

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: City of Kent

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 _____ 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 # FLX 968146		
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 6 times your salary, or \$500,000. Guaranteed Coverage: \$300,000	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$300,000* <input type="checkbox"/> \$500,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$10,000.</i> <input type="checkbox"/> Decline Coverage
Spouse	Benefit: Units of \$10,000 up to \$300,000. Guaranteed Coverage: \$50,000	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$50,000* <input type="checkbox"/> \$300,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$10,000. The amount cannot exceed 100% of the employee's coverage.</i> <input type="checkbox"/> Decline Coverage
Child	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	Maximum Coverage**: \$10,000 <input type="checkbox"/> Decline Coverage

**This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during your enrollment period.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on 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.

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.

Voluntary Term Life Insurance Policy# FLX 968146					
Insured	Beneficiary Name	Relationship	Social Security #	Date of Birth	Percentage <i>(must equal 100% for each insured)</i>
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 _____

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