Evidence of Insurability
Submission

Instructions:

- Print the Evidence of InsurabilityApplication Form
- Print your Benefit Summary Report from the ARS Benefits Website
- Complete and sign the Evidence of Insurability/Insurance Application Form
    - Complete only the sections that apply to the Coverage Elected/ Changed
    - Disregard all sections referencing spouse life insurance, spouse medical history, and spouse signature
- Mail the Evidence of InsurabilityApplication Form Form and the Benefit Summary page to:

  CIGNA Group Insurance
  P.O. Box 20310
  Lehigh Valley, PA 18003-9924

If you have questions, call CIGNA customer service at 1-800-732-1603

EVIDENCE OF INSURABILITY/INSURANCE APPLICATION

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.*

Return completed form to:
Cigna Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Fax: 800-440-0856

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

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

EMPLOYER ARS Acquisition Holdings, LLC

CLASS 1(Life) CLASS STD/LTD DATE OF HIRE ________ ANNUAL SALARY ________ VERIFIED BY ________

REASON FOR REQUEST (LIFE): ☐ NEW HIRE ☐ ONGOING ENROLLMENT EVENT ☐ LATE ENTRANT
REASON FOR REQUEST (STD): ☐ NEW HIRE ☐ LATE ENTRANT
REASON FOR REQUEST (LTD): ☐ NEW HIRE ☐ LATE ENTRANT

	VOLUNTARY EMPLOYEE LIFE
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 ________ Social Security # ________ Birthdate ________
Address ________ City ________ State ________ Zip ________
Work Phone ________ Home Phone ________ Employee ID # ________ Sex: ☐ M ☐ F

Important: You must complete the medical questions in this application if you apply for life or disability insurance and: (1) as a newly hired employee your election exceeds the Guaranteed Coverage Amount, or you are applying for life and disability insurance more than 31 days after you are eligible to elect benefits; (2) you are currently insured under the prior plan and elect to increase your current life or disability insurance amount(s); or (3) you were eligible but did not enroll for life or disability insurance under the prior plan.

TERM LIFE INSURANCE — POLICY NO. FLI-960103

Voluntary Employee-Paid Coverage	Applicant	Decline	Requested Amount	Minimum	Maximum	Guaranteed Coverage Amount*
	Employee	☐	☐ Option 1: $25,000 units________	$25,000	$100,000	$250,000
			☐ Option 2 : $50,000 units________	$150,000	$450,000	
			☐ Option 3: $100,000 units________	$500,000	$1,000,000	
	Spouse	☐	☐ $50,000	$50,000	$50,000	$50,000
	Child(ren)	☐	☐ $10,000	$10,000	$10,000	$10,000

**Guaranteed Coverage Amount is only available during Initial Enrollment and at such other times as identified and outlined in offering materials. Amounts of insurance may be limited by state law.*

Have you smoked cigarettes in the last 12 months? Employee: ☐ Yes ☐ No

ACCIDENT INSURANCE — POLICY NO. OK961575

Voluntary Employee-Paid Coverage

☐ Employee Only ☐ Employee and Family*

Employee Amount: ☐ $100,000 ☐ $200,000 ☐ $300,000 ☐ $400,000 ☐ $500,000 ☐ $600,000 ☐ $700,000

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

DISABILITY INSURANCE (EMPLOYEE ONLY) — POLICY NO(S). STD: LK-750578, LTD: VDT-960348

☐ I am choosing the STD insurance plan provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

☐ I am choosing the LTD insurance plan provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

☛ **Sign Here** Signature ________ Date ________
Month/Day/Year

Pre-Existing Condition Limitation (applicable to disability coverage only): A pre-existing condition is any injury or illness for which you have consulted a physician (or for which a reasonable person would have consulted a physician), received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless you have received no medical treatment, care or services for 12 continuous months after the effective date of your coverage.

ACCEPTANCE/DECLINATION

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

☛ Signature ________ Date ________

Please Sign Here

Important: You must also sign and date the Agreements and Authorization section.

Be sure to make a copy for your own records.

TL-009320

Applicant's 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 information in this section if you (i.e., the Employee) are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee
Height _______ ft _______ in
Weight ________________ lbs

PHYSICIAN INFORMATION (to be completed by the Employee)

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 — Answer Questions A through J for Life Insurance and Questions A through O for Disability Insurance

Within the last 5 years has the proposed insured been:

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

		Employee Yes	Employee 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?	❑	❑

Questions K through O applicable to Disability Insurance Only

		Yes	No
K.	Any condition affecting hearing or vision, including any loss of site or hearing, or dizziness or Vertigo?	❑	❑
L.	Carpal Tunnel Syndrome; neck, back, knee, or joint condition, strain, sprain or other type of injury?	❑	❑
M.	Any bone, joint or muscle condition persisting for, or having been treated for, 6 months or longer?	❑	❑
N.	Fibromyalgia, chronic pain, Chronic Fatigue, Irritable Bowel Syndrome (IBS), Multiple Sclerosis, or Temporomandibular Joint (TMJ) Disease?	❑	❑
O.	Received any form of physical therapy; been seen by a chiropractor or other non-MD medical practitioner or therapist for any reason?	❑	❑

SECTION B — Answer Questions A through F for Life Insurance or Disability Insurance

Within the last 5 years has the proposed insured:

		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?	__________	
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	*Medical 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.*

Important: **You must also sign and date the Agreements and Authorization section.**

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

Applicant's 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. 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 my health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, 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.)

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.

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