Term Life Insurance Change Form

Life Insurance Company of North America (LINA)
a CIGNA Company (herein called the Insurance Company)
For info and customer service call 1-800-732-1603.
• The applicant must sign and date this form.
• This form cannot be considered unless received within 30 days of the date it is dated.

CIGNA Group Insurance
Life · Accident · Disability

Reset Form

Important: *Please enter all dates in mm/dd/yyyy format.*

EMPLOYER USE (MANDATORY DATA NEEDED): In order for the insurance company to process this form, the employer must complete this information.

EMPLOYER City and County of Broomfield **POLICY #** FLX 962091

CLASS_____ **LOCATION/PAYCODE #** _____ **DATE OF HIRE**_____ **ANNUAL SALARY**_____ **VERIFIED BY** _____

REASON FOR REQUEST: ❑ **LIFE STATUS CHANGE** ❑ **ONGOING ENROLLMENT EVENT** ❑ **REINSTATEMENT** ❑ **LATE ENTRANT**

	VOLUNTARY EMPLOYEE	VOLUNTARY SPOUSE
NEW COVERAGE (TOTAL)		
CURRENT COVERAGE		
GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE		
AMOUNT SUBJECT TO MEDICAL EVIDENCE		

Please print (preferably in black ink).

EMPLOYEE SECTION

❑ Mr. ❑ Mrs. ❑ Ms. (Check One)
Employee Name (First)_____ (Last)_____ Social Security #_____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Work Phone _____ Home Phone _____ Employee ID Number _____ Sex: ❑ M ❑ F

COMPLETE IF ELECTING SPOUSE COVERAGE

Spouse Information

❑ I am currently married and my date of marriage is _____
Name (First)_____ (Last)_____ Social Security #_____
Birthdate _____ Sex: ❑ M ❑ F

I WISH TO MAKE THE FOLLOWING CHANGES TO MY LIFE INSURANCE COVERAGE

See your life insurance brochure/application for the coverage election options for your plan. When selecting new coverage amounts, please ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application.

CHECK THE APPROPRIATE BOXES:

❑ ***Increase, decrease or begin coverage on the following individuals as indicated below:***
(Complete the medical questions on the next page if you are electing or increasing coverage for yourself or your spouse.)

	Current **Voluntary Coverage**	***New*** **Voluntary Coverage**	***Total*** **Voluntary Coverage**
❑ Employee			
❑ Spouse			
❑ Child(ren)			

Answer if your plan includes smoker/non-smoker rates:
Have you smoked or used any form of tobacco in the last 12 months? Employee: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

❑ ***Life Status Change***

If this change is being made due to a Life Status Change, please check one of the following, and provide date of change.

❑ Marriage ❑ Divorce ❑ Annulment ❑ Legal Separation ❑ Birth or Adoption of a Child ❑ Death of a Spouse or Child ❑ Leave of Absence
❑ Change in Spouse's Employment ❑ Return to or from Military Duty ❑ Change from full to part-time (or vice-versa)

Date of Life Status Change _____

❑ ***Cancel coverage on the following individuals:***

❑ Employee ❑ Spouse ❑ Child(ren) Effective Date of Cancellation _____

❑ ***Cancel the Automatic Increase Option***

❑ ***Name Change: (Current Name / New Name)***

Employee_____/_____
Spouse _____/_____

Reminder: If you'd like to designate new beneficiaries, please complete a Beneficiary Form.

ACCEPTANCE / DECLINATION

I accept the insurance coverage(s) chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the needed amounts from my earnings.

Sign Here Signature_____ Date _____
Month/Day/Year

****You MUST read and sign the Agreements and Authorization Section.****

Fold and staple to conceal health questions. Return to your employer. Be sure to make a copy for your own records.

Name _____ Social Security #_____

IMPORTANT
Please complete each section that follows if it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse info in this section if you (i.e., the Employee) or your spouse are applying for/increasing Life Insurance: (1) exceeding the guaranteed amount, or (2) due to a reinstatement.

Height and Weight Information

Employee	Spouse
Height ft in	Height ft in
Weight lbs	Weight lbs

PHYSICIAN SECTION

Employee Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

Spouse Physician

Name _____ Phone No. _____

Street Address _____ City _____ State _____ Zip _____

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

SECTION A

Within the last 5 years has the proposed insured been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

	Employee Yes	Employee No	Spouse Yes	Spouse 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?	❑	❑	❑	❑
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑	❑	❑
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	❑	❑	❑	❑
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑	❑	❑
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	❑	❑	❑	❑
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	❑	❑	❑	❑
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	❑	❑	❑	❑
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑	❑	❑
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑	❑	❑
J. Alcohol or drug abuse or dependency?	❑	❑	❑	❑

SECTION B

Within the last 5 years has the proposed insured:

A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑	❑	❑
B. Smoked cigarettes:	❑	❑	❑	❑
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?	❑	❑	❑	❑
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?	❑	❑	❑	❑
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?	❑	❑	❑	❑
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?	❑	❑	❑	❑

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	*Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

Caution: *It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.*

****You MUST read and sign the Agreements and Authorization Section.****

Fold and staple to conceal health questions. Return to your employer. Be sure to make a copy for your own records.

Name _____ **Social Security #** _____

✦✦✦ AGREEMENTS AND AUTHORIZATION ✦✦✦

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 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.)

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Sign Here _____ *Employee's Signature* _____ *Month/Day/Year* _____ *Spouse's Signature (If applying for insurance for your spouse)* _____ *Month/Day/Year*

Reset Form PRINT