

INSURANCE APPLICATION

CIGNA Life Insurance Company of New York
a CIGNA Company (herein called the Insurance Company)
 For info and customer service call 1-800-732-1603.



CIGNA Group Insurance
 Life • Accident • Disability

- All info must be completed by the applicant.
- He/She must sign and date this form.
- This form cannot be considered unless received within 30 days of the date it is dated.
- The Insurance Company must approve your request for insurance before it becomes effective.

Important: Please enter all dates in mm/dd/yyyy format

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

EMPLOYER <u>Pace University</u>			
CLASS <u>1</u>	LOCATION/PAYCODE# _____	DATE OF HIRE _____	ANNUAL SALARY _____
REASON FOR REQUEST: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> INITIAL ENROLLMENT EVENT <input type="checkbox"/> LATE ENTRANT			
	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 _____ Social Security # _____ Birthdate _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____ Sex: M F Height: ___ ft. ___ in. Weight: ___ lbs

Important: You must complete the medical questions in this application if you apply for life insurance: (1) as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying more than 31 days after you are eligible to elect benefits; (2) you were eligible under the prior plan and enroll or increase your insurance amount(s) above the Guaranteed Coverage Amount.

COMPLETE IF ELECTING SPOUSE COVERAGE

I am currently married and my date of marriage is _____

Spouse Name (First) _____ (Last) _____ Social Security # _____
 Information Birthdate _____ Sex: M F Height: ___ ft ___ in Weight: ___ lbs

TERM LIFE INSURANCE — POLICY NO. FLY-960224

	<u>Applicant</u>	<u>Decline</u>	<u>Requested Amount</u>	<u>Guaranteed Coverage Amount*</u>
Voluntary Employee-Paid Coverage	Employee	<input type="checkbox"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 times salary	<i>the lesser of 1 times your salary or \$400,000</i>
	Spouse	<input type="checkbox"/>	<input type="checkbox"/> \$10,000	<i>\$10,000</i>
	Child(ren)	<input type="checkbox"/>	<input type="checkbox"/> \$ 5,000	<i>\$5,000</i>

*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.

ACCIDENT INSURANCE — POLICY NO. YOK-960238

I select the following insurance amount: _____ Employee Benefit Amount: 1 2 3 times salary

BENEFICIARY

To **specify a beneficiary**, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

Insured	Beneficiary	Percentage	Social Security #	Date of Birth	Relationship
Employee (Life)					
Employee (Accident)					

ACCEPTANCE/DECLINATION

I accept the insurance coverages 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.

Signature _____ Date _____

Please Sign Here

Important: You must also sign and date the Agreements and Authorization section.

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

	Employee		Spouse/		Child/ren	
	Yes	No	Yes	No	Yes	No
In the past five years, has the proposed insured been diagnosed with, or treated for, any condition listed below?						
A. Cysts, moles, warts, polyps, cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any alcohol and/or drug addiction and/or substance abuse; mental, emotional or any other nervous disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Is there a current use of prescribed medications by the proposed insured?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Any illness, injury, birth or congenital defect, disease or disorder not mentioned in questions A through F?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or other disease disorder of the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Any surgical operation performed or been advised to have any performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

<i>Name of Employee/Spouse</i>	<i>Medical Condition</i>	<i>Date Occurred</i>	<i>Duration/Treatment Received</i>	<i>Current Status</i>

◆ ◆ 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.

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).



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.