Life Insurance Company of North America

Personal Accident Insurance

POLICYHOLDER

Hospital Employee Benefit Association Trust

POLICY NO.

OK-961075

Complete the following to enroll:

Employer Name _____

Full Name _____ Date of Birth _____ Social Security # _____

Address _____
STREET CITY STATE ZIP

Employment Date _____ Occupation or Job Title _____

❑ Dependent Status Change _____

❑ Beneficiary Change _____

Select Coverage Option: ❑ Employee and Family ❑ Employee Only

Total Cost $ _____ /per Month

My Benefit Amount $ _____ (units of $10,000)

If you select coverage for your family, benefits for family members will be a percentage of yours.

My Beneficiary _____ Relationship _____
PRINT FULL NAME(S)

You will be your family members' beneficiary unless you tell us otherwise in writing. Benefits will not be paid to your Domestic Partner if he or she is not specifically designated.

I enroll and authorize my employer to deduct the premiums from my earnings. I understand that the insurance selected will begin on the effective date as described in the brochure. If I am not actively at work, or my family members are not actively at work, or they are unable to engage in all the usual duties of a person of like age and sex, the effective date of coverage will be delayed until the individual returns to work, or the family member resumes usual duties.

Signature _____ Date _____

❑ **DECLINATION** — Check here and sign above if you do not want this coverage.

CIGNA Group Insurance
Life · Accident · Disability

TL-007112
PM-801232 (Enrollment Form-Class 1) / AR-0511-22588

Return to your employer. Be sure to make a copy for your records.