INSURANCE APPLICATION

Life Insurance Company of North America
Philadelphia, PA

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

CIGNA

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 Bennington College Corporation

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

REASON FOR REQUEST: ❑ **NEW HIRE** ❑ **INITIAL ENROLLMENT EVENT** ❑ **LATE ENTRANT**

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE/ DOMESTIC. PARTNER.	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/DOMESTIC PARTNER COVERAGE

☐ I am currently married and my date of marriage is _____ *–or–* ☐ I currently have an eligible Domestic Partner

Spouse or Domestic Partner Information

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

Birthdate _____ Sex: ❑ M ❑ F Height: ___ ft.___ in. Weight: ___lbs

TERM LIFE INSURANCE — POLICY NO. SGM-603284

Voluntary Employee-Paid Coverage

Applicant	***Decline***	***Requested Amount***	***Guaranteed Coverage Amount****
Employee	❑	❑ Number of $10,000 units _____	$120,000
Spouse/Domestic Partner	❑	❑ Number of $10,000 units** _____	$30,000
Child(ren)	❑	❑ $10,000	$10,000

**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.*

***A Spouse's Life Insurance Benefits cannot exceed 100% of the Employee's Voluntary Life Insurance Benefits.*

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)*					
Spouse/Domestic Partner					
Child(ren)					

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 section on the back of this form.**

Tear off a copy for your employer before completing reverse side. ***Be sure to make a copy for your own records.***

COMPLETE A-G IF APPLYING FOR LIFE INSURANCE ABOVE THE GUARANTEED COVERAGE AMOUNT. COMPLETE A-K IF APPLYING FOR LIFE OR DISABILITY INSURANCE MORE THAN 31 DAYS AFTER YOU ARE INITIALLY ELIGIBLE, OR AFTER YOUR ENROLLMENT PERIOD.

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/ Dom. Part.		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 forAIDS-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 diseaseldisorder 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/Domestic Partner	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

♦ ♦ AGREEMENTS ♦ ♦

***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.)

☛

Sign Here

Employee's Signature	*Month/Day/Year*	*Spouse/Domestic Partner's Signature* *(If applying for insurance for your spouse/domestic partner)*	*Month/Day/Year*

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.

TL-006069

Detach top copy. Fold and staple this copy to conceal health questions. Return both copies to your employer.