INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Return completed form to Cigna Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Phone: 1-800-732-1603

Life Insurance Company of North America

Employer: Metro Auto Auction

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ___

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

❑ I am currently married and my date of marriage is: _____ or ❑ I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information Name _____ **Social Security #** _____

Birthdate _____ Gender _____

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # SGM 608620		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Benefit: Units of $10,000 up to the lesser of 5 times your salary, and $500,000. Guaranteed Coverage: $100,000	❑ $10,000 ❑ $100,000* ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Benefit: Units of $5,000 up to $100,000. Guaranteed Coverage: $20,000	❑ $5,000 ❑ $20,000* ❑ $100,000** ❑ Other _____ *Amount must be a multiple of $5,000. The amount cannot exceed 50% of the employee's coverage.* ❑ Decline Coverage
Child	❑ $10,000	❑ Decline Coverage

Employee-Paid (Voluntary) Accidental Death & Dismemberment Insurance Policy # SOK 606339		
Applicant		
	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Benefit: Units of $10,000 up to the lesser of 5 times your salary, and $500,000.	❑ $10,000 ❑ $250,000 ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	❑ $250,000	❑ Decline Coverage
Child	❑ $10,000	❑ Decline Coverage

Employee-Paid (Core Buy-Up) Short-term Disability Insurance Policy # SGD 609214 *Your employer provides the Basic coverage above at no cost to you. You have the option to elect the following plan in addition to what your employer provides.*		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee	Benefit: 60% of your weekly covered earnings to maximum of $1,000 per week.	❑ Accept Coverage ❑ Decline Coverage

Employee-Paid (Core Buy-Up) Long-term Disability Insurance Policy # SGD 609215 *Your employer provides the Basic coverage above at no cost to you. You have the option to elect the following plan in addition to what your employer provides.*		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee	Benefit: 60% of your monthly covered earnings to maximum of $5,000 per month.	❑ Accept Coverage ❑ Decline Coverage

**This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during this open enrollment.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latter of 01/01/2018 or the date the insurance company approves your application.

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Cigna's approval and 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 go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to disability insurance only): "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Please Sign Here ☛ Signature _____ Date _____

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. If there is not enough room to specify all beneficiaries, attach, sign and date a separate page using the format below.

BENEFICIARY SECTION

Voluntary Term Life Insurance Policy# SGM 608620					
Insured	**Beneficiary Name**	**Relationship**	**Social Security #**	**Date of Birth**	**Percentage** *(must equal 100% for each insured)*
Employee	1.				
	2.				
Spouse					
Child(ren)					

Voluntary Accidental Death & Dismemberment Insurance Policy# SOK 606339					
Insured	**Beneficiary Name**	**Relationship**	**Social Security #**	**Date of Birth**	**Percentage** *(must equal 100% for each insured)*
Employee	1.				
	2.				
Spouse					
Child(ren)					

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____

Employee Signature _____ Date _____

EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA), a Cigna company (herein called the Insurance Company)
P.O. Box 20310
Lehigh Valley, PA 18003-9924

For info and customer service, call 1-800-732-1603.
• All information must be completed by the applicant.
• He/she must sign and date this form.
• This form cannot be considered unless received within 30 days of the date it is dated.
• The Insurance Company must approve your request for insurance before it becomes effective.
• Be sure to make a copy for your records.

Important: *Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink).*

EMPLOYER **Metro Auto Auction** **POLICY** **SGM 608620**

MANDATORY DATA NEEDED: In order to process this application, this information must be completed and returned to Cigna P.O. Box 20310 Lehigh Valley, PA 18003-9924 Fax: 1-800-440-0856

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

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

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE OR DOMESTIC PARTNER
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

EMPLOYEE SECTION

Employee Name: _____

Home Address _____ City _____ State _____ Zip _____

Gender: _____ **Birthdate** _____ **Social Security #** _____
Month/Day/Year

Day Phone _____ Evening Phone _____

COMPLETE IF ELECTING SPOUSE OR DOMESTIC PARTNER COVERAGE

Spouse or Domestic Partner Name _____

Home Address _____ City _____ State _____ Zip _____

Gender _____ Birthdate _____ Social Security # _____
Month/Day/Year

Day Phone _____ Evening Phone _____

❑ I am currently married and my date of marriage is _____

❑ I am currently eligible under the insurance plan as a Domestic Partner*

** In order to be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or any required Domestic Partner Affidavit on file with your employer, and accepted by the Insurance Company. If you do not currently have a state-registered Domestic Partnership, or a Domestic Partner Affidavit on file with your employer, an Affidavit should be requested from and will be made available to you through your employer.*

Employee Name _____ **Social Security #** _____

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

SECTION A

Complete the employee information in this section if you (i.e., the Employee) are:

- applying for Life insurance for yourself that is greater than the guaranteed issue amount, or
- applying for Life insurance for yourself more than 31 days after you were eligible for the insurance.

Complete the spouse/Domestic Partner information if:

- applying for Life insurance for your spouse/Domestic Partner that is greater than the guaranteed issue amount, or
- applying for Life insurance for him/her more than 31 days after the spouse/Domestic Partner was eligible for the Life insurance.

Height and Weight Information

Employee	**Spouse or Domestic Partner**
Height ft. in.	Height ft. in.
Weight lbs.	Weight lbs.

SECTION B

Please indicate your answers for each question in this section by checking the Yes or No box for the question. The questions in Section C must also be answered.

Within the last 5 years has the proposed insured been:

a) diagnosed with any of the conditions shown in this Section,
b) told by a medical professional he/she has or may have any of the conditions shown in items A through F below,
c) or been treated by a medical professional for any of the conditions shown in items A through F below?

	Employee		**Spouse or Dom. Part.**	
	Yes	**No**	**Yes**	**No**
A. A heart attack or stroke?	❑	❑	❑	❑
B. Cancer (other than Non-melanoma Skin Cancer), Hodgkin's disease, or Leukemia?	❑	❑	❑	❑
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	❑	❑	❑	❑
D. HIV Infection or AIDS?	❑	❑	❑	❑
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	❑	❑	❑	❑
F. Alcohol or drug abuse or dependency?	❑	❑	❑	❑

Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑	❑	❑

AGREEMENTS

To the best of my knowledge and belief all written, telephonic and electronic information 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 must report any change in my health that happens before the insurance is effective.
3. I must report any change in the health of my spouse or Domestic Partner for whom coverage is requested that happens before the insurance is effective.
4. Requested insurance above any guaranteed issue amount will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Employee Name _____ **Social Security #** _____

AUTHORIZATION

I hereby authorize any physician, medical professional, hospital or other medical facility, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity, the Medical Information Bureau (MIB) or any other person or organization to provide access to or copies of any medical records or other information, including motor vehicle driving record, relating to me, my spouse or domestic partner, to my employer's Plan Administrator and to their authorized representatives including Life Insurance Company of North America. I understand that this information may include, but is not limited to, information concerning: mental illness, psychiatric, substance abuse or use, disability, HIV testing and illness, Acquired Immune Deficiency Syndrome, and genetic testing, but does not include psychotherapy notes. If my employer, union, group association sponsors any other plans, whether or not underwritten or administered by Life Insurance Company of North America, or its affiliates, the information and/or records obtained may also be shared with the underwriting company insurer or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

I understand that the information will be used to assess my request for insurance. It may only be used for the purposes stated above if the information is re-disclosed. Any information provided to a third-party as permitted by this Authorization may not be re-disclosed by that third-party without my Authorization or unless allowed or required by law.

This authorization will remain in effect for a period of Two (2) years. If I wish to obtain a copy of this Authorization, I and/or my authorized agent may receive a copy upon request.

I am aware that I may cancel this authorization at any time by written notice to the Insurance Company at the address at the top of this Application form. If I cancel this Authorization, it will not: (1) change any action taken in reliance on the Authorization up to that date; or (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 information disclosed under this authorization by the recipient is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). The Insurance Company is subject to the Gramm-Leach-Bliley Act and state privacy laws. The Insurance Company may not disclose protected information except as permitted by those laws or as authorized by me.

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 material fact thereto, commits a fraudulent insurance act.*

Sign Her _____ _____ _____

Employee's Signature *Month/Day/Year* *Spouse or Domestic Partner's Signature* *Month/Day/Year*

(If applying for insurance for your spouse or 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.