Term Life Insurance Change Form

Life Insurance Company of North America
Philadelphia, PA

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

CIGNA Group Insurance
Life · Accident · Disability

EMPLOYER USE (MANDATORY DATA NEEDED): In order for the insurance company to process this application, the employer must complete this information.

EMPLOYER_____ **POLICY #**_____

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

REASON FOR REQUEST: ☐ **LIFE STATUS CHANGE** ☐ **ONGOING ENROLLMENT EVENT** ☐ **REINSTATEMENT**

	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 (First)_____ (Last)_____ Social Security #_____ Birthdate _____

Address_____ City_____ State_____ Zip_____

Work Phone _____ Home Phone _____ Sex: ☐ M ☐ F Height: _____ft _____in Weight: _____lbs

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

I WISH TO MAKE THE FOLLOWING CHANGES TO MY LIFE INSURANCE COVERAGE

See your life insurance brochure/application for the coverage election options for your plan. When selecting new coverage amounts, please ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application.

CHECK THE APPROPRIATE BOXES:

☐ ***Increase, decrease or begin coverage on the following individuals as indicated below:***
(Complete the medical questions on the next page for each person electing or increasing coverage)

	Current **Voluntary Coverage**	***New*** **Voluntary Coverage**	***Total*** **Voluntary Coverage**
☐ Employee			
☐ Spouse			
☐ Child(ren)			

Answer if your plan includes smoker/non-smoker rates:

Have you smoked or used any form of tobacco in the last 12 months? Employee: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

☐ ***Life Status Change***

If this change is being made due to a Life Status Change, please check one of the following, and provide date of change.

☐ Marriage ☐ Divorce ☐ Annulment ☐ Legal Separation ☐ Birth or Adoption of a Child ☐ Death of a Spouse or Child ☐ Leave of Absence
☐ Change in Spouse's Employment ☐ Return to or from Military Duty ☐ Change from full to part-time (or vice-versa)

Date of Life Status Change _____

☐ ***Cancel coverage on the following individuals:***

☐ Employee ☐ Spouse ☐ Child(ren) Effective Date of Cancellation _____

☐ ***Cancel the Automatic Increase Option***

☐ ***Name Change: (Current Name / New Name)***

☐ Employee_____/_____

☐ Spouse _____/_____

Employee Signature _____ Date _____

Return to your employer. Be sure to make a copy of your form for your own records.

EVIDENCE OF INSURABILITY FORM

Name _____ **Social Security #**_____

IMPORTANT: COMPLETE THE MEDICAL QUESTIONS BELOW, IF YOU APPLY FOR/INCREASE LIFE INSURANCE: (1) EXCEEDING THE GUARANTEED COVERAGE AMOUNT, OR (2) DUE TO A REINSTATEMENT OF COVERAGE.

During the last five years, has the proposed insured been diagnosed with or received treatment by/from a member of the medical profession for any of the conditions listed in questions below?

	Employee		Spouse		Child/ren	
	Yes	No	Yes	No	Yes	No
A. Cysts, moles, warts, polyps, cancer or tumor?	☐	☐	☐	☐	☐	☐
B. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease or disorder of the heart or circulatory system?	☐	☐	☐	☐	☐	☐
C. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver, gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or disorder of the respiratory tract?	☐	☐	☐	☐	☐	☐
D. Any alcohol and/or drug addiction and/or substance abuse; mental, emotional or any other nervous disorders?	☐	☐	☐	☐	☐	☐
E. Is there a current use of prescribed medications by the proposed insured?	☐	☐	☐	☐	☐	☐
F. Ever been diagnosed with or been treated for AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	☐	☐	☐	☐	☐	☐
G. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions A through F?	☐	☐	☐	☐	☐	☐
H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease/disorder of the nervous system?	☐	☐	☐	☐	☐	☐
I. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease or disorder of the back, spine, muscles, bones or joints?	☐	☐	☐	☐	☐	☐
J. Any surgical operation performed or been advised to have any performed?	☐	☐	☐	☐	☐	☐
K. Ever been in a hospital or sanitarium for rest, treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions A through J?	☐	☐	☐	☐	☐	☐

Use the space below to provide details for "Yes" answers given above and/or medical impairments listed in questions A-K. Complete and attach a separate sheet of paper if additional space is required. Please sign and date the attachment.

Name of Employee/Spouse/Child(ren)	*Medical Condition*	*Date Occurred*	*Duration/ Treatment Received*	*Current Status*

◆◆ AGREEMENTS ◆◆

To the best of my knowledge and belief, all written, telephonic and electronic information I provided is true and complete. I also understand that the insurance I have selected for myself will begin on the effective date, provided I am actively at work on that date. If I am not, the effective date of my personal coverage, as well as dependent coverage, will be delayed until I am actively at work. Also, if any one of my dependents to be insured is not performing normal daily activities* on the effective date, that coverage will be delayed until the date the dependent resumes normal daily activities. I understand that insurance subject to medical questions requires insurance company approval, and additional medical information, including blood work, may be required to approve such insurance. I understand that I am responsible to report to the insurance company any change in my health prior to my coverage effective date, and that no coverage will be effective unless I meet the insurance company's underwriting requirements on the effective date.

* ***Normal Daily Activities*** for a spouse and child are defined as follows: A spouse or child will not be deemed able to do normal tasks if he or she: a) is a patient in a hospital; or b) is confined at home under the care of a doctor for sickness or injury; or c) has had his or her level of activity significantly reduced so that he or she requires human supervision or assistance to perform any of the following Activities of Daily Living: mobility, transferring, feeding, dressing or toileting, which another person of the same age could normally perform; or d) is receiving any disability benefits from any source due to any sickness or injury.

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.*

Authorization: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of me or my health to give any such information to Life Insurance Company of North America and its authorized representatives and reinsurers, for use in the processing and evaluation of my application and eligibility for life or disability insurance coverage. This authorization extends to and includes information or records pertaining to psychiatric, drug or alcohol use history.

This authorization shall be valid for a period of 30 months from the date signed, and a photographic copy shall be as valid as the original. I understand that my authorized representative or I have the right to receive a copy of the authorization upon request. I understand that this authorization may be revoked provided such revocation is in writing. However, such revocation will not affect any action taken in reliance on the authorization. I further understand that this authorization is being given as a condition of obtaining insurance, and that any revocation does not affect the insurer's right to use this authorization in connection with the contest of a claim or of the policy in accordance with applicable law.

Information provided pursuant to this authorization may be redisclosed by the recipient and no longer subject to the protections of the Health Insurance Portability and Accountability Act. (The insurance companies are subject to the Gramm-Leach-Bliley Act and state privacy laws and do not disclose any protected information except as permitted by those laws.)

Please Sign Here _____ ____/____/____ _____ ____/____/____

Employee's Signature *Date* *Spouse's Signature* *Date*

(If applying for insurance for your spouse)

TL-006069 (5/97)

Print Reset Form

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 insurers' privacy practices is available upon request.

Fold and staple to conceal health questions. Return to your employer.