LIFE INSURANCE COMPANY OF NORTH AMERICA

POLICYHOLDER
Salt Lake City School District

POLICY NUMBER
LK 961110

Long-Term Disability (LTD) Enrollment Form

Name _____ Sex: ❑ Male ❑ Female
       Last   *First*   *M. I.*

Date of Birth _____ Social Security No. ___/___/___ - ___/___ - ___/___/___/___

Address _____ Home Phone (____)_____
        Number and Street   *City*   *State*   *Zip Code*

Date Hired _____ Title or Occupation_____ Annual Salary $ _____

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Please check the appropriate box.

❑   I accept the LTD insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

❑   I have been offered LTD insurance and decline to purchase it at this time. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.

Late entrants must complete an Evidence of Insurability Form. Coverage for late entrants is subject to the Insurance Company's approval.

If you are not in active service on the date your coverage would otherwise take effect, you will be covered on the date you return to active service.

Pre-Existing Condition Limitation: A pre-existing condition is any injury or illness for which you have consulted a physician (or for which a reasonable person would have consulted a physician), received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless your disability begins after you have received no medical treatment, care or services for 3 months in connection with the pre-existing condition, or more than 12 months after the effective date of your coverage.

Signature of Applicant _____ Date_____

TL-004038 (BME)

CIGNA Group Insurance
Life • Accident • Disability

Return original to your employer and make a copy for your records.