Mississippi Development Authority

INSURANCE APPLICATION

Life Insurance Company of North America (LINA)
a CIGNA Company (herein called the Insurance Company)

EMPLOYER USE (MANDATORY DATA NEEDED): In order to process this application, the employer must provide this information.			
EMPLOYER Mississippi Development Authority			
CLASS 1	**DIVISION #** 1	**DATE OF HIRE** ______	**ANNUAL SALARY** ______

REASON FOR REQUEST: ☐ NEW HIRE ☒ INITIAL ENROLLMENT EVENT ☐ ONGOING ENROLLMENT EVENT ☐ LATE ENTRANT ☐ LIFE STATUS CHANGE

EMPLOYEE SECTION

❑ Mr. ❑ Mrs. ❑ Ms. (Check One)

Employee Name ____________ Social Security # ______ Birth date ______

Address ____________ City ______ Zip ______

Work Phone ( ) ______ Home Phone ( ) ______ Employee ID Number ______ Sex: ______

COMPLETE IF ELECTING SPOUSE COVERAGE

I am currently married and my date of marriage is ______

Spouse Information Name (First) ______ (Last) ______ Social Security # ______

Birth date ______ Sex: ❑ M ❑ F

VOLUNTARY TERM LIFE

Voluntary Employee-Paid Coverage

Applicant	***Decline***	***Accept: Monthly Deduction.***	
Employee Units	❑	❑$10,000	$
		❑$60,000	$
		❑$130,000	$
		❑$	
Children Units	❑	❑$10,000	$2.00

	Decline	***Accept: Monthly Deduction***	
Spouse Units	❑	❑$5,000	$
		❑$30,000	$
		❑$	

** 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. Guaranteed Coverage Amount is only available to Spouse and Children, as long as they are not confined (at home, in a hospital, or in any other care facility) at the time that coverage is effective.*

SHORT TERM DISABILITY

Applicant	***Benefit Amount***	***Monthly Deduction***	***Weekly Benefit***
Employee	❑ 60% of Weekly Income	$	$

❑ 14 Day Elimination Period Plan
❑ 30 Day Elimination Period Plan
❑ 60 Day Elimination Period Plan

❑ I decline Short Term Disability Coverage

LONG TERM DISABILITY

Applicant	***Benefit Amount***	***Monthly Deduction***	***Monthly Benefit***
Employee	❑ 60% of Monthly Income	$	$

❑ 180 Day Elimination Period

❑ I decline Long Term Disability Coverage

Beneficiary Designations				
Employee's Primary Beneficiary(ies):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Contingent(s):	**Relationship to Employee**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Voluntary Term Life, Life Insurance Company of North America				
Spouse's Beneficiary(ies):	**Relationship to Spouse**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
Voluntary Term Life Insurance, Life Insurance Company of North America				
Children's Beneficiary(ies):	**Relationship to Child**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**

ACCEPTANCE/DECLINATION

I accept/decline the insurance coverage 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.

I certify that I have read the completed application and that I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

To the best of my knowledge and belief all written 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. 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.

Pre-Existing Condition Limitation (Applies to Short & Long-Term Disability Insurance only): 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. "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.

Please Sign Here Signature ______________________________ Date ____________________