

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.



Offered by Life Insurance
Company of North America

Employer: City of Scottsdale

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ Social Security # _____ Birthdate _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____ Employee ID # _____ Gender: _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

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

**My Spouse/
Domestic Partner's
Information** Name _____ Social Security # _____
 Birthdate _____ Gender _____

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # VTL 000468		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of \$10,000 up to the lesser of 5 times your salary, or \$300,000.	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$300,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$10,000.</i> <input type="checkbox"/> Decline Coverage
Spouse	Units of \$10,000 up to \$150,000.	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$150,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$10,000.</i> <input type="checkbox"/> Decline Coverage
Child	Units of \$2,000 up to \$10,000.	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$10,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$2,000.</i> <input type="checkbox"/> Decline Coverage

****This is the maximum amount that you can choose under this plan.**
 All coverage elected during this enrollment period will take effect on the latest of 07/01/2021, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and 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 go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by AZ: Life Insurance Company of North America.

Please Sign Here  Signature _____

Date _____

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Created on 03/2022.

EVIDENCE OF INSURABILITY FORM



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

For info and customer service call

- The applicant must sign and date this form.
 - This form cannot be considered unless received within 30 days of the date it is dated.
- Important: Please enter all dates in mm/dd/yyyy format.

PO Box 20310
Lehigh Valley, PA 18003

Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.

Employer: _____ Policy: _____
 Class: _____ Location: _____ Date of Hire: _____ Annual Salary: _____ Verified By: _____
 Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) _____

VOLUNTARY COVERAGE	EMPLOYEE AMOUNT	SPOUSE* AMOUNT
1. Enter Requested Coverage Amount (Total)		
2. Enter Current Coverage including guarantee issue (enter zero if no current coverage)		
3. Subtract Line #2 from Line # 1, this is the amount subject to Underwriting		

EMPLOYEE SECTION

Employee Name (first, middle, last) _____ Social Security # _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ ID # _____ Birthdate _____ Gender: M F

COMPLETE IF ELECTING SPOUSE* COVERAGE

I am currently married and my date of marriage is: _____ -or- I currently have an eligible Domestic Partner
 Spouse* Name: (first, middle, last) _____ Social Security # _____
 Phone _____ Birthdate _____ Gender: M F

IMPORTANT
 Please complete each section that follows.
 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	Height	ft.	in.	Weight	lbs.
Spouse*	Height	ft.	in.	Weight	lbs.

PHYSICIAN SECTION

Employee Physician Name _____ Phone Number _____
 Street Address _____ City _____ State _____ Zip _____
 Spouse*: Physician Name _____ Phone Number _____
 Street Address _____ City _____ State _____ Zip _____

Name _____

Social Security # _____

Section A: Please indicate your answers for each question in this section by checking the Yes or No box for the question.				
1. Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the conditions:	Employee		Spouse*	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B: Please indicate your answers for each question in this section by checking the Yes or No box for the question.				
1. Within the last 5 years has the proposed insured:	Employee		Spouse*	
	Yes	No	Yes	No
A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Smoked cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. For how many years has the proposed insured smoked?				
2. Approximately how many cigarettes are, or were, smoked on average per day?				
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C. Used any controlled or illegal drug or other substance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any questions above, please provide details in the table below.

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee, Spouse*	Medical Condition	Date Occurred	Duration/Treatment Received	Current Status

AGREEMENTS AND AUTHORIZATION

To the best of my knowledge and belief all written, telephonic and electronic information 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, 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.)

**For purposes of this form, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions.*

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.

 **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.