INSURANCE ENROLLMENT FORM

Life Insurance Company of North America

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Return completed form to Cigna Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Phone: 1-800-732-1603

Employer: The University of Scranton

ALL ABOUT YOU – THE EMPLOYEE

Your Name ____________ **Social Security #** ____________ **Birthdate** ____________

Address ____________ City ____________ State ______ Zip ____________

Work Phone ____________ Home Phone ____________ Employee ID # ____________ Gender: ____

Have you smoked or used any form of tobacco in the last 12 months? Employee: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is: ____________

My Spouse's Information

Name ____________ **Social Security #** ____________

Birthdate ____________ Gender ____________

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 960568

Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Benefit: Units of $10,000 up to the lesser of 5 times your salary, or $500,000. Guaranteed Coverage: $200,000	❑ $10,000 ❑ $200,000* ❑ $500,000** ❑ Other ____________ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Benefit: 50% of the employee's benefit amount	Guaranteed Coverage*: $30,000 ❑ Accept Coverage ❑ Decline Coverage
Child	❑ $10,000	❑ Decline Coverage

Employee-Paid (Voluntary) Critical Illness Insurance – Policy # CI 960858

Choose both an Amount below and who you would like to include in your coverage.
See the enclosed Summary of Benefits for Monthly costs.

Who You Want to Cover	**Dependents**	**Coverage Amount**	**Acceptance**
❑ Employee Only ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Employee + Family	How many children are you covering? ____________	❑ $5,000 ❑ $10,000 ❑ $20,000	❑ Accept Coverage *I understand that I am required to complete an Evidence of Insurability form if I elect coverage above the Guaranteed Coverage amount of $20,000*.* ❑ Decline Coverage

**This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during this open enrollment.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latter of 09/01/2018 or the date the insurance company approves your application.

Form #TL-9334 © 2018 Cigna

Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Cigna's approval and 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 go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to critical illness insurance only):
We will not pay benefits for a Covered Loss caused or contributed to by, or resulting from, a Pre-existing Condition. The term "Pre-existing Condition" means any Sickness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 12 months before the Covered Person's most recent effective date of coverage, and the most recent effective date of any added or increased amount of coverage.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Loss for which the Date of Diagnosis occurs after the Covered Person is insured under this Policy for at least 12 months after the Covered Person's most recent effective date of coverage, and effective date of any added or increased amount of coverage.

For California Residents: By signing below, I certify that I and my dependents for whom I am applying for coverage are currently covered for comprehensive health benefits from an insurance policy, an HMO policy, or an employer health benefit plan. Anyone who is not currently covered for comprehensive health benefits is NOT eligible for Critical Illness and/or Hospital Care coverage.

Please Sign Here Signature ______________________________ Date __________________

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. If there is not enough room to specify all beneficiaries, attach, sign and date a separate page using the format below.

Voluntary Term Life Insurance Policy# FLX 960568

Insured	**Beneficiary Name**	**Relationship**	**Social Security #**	**Date of Birth**	**Percentage** *(must equal 100% for each insured)*
Employee	1.				
	2.				
Spouse					
Child(ren)					

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature ______________________________ Date __________________

Employee Signature ______________________________ Date __________________

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