

**VIP LIFE**  
**A VOLUNTARY LIFE INSURANCE PROGRAM**  
**FOR EMPLOYEE AND SPOUSE**

The following Voluntary Life Insurance Program is available for you and your spouse. This coverage is in addition to your basic group life insurance and is purchased through payroll deduction.

You may select coverage up to \$300,000 in increments of \$10,000. Your spouse does not need to select the same amount of coverage. In addition, all your dependent children are insured automatically. When both the insured employee and spouse have coverage, dependent children's benefits will be provided under both coverages.

Coverage may be requested at any time. To apply or increase amounts of coverage, the applicant needs to complete the enrollment application and health statement on the reverse side. You will be contacted if additional information is required. You will be notified of the effective date upon approval of your application by Regence Life and Health Insurance Company.

Benefits under this Voluntary Life Insurance Program will not be paid for death resulting from suicide, intentionally self-inflicted injury, or any attempt to injure oneself, while sane or insane, during the first two years of coverage.

You must be enrolled in your employer's basic group life insurance plan to be eligible.

Voluntary Life Insurance premium is determined by the applicant's age as set forth below:

**MONTHLY RATE PER \$10,000 OF COVERAGE**

<u>Age</u>	<u>Rate</u>	<u>Age</u>	<u>Rate</u>	<u>Age</u>	<u>Rate</u>
Under 30	\$1.00	50 - 54	\$ 7.00	75 - 79	\$ 65.40
30 - 34	1.10	55 - 59	12.10	80 - 84	100.70
35 - 39	1.40	60 - 64	14.00	85 - 89	154.50
40 - 44	2.40	65 - 69	24.50	90 - 94	237.80
45 - 49	4.20	70 - 74	42.80	95 & Over	391.00

The Voluntary Life Benefit will reduce as follows:

<u>Age</u>	<u>Percentage of Original Face Amount</u>
Less than 70	100%
70-74	65%
75-79	45%
80-84	30%
85-89	20%
90-94	15%
95 and over	10%

All benefits terminate when the insured employee is no longer eligible or retires. Conversion and waiver of premium privileges are included.

When coverage for an insured employee and/or spouse is approved, dependent children are covered for the following:

<u>Children's Coverage</u>	<u>Amount of Coverage</u>
Birth to 6 mos.	\$1,000 or 5% of insured's face amount, whichever is less
6 mos. to 23 years	5% of insured's face amount

**INSTRUCTIONS FOR ENROLLMENT**

1. Employee and Spouse must each fill out a separate Evidence of Insurability application.
2. The applicant must sign the Evidence of Insurability application.
3. For Employee coverage, the beneficiary designation made for the Basic Life Insurance will apply unless the Employee completes a separate beneficiary designation for Voluntary Life. For any Spouse coverage, the Employee will be the beneficiary.
4. Seal this form in a confidential envelope and return to your employer.

**EVIDENCE OF INSURABILITY**

GROUP NO.	THIS APPLICANT IS: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse	EMPLOYEE NAME & SOCIAL SECURITY NO.	<input type="checkbox"/> New Coverage <input type="checkbox"/> Increasing Coverage		APPLICATION IS MADE FOR: (Indicate total Voluntary Life Amt. requested) \$ _____
NAME OF APPLICANT		ADDRESS (Street - City - State - Zip Code)			PHONE NUMBER ( ) ( ) ( )
DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY NO.	SEX M   F	HEIGHT	WEIGHT
APPLICANT'S OCCUPATION		NAME OF EMPLOYER PROVIDING INSURANCE		HIRE DATE	SALARY
FULL NAME & ADDRESS OF YOUR REGULAR PHYSICIAN				DATE LAST CONSULTED – give details below	

**Give details for any "YES" answers below.**

- YES  NO
- During the last five years, have you been absent from work more than five consecutive working days because of illness or injury?
  - Are you now under regular medical observation or taking medical treatment or any kind of medication?
  - Within the last five years, have you consulted a physician for any disease, injury or mental or emotional condition? Have you had or been advised to have any surgical operation or diagnostic test?
  - Are you pregnant? **If "YES," give expected delivery date and describe any complications.**
  - Do you use tobacco products? If "NO," have you ever used tobacco products?  Yes  No  
Date Stopped \_\_\_\_\_
  - Within the last ten years, have you been treated for or diagnosed as having any immune deficiency?
  - Within the last ten years, have you been treated for or diagnosed as having or advised to take a diagnostic test for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?
  - Within the last ten years, have you been diagnosed or treated for any of the following:
 

<input type="checkbox"/> YES	<input type="checkbox"/> NO		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Lung Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or Related Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	Back Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis or Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or Albumin or Sugar in the Urine	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Disorder of the Stomach or Intestines or Liver	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or Defects

CONDITION	DATE	REMAINING EFFECTS	PHYSICIAN'S FULL NAME & ADDRESS

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my knowledge and belief, to be true and complete. I understand that: (a) the insurance applied for shall not take effect until the application is approved; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) I must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my coverage would become effective, my coverage will not begin until the day I return to work.

**Authorization to Release Information:** I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any records or knowledge of me or my health to give the Regence Life and Health Insurance Company or its reinsurers any such information (including information about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases). This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a copy of the Notice of Information Practices.

**Insurance Fraud Warning:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

If your answers on this application are incorrect or untrue, Regence Life and Health Insurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

\_\_\_\_\_  
 Employee Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Spouse Signature (if applicant)

\_\_\_\_\_  
 Date

## **INFORMATION PRACTICES NOTICE**

(retain with your insurance records)

Thank you for enrolling for Group Insurance with Regence Life and Health Insurance 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. Regence Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Regence Life and Health Insurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.