INSURANCE ENROLLMENT FORM

Life Insurance Company of North America

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Return completed form to GDC Financial Group, Inc.
101 Merritt Blvd.
Suite 10
Trumbull, CT 06611
(203)367-4070

ALL ABOUT YOU – THE EMPLOYEE

Your Name ______________________ **Social Security #** ____________ **Birthdate** __________

Address ______________________ City ______________ State _____ Zip __________

Work Phone ____________ Home Phone ____________ Employee ID # __________ Gender: ___

Have you smoked or used any form of tobacco in the last 12 months? Employee: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

FOR CALIFORNIA RESIDENTS ONLY - Are the proposed insured(s): Currently covered for comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan? ❑ Y ❑ N
Anyone for whom the answer is NO is not eligible for this coverage.

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

❑ I am currently married and my date of marriage is: __________ or ❑ I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information

Name ______________________ **Social Security #** ____________

Birthdate ____________ Gender ____________

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 968424		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Benefit: Units of $10,000 up to $500,000. Guaranteed Coverage: $150,000	❑ $10,000 ❑ $150,000* ❑ $500,000** ❑ Other ______________ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Benefit: Units of $5,000 up to $100,000. Guaranteed Coverage: $25,000	❑ $5,000 ❑ $25,000* ❑ $100,000** ❑ Other ______________ *Amount must be a multiple of $5,000. The amount cannot exceed 100% of the employee's coverage.* ❑ Decline Coverage
Child	Benefit: Units of $1,000 up to $10,000.	❑ $1,000 ❑ $10,000** ❑ Other ______________ *Amount must be a multiple of $1,000.* ❑ Decline Coverage

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Employee-Paid (Voluntary) Critical Illness Insurance – Policy # CI 960707			
Choose both an Amount below and who you would like to include in your coverage. See the enclosed Summary of Benefits for Monthly costs.			
Who You Want to Cover	**Dependents**	**Coverage Amount**	**Acceptance**
❑ Employee Only ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Employee + Family	How many children are you covering? _______________	❑ $5,000 ❑ $10,000 ❑ $20,000	❑ Accept Coverage ❑ Decline Coverage

Employee-Paid (Voluntary) Accidental Injury Insurance – Policy # AI 960728			
Choose both a Plan below and who you would like to include in your coverage. See the enclosed Summary of Benefits for Monthly costs.			
Who You Want to Cover	**Dependents**	**Plan**	**Acceptance**
❑ Employee Only ❑ Employee + Spouse ❑ Employee + Children ❑ Employee + Family	How many children are you covering? _________________	❑ Plan 1 ❑ Plan 2	❑ Accept Coverage ❑ Decline Coverage

Employee-Paid (Voluntary) Hospital Care Insurance – Policy # HC 960241		
Choose both a plan below and who you would like to include in your coverage. See the enclosed Summary of Benefits for costs.		
Who You Want to Cover	**Plan**	**Acceptance**
❑ Employee ❑ Employee + Spouse ❑ Employee + Children # of covered children ____ ❑ Employee + Family # of covered children ____	❑ Plan 1	❑ Accept Coverage ❑ Decline Coverage

**This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during this open enrollment.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latter of 09/01/2018 or the date the insurance company approves your application.

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Cigna's approval and 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 go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to critical illness insurance only):
We will not pay benefits for a Covered Loss caused or contributed to by, or resulting from, a Pre-existing Condition. The term "Pre-existing Condition" means any Sickness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 12 months before the Covered Person's most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Loss for which the Date of Diagnosis occurs after the Covered Person is insured under this Policy for at least 12 months after the Covered Person's most recent effective date of insurance, and effective date of any added or increased amount of insurance.

Pre-Existing Condition Limitation (applies to hospital care insurance only):

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

We will not pay benefits for a Covered Injury or Covered Illness caused, contributed to by, or resulting from, a Pre-existing Condition. The term "Pre-existing Condition" means any Illness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines or for which a reasonable person would have consulted a Physician within 12 months before the Covered Person's most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Injury or Covered Illness that occurs after the Covered Person is insured under the Policy for at least 12 continuous months after the Covered Person's most recent effective date of insurance, and effective date of any added or increased amount of coverage.

New Hampshire Residents: I understand that by signing below, I acknowledge that I received and read a copy of the Outline of Coverage.

Washington Residents: I understand that by signing below, I acknowledge that I have received and read a copy of the Summary of Benefits.

Please Sign Here Signature ________________________________ Date ____________________

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. If there is not enough room to specify all beneficiaries, attach, sign and date a separate page using the format below.

Voluntary Term Life Insurance Policy# FLX 968424

Insured	Beneficiary Name	Relationship	Social Security #	Date of Birth	Percentage *(must equal 100% for each insured)*
Employee	1.				
	2.				
Spouse					
Child(ren)					

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature ________________________________ Date ____________________

Employee Signature ________________________________ Date ____________________

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