

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.

VOLUNTARY 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		SEX		PLACE OF BIRTH		ANNUAL SALARY \$		
		Mo Da Yr		M F						
EMPLOYER Lewis & Clark College			GROUP NO.		OCCUPATION			DATE OF EMPLOYMENT		
SPOUSE NAME (If applying for coverage)				SOCIAL SECURITY NUMBER		BIRTHDATE		SEX		PLACE OF BIRTH
						Mo Day Yr		M F		

VOLUNTARY LIFE INSURANCE

Employee Yes No Spouse Yes No

Employee \$ _____ Spouse \$ _____

- Employees and spouses may select amounts in \$10,000 increments from a minimum of \$10,000 to a maximum of \$300,000.
- Employee - Complete Part II on the back of this form IF you are an employee applying for more than \$100,000 during your 31 day initial eligibility period OR for any amount of application made after the 31 day initial eligibility period including during any annual enrollment period.
- Spouse – Complete Part II for Spouse on the back of this form for all amounts of coverage applied for at any time.
- The beneficiary designation made for the Basic Life Insurance will apply unless the Employee completes a separate beneficiary designation for Voluntary Life. Employee will be the beneficiary for any Spouse coverage.

VOLUNTARY DEPENDENT LIFE

\$5,000 Spouse and Child

- Do not complete Part II on the back of this application if you are applying during your initial 31 day eligibility period. If application is made AFTER your initial 31 day eligibility period including during any annual enrollment period, please complete Part II for Spouse and Child(ren on the back of this application.
- The employee is the beneficiary.

VOLUNTARY AD&D INSURANCE

Yes No (If yes, select one plan)

Principal Sum \$ _____ Employee Only Plan Family Plan

- Select an amount in \$25,000 increments to a maximum of \$250,000.
- Part II on the back of this application is NOT required for this benefit.
- The beneficiary designation made for the Basic Life Insurance will apply unless the Employee completes a separate beneficiary designation for Voluntary AD&D. For any Spouse or child coverage, the Employee will be the beneficiary.

LONG TERM DISABILITY BUY-UP / EXEMPT EMPLOYEES

Yes No

- Buy-up increases the maximum monthly benefit to \$12,000.
- If you are applying DURING your initial 31 day eligibility period, do NOT complete Part II on the back of this form.
- If you are applying AFTER your initial 31 day eligibility period including during any annual enrollment period, you MUST complete Part II on the back of this form. Coverage will not be effective unless approved by Regence Life and Health.

LONG TERM DISABILITY BUY-UP / NON- EXEMPT EMPLOYEES

Yes No

- Buy-up reduces the elimination period to 90 days.
- If you are applying DURING your initial 31 day eligibility period, do NOT complete Part II on the back of this form.
- If you are applying AFTER your initial 31 day eligibility period including during any annual enrollment period, you MUST complete Part II on the back of this form. Coverage will not be effective unless approved by Regence Life and Health.

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.

Insurance Fraud Warning: 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.

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

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
		CHILDREN	
		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



Life and Health Insurance Company

Regence Life and Health Insurance Company
100 SW Market Street
Portland, Oregon 97201

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.