LifeMap Assurance Company®
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
ph (503) 721-7161 • (800) 794-5390
fax 855-854-4570
medical.uw@lifemapco.com

Voluntary Benefits
Employee Enrollment and Change Form

For residents of Oregon and Washington, the definition of a Spouse includes your legal husband or wife or your State Certified/Registered Domestic Partner. Please contact your employer for any additional eligibility requirements.

For residents of Idaho, Utah, Montana and Wyoming, the definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

Part 1: Please complete using dark ink.

Employer Name **Associated General Contractors Health Benefits Trust Oregon Columbia Chapter**			**Group Number** **OR300267**
☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____			☐ Change of Existing Enrollment
Employee's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Occupation			Annual Salary
Home Address (Street, City, State and Zip)			Telephone Number ( )
Spouse Name (If applying for coverage)	Date of Birth	☐ M ☐ F	Social Security Number
Within the past 2 years have you or your spouse used cigarettes or other tobacco products? Employee ☐ Y ☐ N Spouse ☐ Y ☐ N			

Please indicate the total amount of voluntary coverage you wish to have for initial enrollment or when making changes to coverage.

Voluntary Life Insurance - Employee

Employee ☐ No ☐ Yes Amount of coverage $ _____

- Please select an amount between $10,000 and $300,000 in $10,000 increments, not to exceed 5 times your annual earnings.
- Any amount of coverage applied for requires completion of Part II of this form.

The beneficiary designation made for Basic Life Insurance, if provided, will apply unless you complete a separate beneficiary designation for Voluntary Life.

Voluntary Life Insurance - Spouse

Spouse ☐ No ☐ Yes Amount of coverage $_____

- Please select an amount between $10,000 and $300,000 in $10,000 increments.
- Any amount of coverage applied for in the future will require completion of Part II of this form.

The employee is the beneficiary for Spouse coverage.

Voluntary Life – Child(ren)

☐ Yes ☐ No

Select Amount:

☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000

- Employee or spouse coverage must be elected and approved to enroll for Voluntary Dependent Child(ren) Life coverage.
- Do not complete Part II of this form for Dependent Children if applying during your initial 31 day eligibility period.
- Any amount of coverage applied for in the future requires completion of Part II of this form.

The employee is the beneficiary for Child(ren) coverage.

Please continue application on the following page.

Voluntary Accident Only Insurance (If available for election)

Select Coverage

Individual – Employee	☐ Elect Coverage	☐ No Coverage	Employee + Spouse	☐ Elect Coverage	☐ No Coverage
Individual – Spouse	☐ Elect Coverage	☐ No Coverage	1 Parent + Child(ren)	☐ Elect Coverage	☐ No Coverage
Individual – Child	☐ Elect Coverage	☐ No Coverage	Family	☐ Elect Coverage	☐ No Coverage

Child Coverage (*complete only if selecting Child Coverage*)

Child's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Child's Name (Last, First MI)	Date of Birth	☐ M ☐ F
Child's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Child's Name (Last, First MI)	Date of Birth	☐ M ☐ F
Child's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Child's Name (Last, First MI)	Date of Birth	☐ M ☐ F

Please continue application on the following page.

Note: The Accident Death and Dismemberment (AD&D), Critical Illness and Accident Only Insurance certificate provide limited benefits. Review your certificate carefully.

Your application for coverage is not complete if this page is not signed and returned.

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 (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; 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 (our) coverage would become effective, my (our) 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 or other organization, institution or person that has any records or knowledge of me or my health to give the LifeMap Assurance 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 Privacy Notice.

Insurance Fraud Warning:

Unless specific state language is provided below, the following general fraud notice applies: 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.

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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

▶ _____ ▶ _____

Employee's Signature Date Signed

▶ _____ ▶ _____

Spouse's Signature (if applying for coverage) Date Signed

Please continue application on the following page.

Part 2: Evidence of Insurability.

Please complete Part 2 if applying for coverage in an amount over the Guarantee Issue Amount or when applying for coverage after your initial 31 day eligibility period.

Employee's Name (Last, First, MI)

Answer the following questions for yourself, your Spouse and your Dependent Child(ren) if applicable.

- If you are applying *only* for AD&D or Accident Only Insurance, it is not necessary to answer *any* of the following medical questions.
- Complete this portion for Dependent Children *only* when application is being made *after* your initial 31 day eligibility period.

Employee Height _____ Weight _____	Child Name (first/last) _____ Date of Birth_____ Gender ☐M ☐F Height _____ Weight _____	Child Name (first/last) _____ Date of Birth _____ Gender ☐M ☐F Height _____ Weight _____ Weight _____
Spouse Height _____ Weight _____		
If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.	Child Name (first/last) _____ Date of Birth _____ Gender ☐M ☐F Height _____ Weight _____ Weight _____	Child Name (first/last) _____ Date of Birth _____ Gender ☐M ☐F Height _____ Weight _____

Please answer Yes or No to all questions for yourself, your Spouse and your Dependent Child(ren).

	Employee	Spouse	Child(ren)
1. Within the past 10 years has any person applying for coverage been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2. Within the past 5 years has any person applying for coverage been diagnosed or treated for any of the following: a. a heart or circulatory disorder, stroke, transient ischemic attack (TIA); b. diabetes requiring treatment with insulin; c. kidney disease (except kidney stones); d. cancer or malignancy of any kind (other than basal cell or squamous cell carcinoma of the skin); e. liver disease (including Hepatitis B and C); f. major organ failure or transplant; g. a lung disease(other than mild asthma); h. Systemic Lupus Erythematosus; or i. a neurological disorder (except for a controlled seizure disorder without a seizure in the past 2 years)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3. Within the past 10 years has any person applying for coverage sought treatment or counseling for excessive use of alcohol or drugs, used any controlled substances, been told by a medical practitioner that you had (or still have) a problem with substance abuse, been convicted of operating a vehicle while intoxicated, or had their drivers license suspended or revoked?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4. Are you pregnant?	☐ Y ☐ N	☐ Y ☐ N	N/A
5. Has any person applying for coverage been advised or recommended by a physician to have surgery which has not yet been performed?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
6. Is any person applying for coverage currently disabled or does any person applying for coverage have a condition which prevents or limits activities?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Please continue completing form on the following page.

	Employee	Spouse	Child(ren)
7. Has any person applying for coverage been diagnosed with, been treated, received medical advice, or taken medication for any disease or disorder of the following: a. the circulatory system including the heart and blood vessels, such as heart murmur, heart palpitations, chest pain, circulatory problems, high blood pressure or high cholesterol; b. the blood, such as anemia, leukemia, non-insulin dependent diabetes or albumin or blood or sugar in the urine; c. the glandular system, including the thyroid; d. the urinary system including the kidneys and bladder; e. the respiratory system, including the chest and lungs, such as asthma; f. the digestive system, including the stomach, pancreas or intestines; g. the muscular or skeletal system, including the back, spine and connective tissue, such as arthritis, fibromyalgia or fibromyositis; h. chronic fatigue syndrome; i. the central nervous system, such as dizziness, headaches, seizures, epilepsy, paralysis, Parkinson's, Alzheimer's, multiple sclerosis, motor neuron disease or ALS; j. the reproductive system; k. the mental nervous system, such as depression, anxiety, or stress; l. the immune system; or m. cancer or malignancy of any kind (more than 5 years ago) including carcinoma in situ, any other form of malignant disease, and any benign tumors of any kind.	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8. Within the past 5 years has any person applying for coverage consulted with or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9. Is any person applying for coverage currently receiving any treatment by a medical practitioner or taking any medication?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
10. During the past 5 years, has any person applying for coverage been absent from work more than five consecutive working days because of an illness or injury (excluding pregnancy)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
11. Is your spouse currently pregnant? If yes, give expected delivery date: _____ and describe any complications below.	N/A	☐ Y ☐ N	N/A

Name and address of **your** personal physician:	Name and address of your **Spouse's** personal physician:
_____ _____ _____	_____ _____ _____
Date last seen and reason: _____	Date last seen and reason: _____

IMPORTANT

Provide details of all 'YES' answers given to medical questions in 7 through 10.

If additional space is required, attach a separate signed and dated sheet.

Question Number & Individual	Illness/Reason for Checkup or Physician's Treatment/Consultation	Dates From	Dates To	Full Name & Complete Address of Attending Physician or Other Practitioner
				_____ _____ _____
				_____ _____ _____

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PRIVACY NOTICE

(Retain with your insurance records)

We, at LifeMap Assurance Company (LifeMap), know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. Because we endeavor to earn and keep your trust, we have long-standing privacy policies, robust training, and full-time staff dedicated to protecting privacy. We also maintain physical, administrative, and technical safeguards to protect your personal information from unauthorized access. Even if you are no longer a LifeMap member, we protect the confidentiality of your personal information as if you were.

Marketing

While other companies may sell or rent your contact information, LifeMap never sells or rents your personal information for marketing purposes. If you want LifeMap to share your personal information with a nonaffiliated third party so the third party can market to you, you must give us your express permission.

Your Personal Information

We collect personal information such as your name, contact information, health information, and financial information from you, your providers, and other insurers that provide coverage to you. We use this information to provide services to you and to conduct insurance transactions. You may receive a copy of your personal information by contacting us at the phone number or address below. We will not disclose your personal information unless we are permitted or required by law or you give your permission. As permitted or required by law, we may provide personal information to our affiliates and agents, reinsurers, insurance administrators, consultants, or regulatory and governmental authorities. We obligate entities receiving this information on our behalf to protect it in the same way that we protect it.

Changes to Our Practices

We may change our privacy practices in an effort to provide even better protection. If we change our privacy practices in a material way, we will notify current customers in writing.

Contact Us

If you have any questions about our privacy program, you may contact us at (800) 794-5390 or write to:

LifeMap Privacy Official
P.O. Box 1271, Mailstop E12P
Portland, OR 97207

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize any physician, pharmacy benefit manager, retail pharmacy, clearing house, health plan or insurance company to disclose prescription drug information about me within their possession to Milliman IntelliScript on behalf of LifeMap Assurance Company ("LifeMap"). The purpose of this disclosure is for Milliman to provide the information to LifeMap to evaluate my application for Life, Disability, and/or Critical Illness insurance products.

I understand that this prescription drug information may contain sensitive data, including data related to the treatment of sexually transmitted diseases, HIV/AIDS, mental health and reproduction or contraception (including prenatal care and abortion). I specifically authorize the disclosure of prescription drug information that is related to alcohol or substance abuse and I understand that my alcohol and substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described below.

I understand and acknowledge the following:

- Once any person(s) or entity(ies) discloses my information to an authorized recipient the privacy protections provided by law may no longer apply.
- I may cancel this authorization at any time by sending written notice to LifeMap Assurance Company, Attn: Individual Underwriting, PO Box 1271 M/S E8L, Portland, OR 97207. Cancellation of this authorization will not affect any actions taken by any entity disclosing information before receiving the cancellation notice.
- Completing this authorization is a condition to be eligible for and enrolled in LifeMap Life, Disability and/or Critical Illness insurance products.
- None of the authorized person(s) and entity(ies) above nor Milliman are responsible for any action taken by an authorized recipient of my protected health information.

This authorization will expire two years from the date signed unless a shorter time frame is requested here (mm/dd/yyyy): _____.

Applicant Full Name (please print clearly)	Date of Birth (MM/DD/YYYY)
Group Name	Group Number
Applicant Signature	Date

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individuals (e.g., Power of Attorney, Guardianship, Conservatorship, etc.)

Name of Personal Representative	Relationship	Phone
Signature of Personal Representative		Date