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.

CIGNA Group Insurance
Life • Accident • Disability

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 on.

EMPLOYER Oconee Regional Education Service Agency — Wilkinson County

CLASS_______ **LOCATION/PAYCODE #** 7 **DATE OF HIRE**___/___/_____ **ANNUAL SALARY**_________ **VERIFIED BY** ____________

REASON FOR REQUEST: ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **ONGOING ENROLLMENT EVENT** ❑ **LATE ENTRANT**

	BASIC EMPLOYEE	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE
NEW COVERAGE (TOTAL)			
CURRENT COVERAGE			
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE			
AMOUNT SUBJECT TO MEDICAL 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 Number ______________ Sex: ❑ M ❑ F

Important: You must complete the medical questions in this application if you apply for life insurance and as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying more than 31 days after you are initially eligible to elect benefits.

COMPLETE IF ELECTING SPOUSE COVERAGE

I am currently married and my date of marriage is ____________

Spouse Information

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

Birthdate ______________ Sex: ❑ M ❑ F

TERM LIFE INSURANCE — POLICY NO. FLI-960047

Basic Employee-Paid Coverage

Applicant	*Decline*	*Requested Amount*	*Guaranteed Coverage Amount**
Employee	❑	❑ $30,000 of coverage	$30,000

Voluntary Employee-Paid Coverage

Applicant	*Decline*	*Requested Amount*	*Guaranteed Coverage Amount**
Employee	❑	❑ $30,000 of coverage	$30,000
Spouse/Children	❑	❑ Spouse–$1,000 / Child(ren)–$1,000	Spouse–$1,000/Child(ren)–$1,000

** 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. 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.

Insured	*Beneficiary*	*Percentage*	*Social Security #*	*Date of Birth*	*Relationship*
Employee *(Life)*					
Employee *(Accident)*					

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.**

TL-009320
(Class 7 Application) / AR-0511-22558(07/08)

Return application to your employer. Be sure to make a copy for your own records.