

INSURANCE ENROLLMENT FORM

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.



Life Insurance Company of
North America

Employer: Snow College

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ Social Security # _____ Birthdate _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____ Employee ID # _____ Gender: _____

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.

Employer-Paid (Basic) Term Life Insurance Policy # FLX 969777		
Applicant	The coverage below is provided by your employer at no cost to you.	
Employee	2 times your salary up to \$125,000	Guaranteed Coverage: Lesser of 2 times your salary or \$125,000
Spouse	\$8,000	
Children	\$8,000	

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 969777		
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	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$200,000* <input type="checkbox"/> \$500,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$10,000.</i> <input type="checkbox"/> Decline Coverage
Spouse	Benefit: Units of \$5,000 up to \$250,000. Guaranteed Coverage: \$30,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$30,000* <input type="checkbox"/> \$250,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$5,000. The amount cannot exceed 100% of the employee's coverage.</i> <input type="checkbox"/> Decline Coverage
Child	<input type="checkbox"/> \$10,000	<input type="checkbox"/> Decline Coverage

Employer-Paid (Basic) Accidental Death & Dismemberment Insurance Policy # OK 971217		
Applicant	The coverage below is provided by your employer at no cost to you.	
Employee	2 times your salary	Maximum Coverage**: \$125,000

Employee-Paid (Voluntary) Short-term Disability Insurance Policy # VDT 963212		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee	Benefit Percentage: 60%	<input type="checkbox"/> Accept Coverage
	Maximum Weekly Benefit Amount: \$1,500	<input type="checkbox"/> Decline Coverage

Employer-Paid (Basic) Long-term Disability Insurance Policy # LK 966489	
Applicant	The coverage below is provided by your employer at no cost to you.
Employee	60% of your monthly covered earnings, to a maximum of \$6,000 per month.

**This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during your enrollment period.*

***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 06/01/2021 or the date the insurance company approves your application.

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: I understand that I will not receive benefits for a pre-existing condition (any injury or sickness for which medical advice, care or treatment was recommended or received during the months just prior to the coverage effective date) unless the disability begins more than 3 months after the effective date of coverage.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 6 months for the Disability coverage.

Pre-Existing Condition Limitation: I understand that I will not receive benefits for a pre-existing condition (any injury or sickness for which medical advice, care or treatment was recommended or received during the months just prior to the coverage effective date) unless the disability begins more than 3 months after the effective date of coverage.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability 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.

Basic Term Life Insurance Policy# FLX 969777					
Insured	Beneficiary Name	Relationship	Social Security #	Date of Birth	Percentage <i>(must equal 100% for each insured)</i>
Employee	1.				
	2.				
Spouse					
Child(ren)					

Voluntary Term Life Insurance Policy# FLX 969777					
Insured	Beneficiary Name	Relationship	Social Security #	Date of Birth	Percentage <i>(must equal 100% for each insured)</i>
Employee	1.				
	2.				
Spouse					
Child(ren)					

BENEFICIARY SECTION

Basic Accidental Death & Dismemberment Insurance Policy# OK 971217

Insured	Beneficiary Name	Relationship	Social Security #	Date of Birth	Percentage <i>(must equal 100% for each insured)</i>
Employee	1.				
	2.				

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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