ACCIDENTAL INJURY ENROLLMENT FORM

Life Insurance Company of North America (LINA)
a Cigna Company (herein called the Insurance Company)

Cigna use only
____ New Hire
____ Initial Enroll
____ Late Entrant
____ Life Status Chg
____ Enroll Event
____ Reinstatement

For info and customer service for Accidental Injury Insurance, call 800.754.3207

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*
- *The Insurance Company must approve your request for insurance before it becomes effective.*
- *All information must be completed by the applicant.*

Important: Please enter all dates in mm/dd/yyyy format.

EMPLOYER CALHOUN COUNTY **Policy** AI960176

EMPLOYEE SECTION

☐Mr. ☐Mrs. ☐Ms. (Check one) Name: (First) _____ (Last) _____ (MI) ____

Address_____ Apt. # _____ City _____State_____ Zip_____

Day Phone _____ Evening Phone _____ Social Security # _____ Date of Birth _____

ID #_____ Class _____ Occupation _____ Location _____ Date of Hire _____

COMPLETE IF ELECTING SPOUSE COVERAGE

*☐ I am currently married and my date of marriage is _____

Name: (First) _____ (Last) _____ (MI) ____ Social Security # _____ Date of Birth _____

ACCIDENT INDEMNITY INSURANCE POLICY NO. AI960176

If you are already enrolled in coverage under the UNUM plan, your coverage will be automatically rolled over. You do not need to complete an enrollment form.

I am electing new Accidental Injury plan coverage

Accept Coverage: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Family

Decline Coverage ☐ I do not wish to enroll in Accident Indemnity

I am electing the following Accidental Indemnity plan

☐ Plan 1

COMPLETE BENEFICIARY INFORMATION ONLY IF ACCIDENTAL DEATH BENEFIT APPLIES

My Beneficiary:_____ Relationship: _____ Date of Birth _____

You will be your family members' beneficiary unless you tell us otherwise in writing.

**If you wish to designate more than one beneficiary please complete a separate Beneficiary Designation Form. This form is available through your Employer*

GAI-9320

Applicant's Name _____ Social Security # _____ ID # _____

ACCEPTANCE/DECLINATION

I enroll and authorize my Employer to deduct the premiums from my earnings. I understand that the insurance selected will begin on the effective date as described in the brochure. If I am not actively at work, or I am unable to engage in all the usual duties of a person of like age and sex, the effective date of coverage will be delayed until the individual returns to work.

Signature_____ Date _____

***Caution**: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.*

For Home Office use only

***Notice:** Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the Insurance Company's privacy practices is available upon request.*

GAI-9320