

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	SAU 40 - Milford School District
CLASS	LOCATION/PAYCODE#
DATE OF HIRE	ANNUAL SALARY
REASON FOR REQUEST: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> INITIAL ENROLLMENT EVENT <input type="checkbox"/> ONGOING ENROLLMENT EVENT <input type="checkbox"/> LATE ENTRANT	VERIFIED BY
VOLUNTARY EMPLOYEE	
NEW COVERAGE (TOTAL)	
CURRENT COVERAGE	
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE	
AMOUNT SUBJECT TOMEDICAL 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

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.

TERM LIFE INSURANCE — POLICY NO. FLX-966704

Voluntary Employee-Paid Coverage	<u>Applicant</u>	<u>Decline</u>	<u>Requested Amount</u>	<u>Guaranteed Coverage Amount*</u>
	Employee	<input type="checkbox"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 times salary	\$200,000

*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.

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
Employee (Life)					

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.