

If you are increasing, decreasing, or adding coverages, you only need to check boxes for coverages you are changing. Coverages to be unchanged need not be checked.

SUPPLEMENTAL BENEFITS ENROLLMENT FORM

P.O. Box 1271 MS E3A
Portland, OR 97207-1271

New Enrollee **Coverage Change**

PART I

EMPLOYEE NAME					PHONE NUMBER () ()								
RESIDENCE ADDRESS		STREET			CITY			STATE		ZIP CODE			
SOCIAL SECURITY NUMBER		BIRTHDATE Mo Da Yr			SEX M F		PLACE OF BIRTH			ANNUAL SALARY			
NAME OF EMPLOYER AND POLICY NUMBER City Of Lewiston ID 03638I					OCCUPATION					DATE OF EMPLOYMENT			
SPOUSE NAME (If applying for coverage)				SOCIAL SECURITY NUMBER			BIRTHDATE Mo Da Yr			SEX M F		PLACE OF BIRTH	

SUPPLEMENTAL EMPLOYEE AND/OR SPOUSE LIFE INSURANCE

Employee Yes No Spouse Yes No

Employee \$ _____ Spouse \$ _____

- Employees and Spouses may select an amount in \$10,000 increments to a maximum of \$300,000.
- Complete Part II on the back of this form IF you are an employee applying for MORE than \$50,000 during your 31 day initial eligibility period OR for ANY amount of application made for spouse coverage or employee coverage after the 31 day initial eligibility period.
- The beneficiary designation made for Basic Life Insurance will apply to Supplemental Life. Employee is the spouse's beneficiary.

SUPPLEMENTAL DEPENDENT CHILD(REN) LIFE INSURANCE

Increments of \$2,500 to a maximum of \$10,000 - Each child \$ _____

- If you are applying DURING your initial 31 day eligibility period, do NOT complete Part II on the back of this form for Dependent Children.
- If application is made AFTER your initial 31 day eligibility period, including during your annual enrollment period, please complete Part II on the back of this form answering all Dependent Child questions. Coverage will not be effective unless approved by Regence Life and Health.
- Employee is the beneficiary for Dependent Child(ren) Life Insurance..

Authorization and Acknowledgement

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 (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 coverage will not begin until the day I return to work.

Authorization to Release Information: I (We) 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 (our) 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 (We) agree that a photocopy of this authorization shall be as valid as the original. I (We) acknowledge that I (we) have received a copy of the Notice of Information Practices.

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.

▲ _____ _____ Date ▲ _____ _____ Date
Employee Signature Spouse Signature (if applying for coverage)

PART II

Complete all spaces/answer Yes or No to all questions for yourself, your spouse and your dependent child(ren). If you are not applying for spouse/dependent children coverage, you do not need to answer questions for them. Circle all conditions which apply and provide details

Employee Height _____ Weight _____	Spouse Height _____ Weight _____	Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____	Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____
Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____		Child Name (first/last) _____ Date of Birth: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Height _____ Weight _____	
		EMPLOYEE	SPOUSE
		If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.	
1. Have you used cigarettes or other tobacco products in the last 2 years?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2. Are you pregnant? If "YES", give expected delivery date and describe complications.		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Within the past 5 years, have you been medically counseled or treated for, or been told by a medical practitioner that you had: high blood pressure; any disease or defect of the heart or blood vessels; diabetes; albumin, blood or sugar in the urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disorder of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder; any immunodeficiency?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Within the past 5 years have you been diagnosed by or received treatment from a member of the medical profession for AIDS or ARC (AIDS Related Complex)? Have you tested positive to the AIDS virus (including but not limited to Human T - Cell Lymphotropic Type III; HTLV - III; HTLV - IV; Human Immunodeficiency Virus (HIV))?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Are you presently receiving any treatment by a medical practitioner or taking any medication?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
7. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Have you ever been rated, declined, postponed or limited in any way for life, health, accident, or sickness insurance?		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Name and address of your personal physician: _____ _____		10. 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 questions stated above. 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 To	Full Name & Complete Address of Attending Physician or Other Practitioner

▲ _____
Employee Signature

_____ Date

▲ _____
Spouse Signature (if applying for coverage)

_____ 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.