

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.



CIGNA Group Insurance
 Life • Accident • Disability

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

CONTRACT HOLDER USE (MANDATORY DATA NEEDED): In order to process this application, the contract holder must complete this information.

CONTRACT HOLDER	Utah School Employee's Association
SCHOOL DISTRICT _____	USEA AUTHORIZED REPRESENTATIVE SIGNATURE _____
DATE MEMBER BECAME ELIGIBLE FOR COVERAGE _____	

Please print (preferably in black ink).

MEMBER SECTION

Mr. Mrs. Ms. (Check One)

Member Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Member ID # _____ Sex: M F

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

Spouse Information

I am currently married and my date of marriage is _____

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

Birthdate _____ Sex: M F

TERM LIFE INSURANCE — POLICY NO. FLX-980123

	<u>Applicant</u>	<u>Decline</u>	<u>Requested Amount</u>	<u>Guaranteed Coverage Amount</u>
Voluntary Member-Paid Coverage	Member Coverage	<input type="checkbox"/>	<input type="checkbox"/> \$5,000	<u>\$5,000</u>
	Dependent Coverage	<input type="checkbox"/>	<input type="checkbox"/> @ \$2,000 for Spouse and \$2,000 for Children	<u>\$2,000</u>

BENEFICIARY

To **specify a beneficiary**, complete the section below. 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
Member (Life)					
Spouse					
Child (ren)					

ACCEPTANCE/DECLINATION

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my contract holder 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: EMIA, 852 E. ARROWHEAD LANE, MURRAY, UT 84107
Be sure to make a copy for your own records.

◆ ◆ ◆ 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) 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.

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.)

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<i>Member's Signature</i>	<i>Month/Day/Year</i>	<i>Spouse's Signature</i>	<i>Month/Day/Year</i>
		<i>(If applying for insurance for your spouse)</i>	

Sign Here

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.