

Company Use Only		
	Employee	Spouse
Approved:	<input type="checkbox"/>	<input type="checkbox"/>
Declined:	<input type="checkbox"/>	<input type="checkbox"/>
Effective:	_____ / _____	
By:	Date: _____	

LifeWise Assurance Company
P.O. Box 2272, Seattle, WA 98111-2272



Voluntary Life Insurance Enrollment Form

PART A

Employee Name: Last _____ First _____ Middle _____			Birthdate: _____ / _____ / _____		Female: <input type="checkbox"/> Male: <input type="checkbox"/>
Coverage Amount Selected: Employee Benefit: \$ _____		Spouse Benefit: \$ _____		Child Benefit: \$ _____	
					<input type="checkbox"/> Initial application <input type="checkbox"/> Increase in coverage
Employer Name _____			Group Number _____		Division: _____
EMPLOYEE Home Address: _____					Social Security Number: _____
Employee Occupation: _____			Date of Hire: _____		Work Hours per Week: _____
Spouse Name: Last _____ First _____ Middle _____			Birthdate: _____ / _____ / _____		Social Security Number: _____
Beneficiary for Employee Coverage/Relationship: <small>(Employee is beneficiary for spouse coverage.)</small>			Mailing Address: _____		
Name _____ / _____ Relationship _____					
Attach a separate sheet if more space is required. In Community Property states, 50% of the payable benefit will be paid to the spouse unless the spouse signs a notarized statement waiving the rights to these proceeds.					
I hereby apply for voluntary life insurance under the provisions of the Group Policy for which I am eligible and authorize deductions from my wages to cover the cost of the insurance.					
Date: _____ / _____ / _____ Signature: _____					

IF YOU ARE DECLINING COVERAGE, YOU MUST SIGN BELOW AND RETURN THIS FORM TO YOUR EMPLOYER. DO NOT COMPLETE PART B.

WAIVER OPTION

I acknowledge that I have been offered Voluntary Life Insurance issued by my employer. I hereby wish to waive my right to be insured under this plan. I am aware that I must furnish evidence of insurability satisfactory to LifeWise Assurance Company, at my own expense, if I should apply at a later date.

Date: _____ Signature: _____

Employee retain bottom copy. Return remaining copies to LifeWise Assurance Company

PART B

This section to be completed only if requesting amounts over the Guarantee Issue Amount, requesting an increase in insurance, or if you are a late enrollee. If you are declining coverage, do not complete this section.

Name and address of the Doctor or facility that has your medical records: _____		Employee's Doctor: _____		Spouse's Doctor: _____	
Address: _____		Address: _____		Address: _____	
Employee: Height: _____ Weight: _____		Spouse: Height: _____ Weight: _____			
Have you gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds. <small>(Explain)</small>		Have you gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount <input type="checkbox"/> gained or <input type="checkbox"/> lost: _____ pounds. <small>(Explain)</small>			
Annual Salary: \$ _____					

Check yes or no for each of these questions and give details for any "yes" answers after Item #5. Attach a separate sheet if more space is required.

	Employee		Spouse		
	YES	NO	YES	NO	
1. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you now under regular medical observation or taking medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Within the last five years, have you consulted a physician for any disease or injury, or have you had or been advised to have any surgical operation or diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. To the best of your knowledge, have you had or been told you had an Immune Deficiency Disorder (AIDS), or the AIDS Related Complex (ARC), or tests results indicating exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Please check either "yes" or "no" if you or your spouse ever had or been told that you had any of the following. (Indicate if applicable to you or your spouse.)					
	YES	NO	YES	NO	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, Albumin or Sugar in the Urine	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Disorder of the stomach, intestines or liver	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis or Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumors	<input type="checkbox"/>	<input type="checkbox"/>
			Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Back Disorder	<input type="checkbox"/>	<input type="checkbox"/>

EE or Sp	CONDITION	DATE	REMAINING EFFECTS	PHYSICIAN'S FULL NAME AND ADDRESS

I have read the statements on this application and agree that the above answers are complete and true to the best of my knowledge and belief. I acknowledge receipt and understanding of the "Notice of Exchange of Information" explained on the back of this form. I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give LifeWise Assurance Company or its reinsurers any such information. A photographic copy of this authorization shall be valid as the original.

Date: _____ / _____ / _____ Employee Signature: _____

Date: _____ / _____ / _____ Spouse Signature (if applying for coverage) _____

NOTICE OF EXCHANGE OF INFORMATION

Thank you for enrolling for Voluntary Group Life Insurance with LifeWise Assurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. LifeWise Assurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit organization of life insurance companies which operates as information exchange in behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston Massachusetts 02112, telephone number (617) 426-3660.

LifeWise Assurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.