Regence
Life and Health Insurance Company

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 Mo / Da / Yr	SEX M / F	PLACE OF BIRTH	ANNUAL SALARY $	DATE ON WHICH YOUR ANNUAL SALARY FIRST EXCEEDED $100,000 _____

EMPLOYER	GROUP NO.	OCCUPATION	DATE OF EMPLOYMENT
Lewis & Clark College	**WBT000528**		

SPOUSE NAME (If applying for coverage)	SOCIAL SECURITY NUMBER	BIRTHDATE Mo / Day / Yr	SEX M / F	PLACE OF BIRTH

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 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 $300,000.
- 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.

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.

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 OR during annual open enrollment, do NOT complete Part II on the back of this form.
- If you are applying at any other time AFTER your initial 31 day eligibility period, please complete Part II on the back of this form.

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 OR during annual open enrollment, do NOT complete Part II on the back of this form.
- If you are applying at any other time AFTER your initial 31 day eligibility period, please complete Part II on the back of this form

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 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 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: 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.

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.

▲ _____ 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 ☐M ☐F 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 _____		Child Name (first/last) _____ Date of Birth:_____Gender ☐M ☐F Height _____Weight _____	

If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.

	EMPLOYEE	SPOUSE	CHILDREN
1. Have you used cigarettes or other tobacco products in the last 2 years?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2. Are you pregnant? If "YES", give expected delivery date and describe complications.	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ 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?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ 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))?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ 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?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
6. Are you presently receiving any treatment by a medical practitioner or taking any medication?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8. Have you ever been rated, declined, postponed or limited in any way for life, health, accident, or sickness insurance?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ 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 _____

Regence
Life and Health Insurance Company

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

PRIVACY NOTICE

We, at Regence Life and Health, 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 Regence member, we protect the confidentiality of your personal information as if you were.

Marketing
While other companies may sell or rent your contact information, Regence never sells or rents your personal information for marketing purposes. If you want Regence 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:

Regence Privacy Official
P.O. Box 1071, Mailstop E12B
Portland, OR 97207