Term Life Insurance Change Form

CIGNA Life Insurance Company of New York
New York, NY

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 Pace University **POLICY #** FLY 960224

CLASS 1 **LOCATION/PAYCODE #** 001 **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 _____

TY-009175 (NY)

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 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 family members' coverage will not go into effect unless the family member is not confined in a hospital or institution, or receiving certain medical treatment. These conditions 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) My child may need to take medical tests. The results of those tests must be reported to the Insurance Company.
(5) I must report any change in my health that happens before the insurance is effective.
(6) I must report any change in the health of a child for whom coverage is requested that happens before the insurance is effective.
(7) 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.

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. This is a crime subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.*

Authorization: I permit Named Parties with any records or knowledge of personal info, medical history, mental or physical condition, diagnosis or treatment of me and my children to give such info to the Insurance Company, its authorized agents or its reinsurers. "Named Parties" are: licensed practitioners, hospitals, clinics, Veterans Administration or medically related facilities, insurance companies, employers, or other organizations, institutions or persons. This permission 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 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. They do not disclose protected information except as permitted by those laws).

Please Sign Here _____ *Employee's Signature* ____/____/____ *Date* _____ *Spouse's Signature (If applying for insurance for your spouse)* ____/____/____ *Date*

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.

Print Reset Form

TY-009175 (NY)

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