

# LIFE INSURANCE APPLICATION

Life Insurance Company of North America  
Philadelphia, PA

For information and  
customer service,  
call 1-800-732-1603



CIGNA Group Insurance  
Life • Accident • Disability

Please print (preferably in black ink).

|                                                                                                                                                                                           |                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| <b>EMPLOYER USE (MANDATORY DATA NEEDED):</b> In order for the Insurance Company to process this application, the employer must complete this information on the second copy of this form. |                                  |
| <b>EMPLOYER</b>                                                                                                                                                                           | <b>Broward Community College</b> |
| <b>CLASS</b> _____ <b>LOCATION/PAYCODE #</b> _____ <b>DATE OF HIRE</b> ___/___/___ <b>ANNUAL SALARY</b> _____ <b>VERIFIED BY</b> _____                                                    |                                  |
| <b>REASON FOR REQUEST:</b> <input type="checkbox"/> NEW HIRE <input type="checkbox"/> INITIAL ENROLLMENT EVENT <input type="checkbox"/> LATE ENTRANT                                      |                                  |
|                                                                                                                                                                                           | <b>VOLUNTARY EMPLOYEE</b>        |
| <b>NEW COVERAGE (TOTAL)</b>                                                                                                                                                               |                                  |
| <b>CURRENT COVERAGE</b>                                                                                                                                                                   |                                  |
| <b>GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE</b>                                                                                                                                  |                                  |
| <b>AMOUNT SUBJECT TO MEDICAL EVIDENCE</b>                                                                                                                                                 |                                  |

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 ( ) \_\_\_\_\_ Sex:  M  F Height: \_\_\_ ft \_\_\_ in Weight: \_\_\_\_\_ lbs

**Important:** You must complete the medical questions in this application if you apply for life insurance and: (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 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.

**BASIC TERM LIFE INSURANCE — POLICY NO. FLX-961000**

|                         |                          |                          |                                           |
|-------------------------|--------------------------|--------------------------|-------------------------------------------|
| <u><b>Applicant</b></u> | <u><b>Accept</b></u>     | <u><b>Decline</b></u>    | <u><b>Amount of Life Insurance</b></u>    |
| Employee                | <input type="checkbox"/> | <input type="checkbox"/> | 1 times annual salary (maximum \$250,000) |

**VOLUNTARY TERM LIFE INSURANCE — POLICY NO. FLX-961000**

|                         |                          |                          |                                                                    |                                                                                                                                                                                    |
|-------------------------|--------------------------|--------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <u><b>Applicant</b></u> | <u><b>Yes</b></u>        | <u><b>No</b></u>         | <u><b>Amount</b></u>                                               | <u><b>Guaranteed Coverage Amount*</b></u>                                                                                                                                          |
| Employee                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> 1 <input type="checkbox"/> 2 times salary | The greater of:<br>a) the lesser of 2 times annual salary or \$200,000, or<br>b) an amount equal to the life insurance benefit in effect on the termination date of the prior plan |

\* *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.*

**BASIC ACCIDENT INSURANCE — POLICY NO. OK-961040**

|                         |                          |                          |                                            |
|-------------------------|--------------------------|--------------------------|--------------------------------------------|
| <u><b>Applicant</b></u> | <u><b>Accept</b></u>     | <u><b>Decline</b></u>    | <u><b>Amount of Accident Insurance</b></u> |
| Employee                | <input type="checkbox"/> | <input type="checkbox"/> | 1 times annual salary (maximum \$250,000)  |

**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.

| <i>Insured</i>         | <i>Beneficiary</i> | <i>Percentage</i> | <i>Social Security #</i> | <i>Date of Birth</i> | <i>Relationship</i> |
|------------------------|--------------------|-------------------|--------------------------|----------------------|---------------------|
| <i>Employee (Life)</i> |                    |                   |                          |                      |                     |
|                        |                    |                   |                          |                      |                     |
| <i>(Accident)</i>      |                    |                   |                          |                      |                     |
|                        |                    |                   |                          |                      |                     |

**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 section on the back of this form.

**Tear off top copy for your employer before completing reverse side.**

**COMPLETE A-G IF APPLYING FOR LIFE INSURANCE ABOVE THE GUARANTEED COVERAGE AMOUNT. COMPLETE A-K IF: (1) YOU ARE APPLYING FOR LIFE INSURANCE MORE THAN 31 DAYS AFTER YOU ARE INITIALLY ELIGIBLE, (2) YOU ARE ELECTING TO INCREASE THE COVERAGE AMOUNT(S) YOU HAVE UNDER THE PRIOR LIFE INSURANCE PLAN, OR (3) YOU WERE ELIGIBLE BUT DID NOT ENROLL FOR INSURANCE UNDER THE PRIOR LIFE INSURANCE PLAN.**

During the last five years, has the proposed insured been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in questions below?

**Employee**  
**Yes No**

- |                                                                                                                                                                                                                                                                                                                                                   |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| A. Cysts, moles, warts, polyps, cancer or tumor?                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system?                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Any alcohol and/or drug addiction and/or substance abuse; mental, emotional or any other nervous disorders?                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Is there a current use of prescribed medications by the proposed insured?                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Ever been diagnosed with AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions A through F?                                                                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease/disorder of the nervous system?                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Any surgical operation performed or been advised to have any performed?                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Ever been in a hospital or sanitarium for rest, treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions A through J?                     | <input type="checkbox"/> | <input type="checkbox"/> |

**Use the space below to provide details for "Yes" answers given above and/or medical impairments listed in questions A-K. Complete and attach a separate sheet of paper if additional space is required. Please sign and date the attachment.**

| Name of Employee | Medical Condition | Date Occurred | Duration/ Treatment Received | Current Status |
|------------------|-------------------|---------------|------------------------------|----------------|
|                  |                   |               |                              |                |
|                  |                   |               |                              |                |
|                  |                   |               |                              |                |

**◆◆ AGREEMENTS ◆◆**

To the best of my knowledge and belief, all written, telephonic and electronic information I provided is true and complete. I also understand that the insurance I have selected for myself will begin on the effective date, provided I am actively at work on that date. If I am not, the effective date of my personal coverage, will be delayed until I am actively at work. I understand that insurance subject to medical questions requires insurance company approval, and additional medical information, including blood work, may be required to approve such insurance. I understand that I am responsible to report to the insurance company any change in my health prior to my coverage effective date, and that no coverage will be effective unless I meet the insurance company's underwriting requirements on the effective date.

**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.

**Authorization:** I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of me or my health to give any such information to Life Insurance Company of North America and its authorized representatives and reinsurers, for use in the processing and evaluation of my application and eligibility for life or disability insurance coverage. This authorization extends to and includes information or records pertaining to psychiatric, drug or alcohol use history.

This authorization shall be valid for a period of 30 months from the date signed, and a photographic copy shall be as valid as the original. I understand that my authorized representative or I have the right to receive a copy of the authorization upon request. I understand that this authorization may be revoked provided such revocation is in writing. However, such revocation will not affect any action taken in reliance on the authorization. I further understand that this authorization is being given as a condition of obtaining insurance, and that any revocation does not affect the insurer's right to use this authorization in connection with the contest of a claim or of the policy in accordance with applicable law.

Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the Health Insurance Portability and Accountability Act. (The insurance companies are subject to the Gramm-Leach-Bliley Act and state privacy laws and do not disclose any protected information except as permitted by those laws.)

 **Please Sign Here** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*Employee's Signature* *Date*

Licensed Resident Agent: Christine Carolyn Wise License #E026735

TL-006069 (5/97) FL

**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 insurers' privacy practices is available upon request.

*Detach top copy. Fold and staple this copy to conceal health questions. Return both copies to your employer.*