

Evidence of Insurability (EVI) Instructions for Supplemental Life and Dependent Life through CIGNA Group Insurance

The following information is **required** to process your application:

- CIGNA Group Insurance Term Life Insurance Change Form (TL-009320 MN)
3 pages
- City of Minneapolis Optional/Dependent Group Term Life Enrollment Form

CIGNA Group Insurance Term Life Insurance Change Form

1. Employee Section: Please complete all sections.
2. Spousal Information: Please complete if electing spousal coverage.
3. Changes: Please indicate if an increase, decrease or beginning coverage.

Do not complete the chart. Benefits staff will complete this information based on your elections on the Group Term Life Enrollment Form.

4. Life Status Change: Please indicate type and date of change.
5. Cancellation of Coverage: Please indicate the individual and date.
6. Name Change: Please indicate current and new name.
7. Employee Signature: Please read and sign the acceptance or declination.
8. Health, Weight and Physician information: Complete the medical questions if you are electing or increasing coverage for yourself or your spouse.
9. Agreements, Authorization and Signatures: Employee signature and date is required.

City of Minneapolis Optional/Dependent Group Term Life Enrollment Form

Incomplete applications may cause a delay in the processing of your request for coverage.

Please keep a copy of the completed applications for your records and forward your completed forms to:

City of Minneapolis
Human Resources - Benefits
Room 100, Public Service Center
250 South 4th Street
Minneapolis, MN 55415-1339

DO NOT RETURN COMPLETED FORMS TO CIGNA Group Insurance

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

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 _____	POLICY # _____			
CLASS _____	LOCATION/PAYCODE # _____	DATE OF HIRE _____	ANNUAL SALARY _____	VERIFIED BY _____
REASON FOR REQUEST: <input type="checkbox"/> LIFE STATUS CHANGE <input type="checkbox"/> ONGOING ENROLLMENT EVENT <input type="checkbox"/> REINSTATEMENT <input type="checkbox"/> 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

I am currently married and my date of marriage is _____

Spouse Information
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.)

	<u>Current</u> Voluntary Coverage	<u>New</u> Voluntary Coverage	<u>Total</u> Voluntary Coverage
<input type="checkbox"/> Employee			
<input type="checkbox"/> Spouse			
<input type="checkbox"/> 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.

 Signature _____ Date _____
Month/Day/Year

Sign Here

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

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

Note: The applicant does not have to disclose the presence of ****bloodborne pathogens** which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as result of performing emergency medical services. See Authorization at ****** for a definition of “bloodborne pathogens” and “emergency medical personnel.”

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		Spouse	
	Yes	No	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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, Tumor, Leukemia, Hodgkin’s Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Smoked cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

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

◆◆◆ AGREEMENTS AND AUTHORIZATION ◆◆◆

To the best of my knowledge 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), Veterans Administration 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 shall be valid for a period of 26 months from the date signed, and a photographic copy shall be as valid as the original. This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as result of performing emergency medical services.) **The term bloodborne pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to Hepatitis B virus (HBV), the Hepatitis C virus (HCV) and the Human Immunodeficiency (HIV) virus. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

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
Spouse's Signature
Month/Day/Year

(If applying for insurance for your spouse)

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.

**CITY OF MINNEAPOLIS
OPTIONAL/DEPENDENT GROUP TERM LIFE ENROLLMENT FORM**

		Upon Application Approval
Employee Name (Last, First, MI)	Employee ID	Effective Date

Listed below are the optional and dependent life insurance coverage options. Once the Benefits Department is notified by the insurance company of your approved application, the appropriate paycheck deduction changes will be made. When making your selection, note the number to the right of each choice (1) and write this number on the 'Option Code' line to the far right.

YOUR OPTIONS

City Optional Life

- | | |
|---|------|
| CIGNA Group Ins. 1x Annual Salary B-Tax | (1) |
| CIGNA Group Ins. 2x Annual Salary B-Tax | (2) |
| CIGNA Group Ins. 3x Annual Salary B-Tax | (3) |
| CIGNA Group Ins. 4x Annual Salary B-Tax | (4) |
| CIGNA Group Ins. 5x Annual Salary B-Tax | (5) |
| CIGNA Group Ins. 1x Annual Salary A-Tax | (6) |
| CIGNA Group Ins. 2x Annual Salary A-Tax | (7) |
| CIGNA Group Ins. 3x Annual Salary A-Tax | (8) |
| CIGNA Group Ins. 4x Annual Salary A-Tax | (9) |
| CIGNA Group Ins. 5x Annual Salary A-Tax | (10) |
| Waive | (W) |

Option Selected

Option Code: _____

B-Tax=Pre-tax deductions
A-Tax=After-tax deductions

City Dependent Life

You must be enrolled in Optional Life in order to enroll in Dependent Life.

- | | | |
|--------------------------------|--------|-----|
| CIGNA Group Ins. \$5,000 A-Tax | \$1.60 | (1) |
| Waive | \$0.00 | (W) |

Option Code: _____

City Dependent Life
DEPENDENT(S) TO BE COVERED

Verification of Non-Smoking Status

This certifies that I have not used tobacco during the past 12 consecutive months and claim the right to enroll for the coverage indicated above at the reduced non-smoker rate applicable to my age bracket.

Signature

Please fill in percent of benefit for primary and contingent beneficiaries. Beneficiaries are considered to be primary unless specified as contingent (CON). The contingent is entitled to the life insurance benefit only in the event the primary beneficiary(s) is deceased at the time of payment. The total of all primary percentages must equal 100% and the total of all contingent percentages must equal 100%.

Dependent/Beneficiary Info	%	%	RELATIONSHIP	DOB	SEX
DEPENDENT/BENEFICIARY NAME	BEN	CON			

Some of the requested information on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13. The data requested allows Benefit staff to verify eligibility and enroll you and your dependents in health plan(s) and allows the plan provider(s) the ability to establish an enrollment record for you and your dependents. You are not required to provide this information, however, failure to do so may result in ineligibility and non-enrollment. This form may be available to City and plan provider employees or agents, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, or to others through subpoena or pursuant to Federal and State law

By my signature below, I authorize the deductions necessary (pre-tax or after-tax as applicable) to ensure coverage under my plan choices as indicated above.

SIGNATURE: _____ DATE: _____

Optional Life Insurance Age-Based Rates

CIGNA Group Insurance	FOR EMPLOYEES COVERAGE PER \$1,000 OF OPTIONAL TERM LIFE INSURANCE	
	For Employees Classified As Smokers on the Employer's Record	For Employees Classified As Non-Smokers on the Employer's Record
Your Age as of January 1		
Less than age 25	\$.06	\$.043
Age 25 but less than 30	.06	.043
Age 30 but less than age 35	.068	.068
Age 35 but less than age 40	.085	.077
Age 40 but less than age 45	.136	.094
Age 45 but less than age 50	.230	.170
Age 50 but less than age 55	.417	.298
Age 55 but less than age 60	.646	.417
Age 60 but less than age 65	1.003	.706
Age 65 but less that age 70	1.165	1.148
Age 70 and over	2.168	1.828

- You may elect 1, 2, 3, 4 or 5 times your annual earnings. Optional life insurance contributions for any month will be based upon your age and salary as recorded in HRIS, as of the first day of each calendar year. (Negotiated Union contract pay changes **effective for January 1st** may change the amount of coverage and premium deduction during the year.)
- Dependent Life insurance is \$1.60 per dependent unit (family) per month and covers a legal spouse and dependent children to age 19 for \$5,000.00 each. (Newborns 14 days to 6 months are covered for \$500.00.) You must elect Optional Life insurance in order to enroll in Dependent life coverage.

EXAMPLE OF PREMIUM CALCULATION:

Employee age 41, non-smoker, with an annual salary of \$36,000, enrolled for 2 times their annual salary in coverage.

$\$36,000 \times 2 = \$72,000$ of coverage, divided by $\$1000 = 72$
 Non-smoker rate for age 41 is $\$.094 \times 72$ (thousands) = \$ 6.77 per month

Your Salary \$_____ x (1, 2, 3, 4 or 5) = \$_____ (rounded to next \$1000), divided by \$1000 = \$_____ (thousands) x rate from chart above (smoker or non-smoker) = \$_____ estimated monthly premium.

Pre-tax premium deductions can result in an IRS required imputed income calculation that may decrease tax savings that normally occur with pre-tax premium deductions. In general you will do better with pre-tax deductions if you are under age 60 with less than 3 times your salary in coverage.

Pre-tax enrollments cannot be changed until the end of the year. Increases are subject to Evidence of Insurability application and insurance carrier approval.