INSURANCE ENROLLMENT FORM

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

• *The applicant must sign and date this form.*

EMPLOYER	**University Of Massachusetts Medical School**

Important: Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink)

EMPLOYEE SECTION

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Date of Hire _____ Employee ID # _____ Sex: ☐ M ☐ F

Job Title/ Occupation _____ Annual Salary _____ Effective Date of Coverage _____

SPOUSE AND DEPENDENT SECTION (Only complete if electing Spousal or Dependent Coverage)

Spouse Information

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

Birthdate _____ Sex: ☐ M ☐ F

Dependent Information

Name (s) _____

Birthdate (s) _____

Important: You must complete an Evidence of Insurability Form if you apply for life insurance: (1) as a newly hired employee 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) after the completion of the Initial Enrollment period.

TERM LIFE INSURANCE — POLICY NO. FLX966366 AD&D INSURANCE — POLICY NO. OK967900

Voluntary Employee-Paid Coverage

Applicant	***Decline***	***Requested Amount***	***Guaranteed Coverage Amount****
Employee	☐	☐ Number of $50,000 units to a maximum of $1,000,000 _____	500,000
Spouse	☐	☐ Number of $50,000 units to the lesser of $300,000 or 100% of Employee's Basic and Voluntary Life amount _____	50,000
Child(ren)	☐	☐ Number of $10,000 units to a maximum of $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.*

LTD INSURANCE — POLICY NO. FLK-960846

LTD Core/Buy-Up:

- ❑ I accept the LTD Buy-Up insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.
- ❑ I have been offered LTD Buy-Up insurance and decline to purchase it at this time. 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.

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.

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.

☞ Signature _____ Date _____

Please Sign Here

Complete the form and click on the submit box below. Be sure to make a copy for your own records.

11/2014

Complete Form and Click Here to Submit Form Electronically