

INSURANCE APPLICATION

Life Insurance Company of North America
Philadelphia, PA

For information and
customer service,
call 1-800-732-1603



CIGNA Group Insurance
Life · Accident · Disability

Please print (preferably in black ink).

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must complete this information on the second copy of this form.

EMPLOYER CITY OF ALBANY

CLASS _____ **LOCATION/PAYCODE #** _____ **DATE OF HIRE** ___/___/___ **ANNUAL SALARY** _____ **VERIFIED BY** _____

REASON FOR REQUEST: NEW HIRE INITIAL ENROLLMENT EVENT LATE ENTRANT

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE	VOLUNTARY CHILD
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 () _____ Sex: M F Height: ___ft ___in Weight: ___lbs

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 Height: ___ft ___in Weight: ___lbs

TERM LIFE INSURANCE — POLICY NO. FLX-961405

<i>Applicant</i>	<i>Decline</i>	<i>Requested Amount</i>	<i>Guaranteed Coverage Amount*</i>
Employee	<input type="checkbox"/>	<input type="checkbox"/> Number of \$10,000 units _____	\$50,000
Spouse	<input type="checkbox"/>	<input type="checkbox"/> Number of \$10,000 units _____	\$10,000
Children	<input type="checkbox"/>	<input type="checkbox"/> Number of \$2,000 units _____	\$10,000

* *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.

<i>Insured</i>	<i>Beneficiary</i>	<i>Percentage</i>	<i>Social Security #</i>	<i>Date of Birth</i>	<i>Relationship</i>
Employee (Life)					
Spouse					
Child(ren)					

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 section on the back of this form.

Tear off top copy for your employer before completing reverse side.

