

New Enrollee Coverage Change

PART I (Complete using dark ink)

EMPLOYEE NAME (Please Print) LAST FIRST MI			PHONE NUMBER () () ()		
RESIDENCE ADDRESS		STREET		CITY STATE ZIP CODE	
SOCIAL SECURITY NUMBER		BIRTHDATE Mo Da Yr		SEX M F	
		PLACE OF BIRTH		ANNUAL SALARY \$	
NAME OF EMPLOYER PROVIDING INSURANCE			OCCUPATION		
			DATE OF EMPLOYMENT		
SPOUSE NAME (If applying for coverage)			SOCIAL SECURITY NUMBER		PLACE OF BIRTH
			BIRTHDATE Mo Da Yr		SEX M F

SELECT VOLUNTARY LIFE INSURANCE
Select amount in \$10,000 increments to a maximum of \$300,000.

Employee Yes No Employee \$ _____
Spouse Yes No Spouse \$ _____

Spouse coverage may not exceed 100% of Employee's benefit amount.

Complete Part II of this form.
 The beneficiary designation made for Basic Life Insurance will apply unless you complete a separate beneficiary designation for Voluntary Select Life. Employee is the beneficiary of any Spouse or Child coverage.

VOLUNTARY AD&D INSURANCE

Yes No
Principal Sum \$ _____

Employee Only Plan Family Plan

Select amount in \$25,000 increments to a maximum of \$300,000.
 Select Employee Only or Family coverage.
 If a husband and wife are both employees, only one may select the Family Plan.

VOLUNTARY LIFE INSURANCE FOR CHILDREN Yes No

Select Amount
Employee \$2,000 \$4,000 \$6,000 \$8,000 \$10,000
Spouse \$2,000 \$4,000 \$6,000 \$8,000 \$10,000

You or your Spouse must be approved for Select Voluntary Life Insurance coverage in order for your Dependent Children to be enrolled.
 Complete Part II for Dependent Children only if application is being made AFTER your initial 31-day eligibility period

Important Note: If you are increasing, decreasing or adding coverages, you only need to check boxes for coverages you are changing. Coverages remaining the same need not be checked.

VOLUNTARY SHORT TERM DISABILITY INSURANCE

Yes No

Select benefit amount in \$50 increments from \$100 to \$500, not to exceed 60% of basic weekly earnings.
\$ _____

STD benefits will be paid weekly.
 New STD plans and increases in weekly benefits are subject to a pre-existing condition exclusion.
 Enrollment will require prior approval of evidence of insurability if the minimum participation requirements for this coverage are not attained.

VOLUNTARY LONG TERM DISABILITY INSURANCE

Yes No

Select benefit amount in \$100 increments from \$300 to \$5,000, not to exceed 60% of basic monthly earnings.
\$ _____

LTD benefits will be paid monthly.
 New LTD plans and benefit increases are subject to a pre-existing condition exclusion and integration with other benefits.
 Enrollment will require prior approval of evidence of insurability if the minimum participation requirements for this coverage are not attained.

TIER II – ACTIVITIES OF DAILY LIVING RIDER
Available only if offered by your employer and with the purchase of disability benefits.

Monthly Benefit Amount (select one): \$500 \$1,000 \$1,500 \$2,000 None

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance effective date; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) I must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB or other organization, institution or person that has any records or knowledge of me or my health to give the Regence Life and Health Insurance Company or its reinsurers any such information (including information about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases). This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a copy of the Notice of Information Practices.

Insurance Fraud Warning: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits. If your answers on this application are incorrect or untrue, Regence Life and Health Insurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

Employee SignatureDateSpouse Signature (if applying for coverage)Date

PART II

Complete all spaces/answer Yes or No to all questions for yourself, your spouse and your dependent child(ren). If you are not applying for spouse/dependent children coverage, you do not need to answer questions for them. Circle all conditions which apply and provide details below.

Employee Height _____ Weight _____	Spouse Height _____ Weight _____	Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____	Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____						
Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____		Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; text-align:center;">EMPLOYEE</td> <td style="width:33%; text-align:center;">SPOUSE</td> <td style="width:33%; text-align:center;">CHILDREN</td> </tr> <tr> <td colspan="3" style="font-size: small;">If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.</td> </tr> </table>	EMPLOYEE	SPOUSE	CHILDREN	If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.		
EMPLOYEE	SPOUSE	CHILDREN							
If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.									
1. Have you used cigarettes or other tobacco products in the last 2 years?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						
2. Are you pregnant? If "YES", give expected delivery date and describe any complications.		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						
3. Within the past 5 years, have you been medically counseled or treated for, or been told by a medical practitioner that you had: high blood pressure; any disease or defect of the heart or blood vessels; diabetes; albumin, blood or sugar in the urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disorder of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder; any immunodeficiency?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						
4. Within the past 5 years have you been treated for or diagnosed as having or advised to take a diagnostic test for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						
5. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						
6. Are you presently receiving any treatment by a medical practitioner or taking any medication?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						
7. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						
8. Have you ever been rated, declined, postponed or limited in any way for life, health, accident, or sickness insurance?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N						

9. Name and address of **your** personal physician:

10. Name and address of your **spouse's** personal physician:

Date last seen and reason:

Date last seen and reason:

IMPORTANT: Provide details of all 'YES' answers given to questions stated above. If additional space is required, attach a separate signed and dated sheet.

Question Number & Individual	Illness/Reason for Checkup or Physician's Treatment/Consultation	Dates From To	Full Name & Complete Address of Attending Physician or Other Practitioner

Regence

Life and Health Insurance Company

100 SW Market Street
P.O. Box 1271 E-3A
Portland, Oregon 97207-1271
(503) 721-7161 • (800) 794-5390

INFORMATION PRACTICES NOTICE

(Retain with your insurance records)

Thank you for enrolling for Group Insurance with Regence Life and Health Insurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. Regence Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Regence Life and Health Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Before submitting this application:

- **Please sign and date the Authorization and Acknowledgement section of Part I.**
- **Please complete Part II in full if you are applying for Voluntary Life, STD and/or LTD coverage.**
- **Please have your Spouse sign and date the Authorization in Part I of this form if your Spouse is applying for coverage.**
- **Please retain the Information Practices Notice that accompanies this form for your records.**