

**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.

**Important:** Please enter all dates in mm/dd/yyyy format.

<b>EMPLOYER USE (MANDATORY DATA NEEDED):</b> In order to process this application, the employer must complete this information.		
<b>EMPLOYER</b>	The City of San Rafael	
<b>CLASS</b>	<b>LOCATION/PAYCODE#</b>	<b>DATE OF HIRE</b>
<b>REASON FOR REQUEST:</b>	<b>ANNUAL SALARY</b>	<b>VERIFIED BY</b>
<input type="checkbox"/> NEW HIRE <input type="checkbox"/> INITIAL ENROLLMENT EVENT <input type="checkbox"/> ONGOING ENROLLMENT EVENT <input type="checkbox"/> LATE ENTRANT		
	<b>VOLUNTARY EMPLOYEE</b>	<b>VOLUNTARY SPOUSE/DOMESTIC PARTNER</b>
<b>NEW COVERAGE (TOTAL)</b>		
<b>CURRENT COVERAGE</b>		
<b>GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE</b>		
<b>AMOUNT SUBJECT TO MEDICAL EVIDENCE</b>		

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: (1) as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying more than 31 days after you are eligible to elect benefits; (2) you were eligible under the prior plan and enroll or increase your insurance amount(s) above the Guaranteed Coverage Amount.

**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 or Domestic Partner Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Sex:  M  F  
 Information

**TERM LIFE INSURANCE — POLICY NO. FLX-960830**

	<u>Applicant</u>	<u>Decline</u>	<u>Requested Amount</u>	<u>Guaranteed Coverage Amount*</u>
Voluntary Employee-Paid Coverage	Employee	<input type="checkbox"/>	<input type="checkbox"/> Number of \$10,000 units _____	\$200,000
	Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/> Number of \$5,000 units _____	\$25,000
	Child(ren)	<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. If requesting coverage above these amounts (or any amount outside of initial enrollment) you must complete page 3

**BENEFICIARY**

To **specify a beneficiary**, complete the section below. You will be the beneficiary for your spouse/domestic partner 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					
Spouse/Domestic Partner					
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.

**Be sure to make a copy of your application for your own records.**

## ◆ ◆ ◆ AGREEMENTS AND AUTHORIZATION ◆ ◆ ◆

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand 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 not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Insurance Company.
- (4) I must report any change in my health that happens before the insurance is effective.
- (5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

**Authorization.** I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)



**Sign Here**

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Month/Day/Year*

\_\_\_\_\_  
*Spouse/Domestic Partner's Signature*

\_\_\_\_\_  
*Month/Day/Year*

*(If applying for insurance for your spouse/domestic partner)*

**Notice:** Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

TL-009320 (CA)

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

Complete the employee and spouse/domestic partner information in this section if you (i.e., the Employee) or your spouse/domestic partner are applying for Life Insurance that is 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/Domestic Partner		
Height	ft	in	Height	ft	in
Weight		lbs	Weight		lbs

**PHYSICIAN SECTION**

**Employee Physician**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Spouse/Domestic Partner 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:**

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

	Employee		Spouse/ Dom. Part.	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION B**

**Within the last 5 years has the proposed insured:**

A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Smoked cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. For how many years has the proposed insured smoked?	_____		_____	
2. Approximately how many cigarettes are, or were, smoked on average per day?	_____		_____	
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?	_____		_____	
C. Used any controlled or illegal drug or other substance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee, Spouse/Domestic Partner	Medical Condition	Date Occurred	Duration/Treatment Received	Current Status

**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.

**Important:** You must also sign and date the Agreements and Authorization section.

**Fold and staple this page to conceal health questions.**

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