

Company name _____ Account number _____

A. Employee Information

Your name (last, first, middle initial) _____ Social security number _____

Address (street or P.O. box) _____ City _____ State _____ ZIP code _____

Date of birth _____ male _____ female _____ single _____ married _____ Phone number _____ County _____

B. Benefit Election: Ask your employer what coverages the group policy has. Check your election option(s) below.

Basic life elect waive* amount \$ _____ or _____ times annual salary \$ _____

Basic AD&D elect waive* amount \$ _____ or _____ times annual salary \$ _____

Supplemental life elect waive* amount \$ _____ or _____ times annual salary \$ _____

Supplemental AD&D elect waive* amount \$ _____ or _____ times annual salary \$ _____

Dependent life elect waive* amount \$ _____

Dependent AD&D elect waive* amount \$ _____

Dependent supplemental life elect waive* amount \$ _____

Long term disability elect waive*

Short term disability elect waive*

Medical coverage for: myself elect waive* spouse elect waive*
 children elect waive* _____ (number of eligible child(ren) to be covered)

Medical options (if applicable to your group policy): deductible _____ PPO network _____

If your employer offers a high option and a low option plan, please select the medical plan option which you are electing:
 high plan low plan

Dental coverage for: myself elect waive* spouse elect waive*
 children elect waive* _____ (number of eligible child(ren) to be covered)

Vision coverage for: myself elect waive* spouse elect waive*
 children elect waive* _____ (number of eligible child(ren) to be covered)

*** Reason for waiving coverages(s): (Please read the Waiving Coverage in Section E for information relating to consequences of refusing initial coverage.)**

individual coverage COBRA, USERRA or state continuation government coverage
 spouse's group my employer's HMO I am retiring from firm
 other _____

C. Beneficiary Designation: Complete if your coverages include group term life insurance.

Beneficiary for employee group term life insurance (Print as "Doe, Mary A.", not "Mrs. John Doe")
 last name _____ first name _____ middle initial _____ relationship to you _____

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

D. Dependent Information: Please list your spouse and all eligible children.

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Spouse's name (last, first, middle initial)	Social security number	Date of birth	male	female
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Do you and your spouse work for the same employer? yes no

Full name of dependent child(ren)	Date of birth	Full-time student	Foster child	Step child	Handicapped child	Male	Female
1.							
2.							
3.							

Dependents must meet eligibility requirements. Foster child and stepchild eligibility may be subject to approval by Nippon Life Insurance Company of America (NLI America). Complete a Foster Child and/or Stepchild Questionnaire. If you have developmentally disabled/physically handicapped children over age 19 (or any other age as required by state law) complete an Application to Continue Handicapped Child. Contact your employer for assistance with any questions.

E. Employee Signature**Waiving Coverage – Important information, please read if you are waiving any coverage:**

I declare that I have been given an opportunity to apply for coverage. I understand if I refuse coverage:

- (a) My dependents are not eligible for any coverage for which I am not covered.
- (b) I cannot under any conditions reenter as a retired person.
- (c) I (and/or my dependents) may enroll for medical coverage later; however, unless eligible for the special enrollment rights described in the Notice to Enrollees, I (and/or my dependents) will be subject to the late enrollee provisions.
- (d) If I am enrolled in a health maintenance organization (HMO) sponsored by my employer, and if there is an open enrollment period under the policyholder or employer plan or the NLI America medical policy, I may transfer to the NLI America medical policy during that time.
- (e) I (and/or my dependents) may enroll for dental coverage later; however, such enrollment could affect my initial level of dental benefits.
- (f) I (and/or my dependents) may enroll for nonmedical coverage later; however, necessary proof of good health must be provided at my own expense and coverage will not become effective until approved by NLI America, subject to actively at work and period of limited activity provisions. Health conditions which may be present now or develop later may prevent me (and/or my dependents) from ever being approved for coverage.

Electing Coverage – Please read if you are electing any coverage:

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If the group policy requires my contributions, I authorize my employer to deduct from my pay.
- Applicable if medical coverage is an option under the group policy: I have been given a Notice to Enrollees regarding the preexisting condition exclusions and special enrollment rights, and I understand these provisions.
- I represent all information on this form and attachments is complete and true to the best of my knowledge and belief. They are part of this request for coverage. I agree NLI America is not liable for a claim before the effective date of coverage and all group policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- I authorize NLI America to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by NLI America for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and/or my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by NLI America only as allowed by law.

Applicable to all enrollees:

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from NLI America.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

Employee signature required _____ Date signed _____

Requested date of change _____

Employer to Complete this Section		NLI America to Complete	
Company name as it appears on your billing		Employee effective date	Dependent effective date
Date employed	Job/class	Hours worked per week	
Location	Earnings	yr	wk mo hr
	\$		

Employer Instructions

After this form is completed and signed, make two copies and send the original to Nippon Life Insurance Company of America, keep one copy for your records and give one copy to the employee.