VOLUNTARY BENEFITS ENROLLMENT FORM

P.O. Box 1271 MS E3A
Portland, OR 97207-1271

☐ **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
Lincoln County School District (OR 000322)		

SPOUSE NAME (If applying for coverage)	SOCIAL SECURITY NUMBER	BIRTHDATE Mo Da Yr	SEX M F	PLACE OF BIRTH

VOLUNTARY LIFE INSURANCE

Employee ☐ Yes ☐ No Employee $ _____
Select amount in $10,000 increments to a maximum of $500,000.

Spouse ☐ Yes ☐ No Spouse $ _____
Select amount in $10,000 increments to a maximum of $250,000.

☒ Complete Part II of this form if:

- You are an Employee who is enrolling within 31 days of your initial eligibility date for an amount of coverage in excess of $50,000.
- You are a Spouse who is enrolling within 31 days of your initial eligibility date for an amount of coverage in excess of $10,000.
- You are an Employee or a Spouse who is enrolling for any amount of coverage, including the amounts shown above, more than 31 days after your initial eligibility.

☒ 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.

MONTHLY LIFE RATES PER $1,000 OF COVERAGE FOR EMPLOYEE/SPOUSE

AGE	RATES	AGE	RATES
Under 25	$.057	55-59	$.554
25-29	$.061	60-64	$.753
30-34	$.070	65-69	$1.078
35-39	$.085	70-74	$1.668
40-44	$.12	75+	$2.550
45-49	$.207		
50-54	$.353		

VOLUNTARY LIFE INSURANCE FOR CHILDREN ☐ Yes ☐ No

Select Amount

☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000

The monthly rate is $.14 per $2,000, regardless of the number of children in the family. Voluntary Life coverage is available for children from birth to age 23, or 26 if a full-time student. 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.

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 or other organization, institution or person that has any records or knowledge of me or my health to give the LifeMap Assurance 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 Privacy Notice.

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, LifeMap Assurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

▶ _____ _____
Employee Signature Date

▶ _____ _____
Spouse 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 ☐M ☐F Height Weight	Child Name (first/last) _____ Date of Birth:_____Gender ☐M ☐F Height Weight
Child Name (first/last) _____ Date of Birth:_____Gender ☐M ☐F Height Weight		Child Name (first/last) _____ Date of Birth:_____Gender ☐M ☐F Height Weight	If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.

	EMPLOYEE	SPOUSE	CHILDREN
1. Have you used cigarettes or other tobacco products in the last 2 years?	☐Y ☐N	☐Y ☐N	☐Y ☐N
2. Are you pregnant? If "YES", give expected delivery date and describe any complications.	☐Y ☐N	☐Y ☐N	☐Y ☐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?	☐Y ☐N	☐Y ☐N	☐Y ☐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)?	☐Y ☐N	☐Y ☐N	☐Y ☐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?	☐Y ☐N	☐Y ☐N	☐Y ☐N
6. Are you presently receiving any treatment by a medical practitioner or taking any medication?	☐Y ☐N	☐Y ☐N	☐Y ☐N
7. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	☐Y ☐N	☐Y ☐N	☐Y ☐N
8. Have you ever been rated, declined, postponed or limited in any way for life, health, accident, or sickness insurance?	☐Y ☐N	☐Y ☐N	☐Y ☐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

PRIVACY NOTICE

We, at LifeMap, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. Because we endeavor to earn and keep your trust, we have long-standing privacy policies, robust training, and full-time staff dedicated to protecting privacy. We also maintain physical, administrative, and technical safeguards to protect your personal information from unauthorized access. Even if you are no longer a LifeMap member, we protect the confidentiality of your personal information as if you were.

Marketing
While other companies may sell or rent your contact information, LifeMap never sells or rents your personal information for marketing purposes. If you want LifeMap to share your personal information with a nonaffiliated third party so the third party can market to you, you must give us your express permission.

Your Personal Information
We collect personal information such as your name, contact information, health information, and financial information from you, your providers, and other insurers that provide coverage to you. We use this information to provide services to you and to conduct insurance transactions. You may receive a copy of your personal information by contacting us at the phone number or address below. We will not disclose your personal information unless we are permitted or required by law or you give your permission. As permitted or required by law, we may provide personal information to our affiliates and agents, reinsurers, insurance administrators, consultants, or regulatory and governmental authorities. We obligate entities receiving this information on our behalf to protect it in the same way that we protect it.

Changes to Our Practices
We may change our privacy practices in an effort to provide even better protection. If we change our privacy practices in a material way, we will notify current customers in writing.

Contact Us
If you have any questions about our privacy program, you may contact us at (800) 794-5390 or write to:

LifeMap Privacy Official
P.O. Box 1071, Mailstop E12B
Portland, OR 97207

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 Select Voluntary Life.**
- **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 Privacy Notice that accompanies this form for your records.**