Home Phone Employee ID Number Sec: M COMPLETE IF ELECTING SPOUSE COVERAGE Sec: M General Address Sec: M Information Name (First) (flast) Social Security # Social Security #<	AMOUNT SUBJECT TO			
Mr Mr Mrs Ms. (Check One)	Please print (preferably in black ink).			
Employee Name (First) (Last) Social Security # Birthdate Address City State Zip Work Phone Home Phone Employee ID Number Sex: M COMPLETE IF ELECTING SPOUSE COVERAGE Spouse Name (First) (Last) Social Security # Birthdate Social Security # Social Security # Birthdate Sex: M F Secure and the problem of the coverage election options for your plan. When selecting new coverage amounts, plete ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or applicatio CHECK THE APPROPRIATE BOXES: Increase, decrease or begin coverage on the following individuals as indicated below: (Complete the medical questions on the next page for each person electing or increasing coverage) Cotal Voluntary Coverage Employee		EMPLO	YEE SECTION	
Address				
Work Phone				
COMPLETE IF ELECTING SPOUSE COVERAGE Spouse I am currently married and my date of marriage is				
Spouse I am currently married and my date of marriage is	Work Phone	Home Phone	Employee ID Number	er Sex: 🗅 M 🗔 I
Spouse		COMPLETE IF ELEC	TING SPOUSE COVERAGE	
Information Name (First)		and my date of marriage is _		
Birthdate	Spouse Information Name (First)	(Last)		Social Security #
See your life insurance brochure/application for the coverage election options for your plan. When selecting new coverage amounts, plex ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application CHECK THE APPROPRIATE BOXES: Increase, decrease or begin coverage on the following individuals as indicated below: (Complete the medical questions on the next page for each person electing or increasing coverage) Employee Spouse Child(ren)* **Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: Name DOB / / / Have you smoked or used any form of tobacco in the last 12 months? Employee: Yes No Spouse: Yes If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change Employee Employee Employee Employee Cancel toverage on the following individuals: Employee Concel coverage on the following individuals: Employee Concel coverage on the following individuals: Concel lation Concel coverage on the following indiv	0	Sex:	Пм ПF	
ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application CHECK THE APPROPRIATE BOXES: Increase, decrease or begin coverage on the following individuals as indicated below: (Complete the medical questions on the next page for each person electing or increasing coverage) Employee Spouse Child(ren)* *Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: Name DOB Life Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Change in Spouse's Employment Return to or from Military Duty Change in Spouse Child(ren) Employee If effective Date of Cancellation Cancel coverage on the following individuals: Employee Spouse Child(ren) Effective Date of Cancellation	I WISH TO	MAKE THE FOLLOWING CH	IANGES TO MY LIFE INSURANC	E COVERAGE
ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application CHECK THE APPROPRIATE BOXES: Increase, decrease or begin coverage on the following individuals as indicated below: (Complete the medical questions on the next page for each person electing or increasing coverage) Employee Spouse Child(ren)* *Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: Name DOB Life Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Change in Spouse's Employment Return to or from Military Duty Change in Spouse Child(ren) Employee If effective Date of Cancellation Cancel coverage on the following individuals: Employee Spouse Child(ren) Effective Date of Cancellation			, e e i veri	1
CHECK THE APPROPRIATE BOXES: Increase, decrease or begin coverage on the following individuals as indicated below: (Complete the medical questions on the next page for each person electing or increasing coverage) Employee Spouse Child(ren)* *Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: Name DOB / _ /_ Have you smoked or used any form of tobacco in the last 12 months? Employee: Yes No Spouse: Yes No Iffe Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change Iteresting individuals: Employee Spouse Child(ren) Effective Date of Cancellation Iteresting individuals:	see your life insurance brochure/appli- ensure that your election(s) match the	cation for the coverage electric electr	ion options for your plan. When s	selecting new coverage amounts, please
(Complete the medical questions on the next page for each person electing or increasing coverage) <u>Current</u> Voluntary Coverage <u>New</u> Voluntary Coverage <u>Total</u> Voluntary Coverage Employee Spouse Child(ren)* <u>Attack a separate sheet:</u> Name <u>DOB</u> _ / _ / _ *Include your child(ren) names and DOB. If more spaces are needed, attack a separate sheet: Name DOB _ / _ / _ Have you smoked or used any form of tobacco in the last 12 months? Employee: Yes No Spouse: Yes No Life Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abse Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change Employee Spouse Child(ren) Effective Date of Cancellation Employee Spouse Child(ren) Effective Date of Cancellation Cancel the Automatic Increase Option	CHECK THE APPROPRIATE BOXES:			
Image: Current Voluntary Coverage New Voluntary Coverage Total Voluntary Coverage Image: Employee Image: Current Voluntary Coverage Image: Voluntary Coverage Image: Spouse Image: Current Voluntary Coverage Image: Voluntary Coverage Image: Spouse Image: Coverage Image: Coverage Image: Child(ren)* Image: Coverage Image: Coverage *Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: Name DOB Have you smoked or used any form of tobacco in the last 12 months? Employee: Imployee: Imployee: Imployee: Imployee: Imployee Yes No Image: If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Image:	□ Increase, decrease or begin cover	rage on the following ind	ividuals as indicated below:	
Employee Employee Geneel the Automatic Increase Option	(Complete the medical questions on t	he next page for each pers	on electing or increasing cover	rage)
Spouse Child(ren)* *Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: NameDOB _/ / Have you smoked or used any form of tobacco in the last 12 months? Employee: Pres No Spouse: Yes No Life Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change Cancel coverage on the following individuals: Employee Spouse Child(ren) Effective Date of Cancellation	Curr	<u>rent</u> Voluntary Coverage	<u>New</u> Voluntary Coverage	Total Voluntary Coverage
Child(ren)* *Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: NameDOB / _ / _ Have you smoked or used any form of tobacco in the last 12 months? Employee: Yes No Spouse: Yes No Life Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change Cancel coverage on the following individuals: Employee Spouse Child(ren) Effective Date of Cancellation	Employee			
*Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: Name	□ Spouse			
Include your child(ren) names and DOB. If more spaces are needed, attach a separate sheet: Name	Child(ren)			
 Have you smoked or used any form of tobacco in the last 12 months? Employee: Yes No Spouse: Yes No Life Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change Individuals: Employee Spouse Child(ren) Effective Date of Cancellation Cancel the Automatic Increase Option 		Emone staces and mended attach	a sobarata shaat. NT-ma	
 Life Status Change If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change				
If this change is being made due to a Life Status Change, please check one of the following, and provide date of change. Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change <i>Cancel coverage on the following individuals:</i> Employee Spouse Child(ren) Effective Date of Cancellation				
 Marriage Divorce Annulment Legal Separation Birth or Adoption of a Child Death of a Spouse or Child Leave of Abs Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change <i>Cancel coverage on the following individuals:</i> Employee Spouse Child(ren) Effective Date of Cancellation <i>Cancel the Automatic Increase Option</i> 	•	Status Change, please check one	of the following and provide date of	change
 Change in Spouse's Employment Return to or from Military Duty Change from full to part-time (or vice-versa) Date of Life Status Change <i>Cancel coverage on the following individuals:</i> Employee Spouse Child(ren) Effective Date of Cancellation <i>Cancel the Automatic Increase Option</i> 				
Date of Life Status Change Cancel coverage on the following individuals: Employee Spouse Child(ren) Effective Date of Cancellation Cancel the Automatic Increase Option	<u> </u>		*	*
Cancel coverage on the following individuals: Employee Spouse Child(ren) Effective Date of Cancellation Cancel the Automatic Increase Option	• • • • •			
Employee Spouse Child(ren) Effective Date of Cancellation Cancel the Automatic Increase Option	-			
Cancel the Automatic Increase Option			on	
	_			
Employee/	0	-		
Spouse /	Spouse	/		
Reminder: If you'd like to designate new beneficiaries, please complete a Beneficiary Form.	÷		(; ; , , , , , , , , , , , , , , , , , ,	
ACCEPTANCE / DECLINATION	Reminder: If you'd like to designate new be	neficiaries, please complete a Ber	neficiary Form.	
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 earnings.	Reminder: If you'd like to designate new be	· • •	·	
	I accept the insurance coverage(s) chosen	ACCEPTANC	E / DECLINATION	ployer to deduct the needed amounts from my
In order to confirm your election, you must provide a signature for each underwriting company whose coverage you chose.	I accept the insurance coverage(s) chosen earnings.	ACCEPTANC above. If premiums are to be	E / DECLINATION paid by payroll, I authorize my emp	
In order to confirm your election, you must provide a signature for each underwriting company whose coverage you chose.For coverage(s) provided by Life Insurance Company of North America	I accept the insurance coverage(s) chosen earnings. In order to confirm your election, you mus	ACCEPTANC above. If premiums are to be t provide a signature for each	E / DECLINATION paid by payroll, I authorize my emp underwriting company whose cove	

IMPORTANT

Social Security #_

IMPORIANT 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 info in this section if you (i.e., the Employee) or your spouse are applying for/increasing Life Insurance: (1) exceeding the guaranteed amount, or (2) due to a reinstatement.

Height and Weight Information

Employee	Spouse
Height ft in	Height ft in
Weight lbs	Weight lbs

PHYSICIAN SECTION

Employee Physician

Name	Phone No			
StreetAddress	City	State	Zip	
Spouse Physician				
Name	Phone No			
Street Address	Cita	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**

А.	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			
Wi	thin 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?			
В.	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?			
С.	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	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.

Spouse

Yes No

Yes No

+++ 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 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 or my children 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's Signature (If applying for insurance for your spouse)

Month/Day/Year