

**Term Life Insurance Change Form**  
**Life Insurance Company of North America (LINA)**  
**a Cigna Company (herein called the Insurance Company)**  
 For info and customer service call 1-866-607-2360.

P. O. Box 20310  
 Lehigh Valley, PA 18003-9924  
 Fax: 1.800.440.0856



- The applicant must sign and date this form.
- This form cannot be considered unless received within 30 days of the date it is dated.

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

<b>EMPLOYER USE (MANDATORY DATA NEEDED):</b> In order for the insurance company to process this form, the employer must complete this information.			
EMPLOYER	Cummins Inc.	Policy	FLX-961997
LOCATION/PAYCODE #	0000		
REASON FOR REQUEST: <input type="checkbox"/> LIFE STATUS CHANGE <input type="checkbox"/> ONGOING ENROLLMENT EVENT <input type="checkbox"/> REINSTATEMENT <input type="checkbox"/> LATE ENTRANT			

Please print (preferably in black ink).

**EMPLOYEE SECTION**

Mr.    Mrs.    Ms. (Check One)

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Employee ID # \_\_\_\_\_ Sex:  M  F

**COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE**

I am currently married and my date of marriage is \_\_\_\_\_ -or-  I currently have an eligible Domestic Partner

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse or Domestic Partner Information Birthdate \_\_\_\_\_ Sex:  M  F Height: \_\_\_\_\_ft \_\_\_\_\_in Weight: \_\_\_\_\_lbs

\*In order to be eligible for Domestic Partner coverage, you must have any required Domestic Partner Affidavit or its equivalent on file with your employer, and accepted by the insurance company. If you do not currently have one on file with your employer, one will be made available through your employer.

**I WISH TO MAKE THE FOLLOWING CHANGES TO MY LIFE INSURANCE COVERAGE**

See your life insurance brochure/application for the coverage election options for your plan. When selecting new coverage amounts, please ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application.

**CHECK THE APPROPRIATE BOXES:**

Increase, decrease or begin coverage on the following individuals as indicated below:

(Complete the medical questions on the next page if you are electing or increasing coverage for yourself or your spouse/domestic partner.)

	<u>Current</u> Voluntary Coverage	<u>New</u> Voluntary Coverage	<u>Total</u> Voluntary Coverage
<input type="checkbox"/> Employee			
<input type="checkbox"/> Spouse/Domestic Partner			
<input type="checkbox"/> Child(ren)			

**Life Status Change**

If this change is being made due to a Life Status Change, please check one of the following, and provide date of change.

- Marriage    Divorce    Annulment    Legal Separation    Birth or Adoption of a Child    Death of a Spouse/Domestic Partner or Child
- Leave of Absence    Change in Spouse/Domestic Partner's Employment    Return to or from Military Duty    Change from full to part-time (or vice-versa)

Date of Life Status Change \_\_\_\_\_

**Cancel coverage on the following individuals:**

Employee    Spouse/Domestic Partner    Child(ren)   Effective Date of Cancellation \_\_\_\_\_

**Cancel the Automatic Increase Option**

**Name Change: (Current / New Name)**

Employee \_\_\_\_\_ / \_\_\_\_\_

Spouse/Domestic Partner \_\_\_\_\_ / \_\_\_\_\_

**Reminder:** If you'd like to designate new beneficiaries, please complete a Beneficiary Form

**ACCEPTANCE / DECLINATION**

I accept the insurance coverage(s) chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the needed amounts from my earnings

**Sign Here** Signature \_\_\_\_\_ Date \_\_\_\_\_  
Month/Day/Year

**Important: You must also sign and date the Agreements and Authorization section.**

**IMPORTANT**  
 Please complete each section that follows if it is needed.  
 Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse/domestic partner info in this section if you (i.e., the Employee) or your spouse/domestic partner are applying for/increasing Life Insurance: (1) exceeding the guaranteed amount, or (2) due to a reinstatement.

**Height and Weight Information**

Employee			Spouse/Domestic Partner		
Height	ft	in	Height	ft	in
Weight	lbs		Weight	lbs	

**PHYSICIAN SECTION**

**Employee Physician**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Spouse/Domestic Partner Physician**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please indicate your answers for each question by checking the Yes or No box for the question.**

**SECTION A**

**Within the last 5 years has the proposed insured been:**

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

	Employee		Spouse/ Dom. Part.	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION B**

**Within the last 5 years has the proposed insured:**

A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Smoked cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. For how many years has the proposed insured smoked?				
2. Approximately how many cigarettes are, or were, smoked on average per day?				
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C. Used any controlled or illegal drug or other substance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee, Spouse/Domestic Partner	Medical Condition	Date Occurred	Duration/Treatment Received	Current Status

**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.

**Important:** You must also sign and date the Agreements and Authorization section.

*Fold and staple this page to conceal health questions.*

## ◆ ◆ ◆ AGREEMENTS AND AUTHORIZATION ◆ ◆ ◆

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Insurance Company.
- (4) I must report any change in my health that happens before the insurance is effective.
- (5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

**Authorization.** I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)



**Sign Here**

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Month/Day/Year*

\_\_\_\_\_  
*Spouse/Domestic Partner's Signature*

*(If applying for insurance for your spouse/domestic partner)*

\_\_\_\_\_  
*Month/Day/Year*

**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.