

EVIDENCE OF INSURABILITY FORM FOR DISABILITY INSURANCE

**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.*



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	<u>Jackson State University</u>	POLICY #	<u>VDT961421</u>
OCCUPATION		LOCATION/PAYCODE	
ANNUAL SALARY		DATE OF HIRE	
AMOUNT TO BE UNDERWRITTEN		VERIFIED	
REASON FOR REQUEST:	<input type="checkbox"/> LATE ENTRANT	<input type="checkbox"/> LIFE STATUS CHANGE	<input type="checkbox"/> ONGOING ENROLLMENT EVENT

Please print (preferably in black ink).

EMPLOYEE INFORMATION			
Name (First)		(Last)	(Middle Initial)
Social Security #		Employee ID Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address	Apt #	City	State Zip
Day Phone	Evening Phone	Birthdate (Mo/Day/Year)	

ACCEPTANCE/DECLINATION

In order to confirm your election, you must provide a signature for Life Insurance Company of North America.

Signature _____ Date _____ (Mo/Day/Year)

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

Complete the employee info in this section if you (i.e., the Employee) are applying for Disability Insurance more than 31 days after you are eligible.

Height and Weight Information

Employee	Height	ft	in	Weight	lbs
----------	--------	----	----	--------	-----

PHYSICIAN SECTION

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

	Employee	
	Yes	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?	<input type="checkbox"/>	<input type="checkbox"/>
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>
K. Any condition affecting hearing or vision, including any loss of sight or hearing, or dizziness or Vertigo?	<input type="checkbox"/>	<input type="checkbox"/>
L. Carpal Tunnel Syndrome; neck, back, knee or joint condition, strain, sprain or other type of injury?	<input type="checkbox"/>	<input type="checkbox"/>
M. Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?	<input type="checkbox"/>	<input type="checkbox"/>
N. Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or Temporomandibular Joint (TMJ) Disease?	<input type="checkbox"/>	<input type="checkbox"/>
O. Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?	<input type="checkbox"/>	<input type="checkbox"/>

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

SECTION B

Within the last 5 years has the proposed insured:

Employee

Yes No

- 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?
 Month _____ Year _____
- 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	Condition	Date Occurred	Duration/Treatment Received	Current Status

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

◆ ◆ ◆ 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. 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 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.)

Pre-Existing Condition Limitation: "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

 _____
Sign Here *Employee's Signature* *Month/Day/Year*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.



Here are some good reasons to think about Disability insurance:

- Over 50% of all personal bankruptcies and mortgage foreclosures are due to disability.¹
- An illness or accident will keep 1 in 5 workers out of work for at least a year during their working careers.²
- Forty-four percent of employees say that they live paycheck-to-paycheck.³
- 30% of working families could live three months or less on their savings if the primary wage earner lost income due to disability.⁴

Disability insurance helps **protect your income** when you can't work due to illness or injury.

For more information on how much disability insurance you need, visit our online calculator at www.CIGNA.com/disabilitycalculator



Products and services are provided by operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Life Insurance Company of North America and CIGNA Life Insurance Company of New York. "CIGNA," and the "Tree of Life logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries.

©2009 CIGNA 7/09

¹ – Health Affairs, the Policy Journal of the Health Sphere, February 2, 2005
² – U.S. Census Bureau, 1997
³ – 6th annual Study of Employee Benefits Trends, MetLife, 2008
⁴ – American Health Insurance Plan Survey 2004

Welcome to
CIGNA Group Insurance, a
subsidiary of CIGNA
Corporation.

We provide Voluntary Long
Term Disability insurance for
Employees of
Jackson State University

Who Needs Disability Insurance?

You do. Single or married.
Buying your first home or
preparing for retirement.
Raising children or sending
them off to college. No matter
where you are in life, insurance
should be part of your financial
plan.

Having adequate insurance
coverage is not only the basis
for a sound financial blueprint; it
also provides the protection you
need to help ensure that your
family, your home and your
finances will be protected.

By purchasing Disability
insurance through your
employer, you benefit from:

- Affordable group rates
- Convenient payroll deduction
- Guaranteed Coverage with no medical questions
- Access to knowledgeable service representatives

This flyer highlights some of the
benefits available to you. For
more information, refer to the
CIGNA Group Insurance Long
Term Disability booklets
available from your employer.



CIGNA Group Insurance
Life • Accident • Disability

Voluntary Long Term Disability for Employees of *Jackson State University*

Benefits

- What is **Disability Insurance**? Paycheck Insurance. If you get sick or hurt and can't perform your job as stated by a doctor, you will get a percentage of your monthly pay (your paycheck). Coverage is available for all full-time Employees of the Employer regularly working the minimum stated number of hours per week. You must be in Active Employment on the Effective Date to be covered if enrolling for the first time.
- **Voluntary LTD:** 60% of Base monthly Salary to a maximum of \$5,000 per month. Payroll Deducted, Post Tax, Tax Free benefit. Provides Full Coverage up to \$ 100,000 a year in income. If you qualify for PERS, then your benefit will be reduced to 50% and your benefit will **NOT** offset with PERS.
- **90 Day Elimination Period.** This is your waiting period before you qualify for benefits (3 Months). You do not have to be completely disabled to qualify and days do not have to be consecutive.
- Provides a benefit **To Age 65.** If older than age 65, it will still pay a benefit, but will be a reduced duration ranging from a year to 5 years.
- CIGNA LTD allows for **partial disabilities**- do not have to be totally disabled to qualify or continue benefits. You can work part-time and still receive a benefit.
- CIGNA's Policy does not **Offset** (Reduce its benefit amount) by any **Individual Disability** coverage a person may have. You can get paid both the CIGNA LTD plan, plus any individual coverage you may have. You will receive the full 60% or 50% benefit despite having Individual coverage.
- If you chose to elect coverage during this enrollment period, you will not have to show proof of good health or complete an evidence of insurability form. You can not be turned down for coverage if you enroll now. If you opt out of the coverage, you will have to supply evidence in the future, and could be turned down.
- There will be a **pre-existing condition limitation** that excludes, for a period of 12 months, coverage for any condition which you were under treatment for or being affected by during the 3 months prior to your effective date. If you were covered under the prior UNUM plan and have been covered for at least 12 months, pre-ex will not apply.

Cost

- The voluntary coverage is entirely Employee paid, which can be made through payroll deductions.

About CIGNA Group Insurance

- CIGNA Group Insurance is a subsidiary of CIGNA Corporation, a benefits company that has been in business for over 200 years. Our company has received a rating of "Excellent" or better from the A.M. Best Company for the past 15 years.

For Complete Plan Details

- This highlight flyer is intended to provide an overview of the benefits available from your employer, and is *not* a complete description of plan provisions. Receipt of this sheet does *not* certify eligibility for benefits under this plan.
- When you become eligible for benefits, your employer will provide you with the CIGNA Group Insurance Long Term Disability booklets containing complete plan details.

Jackson State University
Long Term Disability- 90 Day EP

Salary	
Monthly	Annual
\$1,666.67	\$20,000
\$1,750.00	\$21,000
\$1,833.33	\$22,000
\$1,916.67	\$23,000
\$2,000.00	\$24,000
\$2,083.33	\$25,000
\$2,166.67	\$26,000
\$2,250.00	\$27,000
\$2,333.33	\$28,000
\$2,416.67	\$29,000
\$2,500.00	\$30,000
\$2,583.33	\$31,000
\$2,666.67	\$32,000
\$2,750.00	\$33,000
\$2,833.33	\$34,000
\$2,916.67	\$35,000
\$3,000.00	\$36,000
\$3,083.33	\$37,000
\$3,166.67	\$38,000
\$3,250.00	\$39,000
\$3,333.33	\$40,000
\$3,416.67	\$41,000
\$3,500.00	\$42,000
\$3,583.33	\$43,000
\$3,666.67	\$44,000
\$3,750.00	\$45,000
\$3,833.33	\$46,000
\$3,916.67	\$47,000
\$4,000.00	\$48,000
\$4,083.33	\$49,000
\$4,166.67	\$50,000
\$4,583.33	\$55,000
\$5,000.00	\$60,000
\$5,416.67	\$65,000
\$5,833.33	\$70,000
\$6,250.00	\$75,000
\$6,666.67	\$80,000
\$7,500.00	\$90,000
\$8,333.33	\$100,000

LTD Deductions	
Semi-Monthly	Monthly
\$5.42	\$10.83
\$5.69	\$11.38
\$5.96	\$11.92
\$6.23	\$12.46
\$6.50	\$13.00
\$6.77	\$13.54
\$7.04	\$14.08
\$7.31	\$14.63
\$7.58	\$15.17
\$7.85	\$15.71
\$8.13	\$16.25
\$8.40	\$16.79
\$8.67	\$17.33
\$8.94	\$17.88
\$9.21	\$18.42
\$9.48	\$18.96
\$9.75	\$19.50
\$10.02	\$20.04
\$10.29	\$20.58
\$10.56	\$21.13
\$10.83	\$21.67
\$11.10	\$22.21
\$11.38	\$22.75
\$11.65	\$23.29
\$11.92	\$23.83
\$12.19	\$24.38
\$12.46	\$24.92
\$12.73	\$25.46
\$13.00	\$26.00
\$13.27	\$26.54
\$13.54	\$27.08
\$14.90	\$29.79
\$16.25	\$32.50
\$17.60	\$35.21
\$18.96	\$37.92
\$20.31	\$40.63
\$21.67	\$43.33
\$24.38	\$48.75
\$27.08	\$54.17

Benefit
Monthly
\$1,000.00
\$1,050.00
\$1,100.00
\$1,150.00
\$1,200.00
\$1,250.00
\$1,300.00
\$1,350.00
\$1,400.00
\$1,450.00
\$1,500.00
\$1,550.00
\$1,600.00
\$1,650.00
\$1,700.00
\$1,750.00
\$1,800.00
\$1,850.00
\$1,900.00
\$1,950.00
\$2,000.00
\$2,050.00
\$2,100.00
\$2,150.00
\$2,200.00
\$2,250.00
\$2,300.00
\$2,350.00
\$2,400.00
\$2,450.00
\$2,500.00
\$2,750.00
\$3,000.00
\$3,250.00
\$3,500.00
\$3,750.00
\$4,000.00
\$4,500.00
\$5,000.00

To Figure Exact Cost: Monthly Earnings (not to exceed \$8,333.33) X .0065 = Monthly Cost



CIGNA Group Insurance
Life • Accident • Disability