Life Insurance Company of North America

Personal Accident Insurance

POLICYHOLDER
University of Hartford

POLICY No.
OK-809423

Complete the following to enroll:

Full Name_____ Date of Birth ____/____/____
PRINT FULL NAME(S)

Address_____ Social Security # ____-____-____
STREET

_____
CITY STATE ZIP

Select Coverage Option: ❑ Employee ❑ Employee and Family

Employee Benefit Amount: $_____ Total Cost $_____/ per month

If you select coverage for your family, benefits for family members will be a percentage of yours..

My Beneficiary_____ Relationship_____

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

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 my family members are not actively at work, or they are 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, or the family member resumes usual duties.

SIGNATURE_____ DATE____/____/____

❑ **DECLINATION** — Check here and sign above if you do not want this coverage.

Return to your employer. Be sure to make a copy for your records.

TL-007112

CIGNA Group Insurance
Life • Accident • Disability