

INSURANCE APPLICATION

Life Insurance Company of North America
Philadelphia, PA

Please print (preferably in black ink).

For information and customer service,
call 1-800-231-1193



CIGNA Group Insurance
Life · Accident · Disability

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process applications, you must either forward a list containing the following information or complete this information on the second copy of this form.

EMPLOYER	TULANE UNIVERSITY	CLASS	BILLING LOCATION	DATE OF HIRE / /	ANNUAL SALARY
EXISTING VOLUNTARY COVERAGE: EMPLOYEE \$	SPOUSE/ DOMESTIC PARTNER \$	CHILD(REN) \$	VERIFIED BY		

Mr./Mrs./Ms. (circle one)
Employee Name (First) _____ (Last) _____ Social Security # _____ - _____ - _____ Birthdate ____/____/____
Address _____ City _____ State _____ Zip _____ Sex: M F
Work Phone () _____ Home Phone () _____ E-Mail Address _____ Height: ____ ft ____ in Weight: ____ lbs
Primary Physician Name _____ Address _____ Phone () _____

Important: You must complete the medical questions in this application, if you apply for life insurance: (1) exceeding the Guaranteed Coverage Amount, or (2) after the completion of any open enrollment period (as agreed upon by your employer and the insurance company), or (3) as a newly hired employee more than 31 days after you are eligible to elect benefits.

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

I am currently married and my date of marriage is ____/____/____ -or- I currently have an eligible Domestic Partner.*

Spouse/Domestic Partner Information
Name (First) _____ (Last) _____ Social Security # _____ - _____ - _____
Birthdate ____/____/____ Height: ____ ft ____ in Weight: ____ lbs Sex: M F
Spouse/Domestic Partner
Primary Physician Name _____ Address _____ Phone () _____

* In order to be eligible for Domestic Partner coverage, you must have a Domestic Partner Affidavit or its equivalent on file with your employer, and accepted by the insurance company. If you do not currently have one on file with your employer, one will be **made available through your employer/sent to you by return mail**.

TERM LIFE INSURANCE — POLICY NO. FLX-051291

<i>Applicant</i>	<i>Yes</i>	<i>No</i>	<i>Amount</i>	<i>Guaranteed Coverage Amount*</i>
Employee	<input type="checkbox"/>	<input type="checkbox"/>	Number of \$10,000 units _____	<i>The lesser of 2x annual salary or \$100,000</i>
Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>	Number of \$10,000 units _____	<i>\$10,000</i>
Children	<input type="checkbox"/>	<input type="checkbox"/>	Number of \$ 2,000 units _____	<i>\$10,000</i>

* *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.*

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

ACCEPT	DECLINE
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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.

BENEFICIARY

To **specify a beneficiary**, complete the section below and sign and date the back of this form. You will be the beneficiary for your spouse and child (ren) unless you specify otherwise. 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>
Employee (Life)					
Spouse/ Domestic Partner					
Child (ren)					

COMPLETE A-G IF APPLYING FOR LIFE INSURANCE ABOVE THE GUARANTEED COVERAGE AMOUNT. COMPLETE A-K IF APPLYING FOR LIFE INSURANCE MORE THAN 31 DAYS AFTER YOU ARE ELIGIBLE, OR AFTER YOUR OPEN ENROLLMENT PERIOD.

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		Spouse/		Child/ren	
	Yes	No	Yes	No	Yes	No
A. Cysts, moles, warts, polyps, cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Ever been diagnosed with or been treated for 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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Any surgical operation performed or been advised to have any performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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/Spouse/Domestic Partner/Child (ren)	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, as well as dependent coverage, will be delayed until I am actively at work. Also, if any one of my dependents to be insured is not performing normal daily activities* on the effective date, that coverage will be delayed until the date the dependent resumes normal daily activities. 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: If proposed for insurance, I authorize the following parties with any records or knowledge of personal information, medical history, mental or physical condition, diagnosis or treatment of me, to give such information to the Insurer, its authorized representatives or reinsurers. The authorized parties include any licensed physician, medical practitioner, hospital, clinic, Veterans Administration or other medically related facility, insurance company, employer, the Medical Information Bureau, or other organization, institution or person. For the purposes of collection and use of information to evaluate my application for insurance, I agree that my authorization is valid for thirty (30) months from the date of my signature below.

I understand that disclosures may be made without my consent as permitted by law. I also understand that the Insurer, its authorized representatives or reinsurers may make a brief report about my health or medical information listed above to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If I apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of my request, the Bureau will arrange disclosure of any information it may have in my file. If I question the accuracy of information in the file, I may contact the Bureau and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The Bureau's information office address is P.O. Box 105, Essex Station, Boston, MA 02112. Telephone: 617.426.3660.

A copy of this authorization will be valid as the original. I understand that my authorized representative or I have the right to receive a copy of this authorization upon request. My authorized representative or I can revoke this authorization at any time, subject to the rights of an individual who acted in reliance on this authorization prior to notice of revocation. The revocation must be in writing, signed and dated by my authorized representative or me.

Electronic/Telephonic Authorization: I authorize the insurance company to accept my telephonic and electronic elections and change requests, as allowed by law. The insurance company will not be legally responsible for any liability if acting in good faith upon any instructions given by telephone or electronic means, or for the authenticity of such instructions.

* **Normal Daily Activities** for a spouse/domestic partner and child are defined as follows: A spouse/domestic partner or child will not be deemed able to do normal tasks if he or she: a) is a patient in a hospital; or b) is confined at home under the care of a doctor for sickness or injury; or c) has had his or her level of activity significantly reduced so that he or she requires human supervision or assistance to perform any of the following Activities of Daily Living: mobility, transferring, feeding, dressing or toileting, which another person of the same age could normally perform; or d) is receiving any disability benefits from any source due to any sickness or injury.

Sign Here _____ /_____/_____
 TL-006069 (5/97) *Employee's Signature* *Date* *Spouse's/Domestic Partner's Signature* *Date*
 Detach top copy. Fold and staple this copy to conceal health questions. Return both copies to your employer.