



New Benefit for UPSEU Members
North American Insurance Trust
Voluntary Group Term Life Insurance



Below is a brief description of your Voluntary Life Insurance coverage with Cigna Group Insurance.

EMPLOYEE:

- Classification: All eligible, full-time employees (17.5 hours or more) who are members of the union and work for a UPSEU employer on a regular basis.
- Amount of Insurance: Increments of \$10,000 to a maximum of \$250,000
- Guaranteed Issue: **\$50,000.00** - New applications only, all increases in coverage subject to underwriting.
- Reduction: To 50% at Age 65. Benefits terminate at age 70.

PORTABILITY of coverage is available at Retirement or Termination.

SPOUSE:

- Amount of Insurance: Up to 50% of the employee's coverage election to a maximum of \$100,000 and a minimum of \$10,000.
- Guaranteed Issue: \$20,000.00 - Spouse must be performing normal daily activities, not confined to home or hospital.
- Reduction: Same as employee.

CHILD:

- Eligibility: Ages 14 days to 19 years old (25 if a fulltime student). Child must be performing normal daily activities, not confined to home or hospital.
- Guaranteed Issue: All amounts are guarantee issue.
- Amount of Insurance: \$2,500, \$5,000, or \$10,000 per child.

NOTE:

No medical questions required up to \$50,000 for eligible members (20,000 for spouse), during the initial enrollment period.

Return Completed Application to:
The D.B.L. Center, Ltd.
555 Broadhollow Road, Suite 271
Melville, NY 11747
631-293-5100

Only the group policy contains all terms and provisions of coverage.

Cigna Group Insurance



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OTHER FEATURES: *Portability*
 Disability waiver prior to age 60
 Accelerated Death Benefits
 Common Carrier provision

VOLUNTARY LIFE RATES

<u>Age of Employee</u>	<u>Monthly Rate Per \$1,000</u>	
Up to Age 29	\$0.07	
30 to 34	\$0.09	
35 to 39	\$0.12	
40 to 44	\$0.19	
45 to 49	\$0.32	
50 to 54	\$0.54	
55 to 59	\$0.85	
60 to 64	\$1.31	
65 to 69	\$2.36	
 Child(ren):	 \$2,500	 \$.50/month
	\$5,000	\$1.00/month
	\$10,000	\$2.00/month

Sample Calculation:	A 44 year-old employee wants \$50,000 for himself, \$20,000			
Smoke Free Environment	for his spouse (also age 44) and \$5,000 for his children:			
	# of 1,000			
Employee	50	x	\$0.19	Rate per \$1,000 = \$ 9.50
Spouse	20	x	\$0.19	Rate per \$1,000 = \$ 3.80
Children	5	x	\$1.00(1)	Rate per unit = \$ 1.00
Total cost per month:				\$ 14.30
	*\$1.00 is the rate for dependent children coverage regardless of the number of dependent children being covered.			

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EMPLOYEE APPLICATION FOR TERM LIFE INSURANCE

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



ENROLLMENT

- Initial Enrollment
- Late Applicant

CHANGE

- Increase Coverage
- Terminate Coverage

- Add Dependant
- Reduce Coverage

- Address Change
- Name Change

EMPLOYER NAME: _____

EMPLOYEE SECTION

- Mr. Mrs. Ms. (select one)

Employee Name: _____ Social Security # _____

Age: _____ Birthdate: ____/____/____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex (select one): M F

VOLUNTARY LIFE INSURANCE

EMPLOYEE

Amount of Coverage Applied for (multiples of \$10,000 to a max of \$250,000) \$ _____

INCREASE/DECREASE

Increase/Decrease Coverage to (multiples of \$10,000 to a max of \$250,000): \$ _____

SPOUSE

Amount of Coverage Applied for (multiples of \$10,000 to a max of \$100,000, not to exceed 50% of Employee's amount): \$ _____

INCREASE/DECREASE

Increase/Decrease Coverage to (multiples of \$10,000 to a max of \$100,000, not to exceed 50% of Employee's amount): \$ _____

DEPENDENT CHILDREN:	
<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$10,000	

COMPLETE THIS SECTION IF ELECTING SPOUSE COVERAGE

I am currently married and my date of marriage is: ____/____/____

Spouse Name (Last, First): _____

Social Security # _____ Birthdate: ____/____/____ Sex (select one): M F

BENEFICIARY

To specify a beneficiary, complete 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, please attach, sign, and date a separate sheet of paper using the format below:

BENEFICIARY	BIRTHDATE	SSN	RELATIONSHIP	% OF BENEFIT

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 day, 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: _____

(Important: You must also sign and date the Agreements and Authorizations section)

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

Date of Hire: _____ Annual Salary: _____ Group Insurance Eligibility Date: _____ Verified by: _____

EMPLOYEE NAME: _____ SOCIAL SECURITY # _____

Important: You must complete the medical questions in this application if: (1) as a newly hired employee you apply for life insurance exceeding the Guaranteed Coverage Amount, or life insurance more than 31 days after you are eligible to elect benefits; or (2) you are currently insured under the prior life insurance plan and elect to increase your current insurance amount(s); or (3) you were eligible but did not enroll for insurance under the prior life insurance plan.

HEIGHT, WEIGHT, AND OTHER INFORMATION

Employee Height: _____ft. _____in. Weight: _____lbs

Spouse (if applicable) Height: _____ft. _____in. Weight: _____lbs

Please indicate your answers for each question in this section by checking the Yes or No box.

1. Within the last 5 years, has the proposed insured been a) diagnosed with any of the conditions shown in items A through F or b) told by a medical professional that he/she has or may have any of the conditions shown in items A through F:

	Employee	Spouse
A. A heart attack or stroke?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. HIV infection or AIDS?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Alcohol or drug abuse or dependency?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Within the last five years, has the proposed insured had a Driving While Intoxicated (DWI) or a Driving Under the Influence (DUI) conviction?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files for an insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of information concerning any fact material thereto, commits a fraudulent insurance act.

AGREEMENTS AND AUTHORIZATIONS

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 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 the 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, of me or my children 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.)

Employee Signature: _____ Date (M/D/YY): _____

Spouse Signature (If applying for insurance): _____ Date (M/D/YY): _____



ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION
Automatic Withdrawals for Insured Installments



I authorize Thomas E. Mestmaker Insurance & Assoc. Inc., on behalf of Cigna Group Insurance to withdraw from my checking account the minimum amount due for my insurance as designated on my application for life insurance. This authority will remain in effect until I provide Cigna Group Insurance notice in writing of my desire to cancel this arrangement.

Note: Policy Effective date will be first of the month following the date eligibility requirements have been met.

POLICY/ACCOUNT HOLDER INFORMATION	
Policy/Account Holder's Name	Policy and/or Account Number
Complete Mailing Address	Telephone Number

FINANCIAL INSTITUTION INFORMATION	
Please attach a voided check AND complete the following information.	
Name of Financial Institution	Financial Institution Telephone Number
Checking Account Routing Number	Checking Account Number
<small>*Routing numbers are always 9 digits long</small>	<small>*Please include all zeros that may precede the account number</small>

(copy of voided check)

When completed, return this form along with your application to:

Return Completed Application to:

**The D.B.L. Center, Ltd.
555 Broadhollow Road
Melville, NY 11747
631-293-5100**

Policy/Account Holder Signature

Date