EVIDENCE OF INSURABILITY FORM

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)
For info and customer service call 1-866-607-2360.

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Return completed form to
Cigna Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Fax: 1-800-440-0856
BethlehemMail@cigna.com

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

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

EMPLOYER Mississippi Development Authority

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		

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

In order to confirm your election, please provide your signature: _____ Date _____

COMPLETE IF ELECTING SPOUSE COVERAGE

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

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

Birthdate _____ Sex: ☐ M ☐ F

LIFE INSURANCE – POLICY NO. – FLX 967252

☐ I accept the Life insurance coverage provided by the Company's Group Insurance Plan. If premiums are to be paid by payroll, I authorize my employer to deduct the needed amounts from my earnings.

Sign Here Signature _____ Date _____
Month/Day/Year

DISABILITY INSURANCE (EMPLOYEE ONLY) — POLICY NO(S). STD: VDT 962082 LTD: VDT 962083

☐ I accept the STD insurance plan provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

☐ I accept the LTD insurance plan provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

Sign Here Signature _____ Date _____
Month/Day/Year

Pre-Existing Condition Limitation: "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.

Fold and staple to conceal health questions. Return application to the above address. Be sure to make a copy for your own records.

TL-009320

Name _____ Social Security #_____

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 information in this section if you (i.e., the Employee) or your Spouse 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			
Height	ft	in	Weight lbs	Height	ft	in	Weight lbs

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 Yes	Employee No	Spouse Yes	Spouse No
A. A heart attack or stroke?	❑	❑	❑	❑
B. Cancer (other than Nonmelanoma 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?	❑	❑	❑	❑
Questions G through 1 are applicable to Disability Insurance Only				
G. Anxiety disorder, Bipolar Disorder or Depression?	❑	❑		
H. Chronic Fatigue, Fibromyalgia or Multiple Sclerosis?	❑	❑		
I. Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?	❑	❑		
1. Has the proposed insured been diagnosed as pregnant within the past 10 months, or been treated for pregnancy?	❑	❑		
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	❑	❑	❑	❑

***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.*

♦ ♦ ♦ 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's Signature* *Month/Day/Year*
(If applying for insurance for your Spouse)

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.

Return to the above address. Be sure to make a copy for your own records.

TL-009320