INSURANCE APPLICATION

Life Insurance Company of North America (LINA)
a CIGNA Company (hereinafter 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.

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

EMPLOYER The University of Scranton

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

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

	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 # _____ Sex: ☐ M ☐ F

Important: You must complete the medical questions in this application if you apply for life insurance and: (1) you are a newly hired employee exceeds the Guaranteed Coverage Amount, or (2) you are applying more than 31 days after you are first 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. FLX-960568

Voluntary Employee-Paid Coverage

Applicant	Decline	Requested Amount	Guaranteed Coverage Amount*
Employee	☐	☐ Number of $10,000 units _____	See below**
Spouse	☐	☐ 50% of employee's coverage amount	See below***
Child(ren)	☐	☐ $10,000	$10,000

BENEFICIARY

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify other specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all and date a separate sheet of paper using the format below.

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

ACCEPTANCE/DECLINATION

I accept the insurance coverage elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary 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 proof of insurability at my own expense and th6 (latem I witer datCxr)5.8.8.8.t my own

Applicant's Name _____ Social Security # _____

IMPORTANT
Please complete each section that follows if it is needed.
Read the Agreements and Authorization, and Sign and date the form in the space provided.

Complete the employee and spouse section if you (i.e., the Employee) or your spouse are applying for Life Insurance greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee			Spouse		
Height	ft	in	Height	ft	in
Weight		lbs	Weight		lbs

PHYSICIAN SECTION

Employee Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Spouse Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Please indicate your answers for each question by checking the Yes or No box for the question.

SECTION A

Within the last 5 years has the proposed insured been:

x

Applicant's Name _____ Social Security # _____