LifeMap Assurance Company
100 SW Market Street
P.O. Box 1271 E-8L
Portland, OR 97207-1271
(800) 794-5390
Billing@lifemapco.com

Voluntary Benefits

Employee Enrollment and Change Form

For Employer Use Only: ___/____/_____ Date Employee's Basic Life Insurance Became Effective
Mo. Day Year

Please indicate the amount of Voluntary Life insurance the employee, spouse and child(ren) is currently insured for not including any Voluntary Life amount that may be applied for on this form. This information is required for any coverage applied for on this form including if the employee is applying for Voluntary AD&D.

Employee $_____ Spouse $_____ Child(ren) $_____

Part 1 Please complete using dark ink.

Employer Name: Washington County School District - UT00521U

☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____ ☐ Change of Existing Enrollment

Employee's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Occupation			Annual Salary
Home Address (Street, City, State and Zip)			Telephone Number ( )
Spouse Name (If applying for coverage)	Date of Birth	☐ M ☐ F	Social Security Number

Within the past 2 years have you or your spouse used cigarettes or other tobacco products? Employee ☐ Y ☐ N Spouse ☐ Y ☐ N

Please indicate the total amount of voluntary coverage you wish to have for initial enrollment or when making changes to coverage.

EMPLOYEE - Voluntary Life Insurance

Select Amount in $5,000 increments to a maximum of $500,000. Board Members are limited to $100,000.
Employee $ _____ ☐ Please check here if you are a board member

- Do not complete Part 2 of this form if you are applying for an amount up to $450,000 DURING your initial 31 day eligibility period.
- Complete Part 2 of this form if you are applying for an amount over $450,000 DURING your initial 31 day eligibility period OR for any amount of coverage made AFTER your initial 31 day eligibility period including during any Annual Enrollment Period.

SPOUSE - Voluntary Life Insurance

Select Amount in $5,000 increments to the lesser of $300,000 or the employee's amount of coverage.

Spouse $ _____

- Do not complete Part 2 of this form if you are applying for an amount up to $50,000 DURING your initial 31 day eligibility period.
- Complete Part 2 of this form if you are applying for an amount over $50,000 DURING your initial 31 day eligibility period OR for any amount of coverage made AFTER your initial 31 day eligibility period including during any Annual Enrollment Period.
- Employee is the beneficiary for spouse coverage.

CHILD(REN) - Voluntary Life Insurance

Select Amount in $2,500 increments to $10,000.

Child(ren) $ _____

- You (employee) must be enrolled for Voluntary Life to be eligible to elect Child(ren) coverage.
- Do not complete Part 2 of this form if you are applying for any amount DURING your initial 31 day eligibility period.
- Complete Part 2 of this form answering all questions for Dependent Child(ren) if you are applying for any amount AFTER your initial 31 day eligibility period including during any Annual Enrollment Period.
- Employee will be the beneficiary for Child(ren) coverage.

Please continue application on the following page.

Voluntary Accidental Death and Dismemberment (AD&D) Insurance

Select Amount in $5,000 increments to a maximum of $500,000. The amount you elect may not exceed your Voluntary Life election.

Board Members are limited to $100,000. ☐ Please check here if you are a board member.

Employee $ _____

Please select one of the following: ☐ Employee Only Plan or ☐ Family Plan

- Part 2 of this form is not required for this coverage.
- Employee will be the beneficiary for spouse and child coverage.

Your application for coverage is not complete if this page is not signed and returned.

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 LifeMap Assurance 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:

Unless specific state language is provided below, the following general fraud notice applies: 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.

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. Penalties may include imprisonment, fines, and denial of insurance benefits.

If your answers on this application are incorrect or untrue, LifeMap Assurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

▶ _____

Employee's Name (Please Print)

▶ _____ ▶ _____

Employee's Signature Date Signed

▶ _____ ▶ _____

Spouse's Signature (only if applying for coverage) Date Signed

LifeMap Assurance Company®
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 794-5390 | Fax (855) 854-4570
Email: Billing@LifeMapCo.com

LifeMap Evidence of Insurability Form

(Part 2 of the Voluntary Benefits Application)

Section 1: Applicant Information. Please complete using dark ink.

Employee's Name (Last, First MI)				
Social Security Number	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F
Spouse Name (If applying for coverage)				
Social Security Number	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F
Dependent Child Name (If applying for coverage)	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F
Dependent Child Name (If applying for coverage)	Date of Birth	Height: ____Ft.____ In.	Weight: _____ lbs	☐ M ☐ F

If you have additional eligible children, please attach a sheet showing their information.

Section 2: Health Questions

Each Applicant must answer each of the following questions to the best of their knowledge and belief. A legal guardian is required to answer each of the questions for minor children.

	Employee	Spouse	Child(ren)
1. Within the past 2 years have you or your spouse, if applying for coverage, used cigarettes or other tobacco products?	☐ Y ☐ N	☐ Y ☐ N	
2. Within the past 5 years has any person applying for coverage been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3. Within the past 5 years has any person applying for coverage been diagnosed with, received medical care, or taken medication for a disease or disorder of any of the following:			
a. **Cardiac or Cardiovascular** (such as Heart Disease, High Blood Pressure, Atherosclerosis, Coronary Artery Disease, Heart Attack, Chest Pain, Heart Murmur or Palpitations, Cardiomyopathy, Heart Valve Disorder or Heart Failure)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
b. **Circulatory** (such as Stroke, Transient Ischemic Attack (TIA) or High Cholesterol)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
c. **Blood** (such as Anemia, Leukemia, Multiple Myeloma or Thrombocytosis)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
d. **Endocrine** (such as Diabetes, Thyroid, Adrenal or Pituitary Disorder)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
e. **Respiratory** (such as Asthma, COPD, Emphysema or Cystic Fibrosis)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
f. **Kidney, Urinary Tract or Prostate** (such as Proteinuria or PSA Abnormality)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
g. **Gastrointestinal or Liver** (such as Hepatitis, Colitis, Diverticulosis, Crohn's Disease, Pancreatitis, Ulcer or Decreased Liver Function)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
h. **Autoimmune or Connective Tissue** (such as Lupus, Rheumatoid Arthritis, Scleroderma, Multiple Sclerosis or Mixed Connective Tissue Disease)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
i. **Nervous, Mental or Emotional** (such as Anxiety, Depression, Memory Loss, Schizophrenia, Mood Disorder or Attempted Suicide)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

EMPLOYEE'S NAME:

	Employee	Spouse	Child(ren)
j. **Neurological or Central Nervous** (such as Epilepsy, Seizure, Dizziness, Motor Neuron Disease, ALS, Muscular Dystrophy, Cerebral Palsy, Paralysis or Parkinson's Disease)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
k. **Musculoskeletal** (such as Arthritis, Osteoarthritis, Degenerative Disc or Joint Disease, Carpal Tunnel, or Knee, Hip, Shoulder or Other Joint Condition)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4. Within the past 5 years has any person applying for coverage been diagnosed with, received medical care, or taken medication for any of the following:			
a. **Cancer, Hodgkin's Disease, Lymphoma, Malignant Growth or Tumor?**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
b. **Epstein Barr, Chronic Fatigue Syndrome or Fibromyalgia?**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
c. **Alcohol, Drug or Substance Abuse?**	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
5. Has any person applying for coverage been advised or recommended by a physician to have surgery or a test or evaluation which has not yet been performed? (except pregnancy or orthopedic)	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
6. Within the past 5 years has any person applying for coverage had a condition that has lasted for 3 months or more for which care or treatment was recommended or received or for which medication was prescribed by a physician or health care provider?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
7. Is any person applying for coverage disabled or does any person applying for coverage have a condition which prevents or limits activities?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8. Are you currently pregnant? If yes, anticipated due date (MM/DD/YY): _____	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9. During the past 5 years have you been absent from work for more than five consecutive working days because of your own illness or injury (excluding pregnancy)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Provide details of all 'YES' answers given to the health questions in Section 2.
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

Section 3: Authorization to Disclose Personal Information & Application for Insurance.
I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, MIB Inc., insurance company or other organization, institution or person that has any records or knowledge of me or my health, gathered during the course and scope of their business, to give the LifeMap Assurance Company or its reinsurers any such information, including information about drug or alcohol use or abuse, mental illness, AIDS virus or other sexually transmitted diseases (with the exception of HIV records), in connection with prior testing for the purpose of obtaining insurance. 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.

IMPORTANT: Please continue completing form on the following page.

EMPLOYEE'S NAME:

Section 4: Authorization to Disclose Protected Health Information.
I authorize any physician, pharmacy benefit manager, retail pharmacy, clearing house, health plan or insurance company to disclose prescription drug information about me within their possession to Milliman IntelliScript on behalf of LifeMap Assurance Company ("LifeMap"). The purpose of this disclosure is for Milliman to provide the information to LifeMap to evaluate my application for Life, Disability, and/or Critical Illness insurance products.

I understand that this prescription drug information may contain sensitive data, including data related to the treatment of sexually transmitted diseases, HIV/AIDS, mental health and reproduction or contraception (including prenatal care and abortion). I specifically authorize the disclosure of prescription drug information that is related to alcohol or substance abuse and I understand that my alcohol and substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described below.

I understand and acknowledge the following:

- I may cancel this authorization at any time by sending written notice to LifeMap Assurance Company, Attn: Individual Underwriting, PO Box 1271 M/S E8L, Portland, OR 97207. Cancellation of this authorization will not (1) affect any actions taken by any entity disclosing information before receiving the cancellation notice or (2) be effective with respect to any reliance on the authorization to contest a claim or the policy itself, to the extent permitted by applicable law.
- Completing this authorization is a condition to be eligible for and enrolled in LifeMap Life, Disability and/or Critical Illness insurance products.
- The physicians, pharmacy benefit managers, retail pharmacies, clearinghouses, health plans, and insurance companies identified above will not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.
- Once any person(s) or entity(ies) discloses my information to an authorized recipient the information could be subject to redisclosure by the recipient and the privacy protections provided by law may no longer apply. Please see LifeMap's Privacy Notice for information on how LifeMap protects the confidentiality of your personal information.
- None of the authorized person(s) and entity(ies) above nor Milliman are responsible for any action taken by an authorized recipient of my protected health information.
- This authorization will expire six (6) months from the date of signature.

THIS FORM IS NOT VALID UNTIL SIGNED AND DATED BY ALL APPLICANTS.

Unless specific state language is provided on Page 4, the following general fraud notice applies: 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.

By signing below, **each** proposed insured(s) agrees to the following:

1) I agree with all the terms, conditions, statements, and representations stated above in Section 1: Applicant Information, Section 2: Health Questions, and,

2) I agree to the authorization in Section 3: Authorization to Disclose Personal Information & Application for Insurance, and Section 4: Authorization to Disclose Protected Health Information.

3) Information in this form is given to obtain insurance, and the statements and answers are represented, to the best of my knowledge and belief, to be true and complete. I understand that 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 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 coverage would become effective, my coverage will not begin until the day I return to work.

4) If my answers on this application are incorrect or untrue, LifeMap Assurance Company has the right to deny benefits or rescind my coverage for up to two years from the date coverage becomes effective.

▶ _____ ▶ _____
EMPLOYEE Signature Date Signed

▶ _____ ▶ _____
SPOUSE Signature (if applying for coverage) Date Signed

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individuals (e.g., Power of Authority, Guardianship, Conservatorship, Etc.)

_____ _____ _____
Name of Personal Representative Relationship Phone Number

▶ _____ ▶ _____
PERSONAL REPRESENTATIVE Signature Date Signed

EMPLOYEE'S NAME:

To help ensure efficient processing, mail, fax or email the completed form to:

LifeMap Assurance Company
P.O. Box 1271, M/S E8L
Portland, OR 97207
Fax (855) 854-4570
Email: Billing@LifeMapCo.com

STATE FRAUD WARNING STATEMENTS

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For your protection California law requires the following statement to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

NOTICE OF INFORMATION PRACTICES
Please read and detach for your records.

In the course of properly underwriting and administering your insurance coverage, LifeMap Assurance Company will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, MIB Inc., and other insurance companies.

Information regarding your insurability will be treated as confidential. LifeMap Assurance Company or its reinsurers may, however, make a brief report 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. 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 50 Braintree Hill Park, Suite 400, Braintree, MA, 02184-8734 or they can be reached by email at infoline@mib.com.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO:

LIFEMAP ASSURANCE COMPANY
ATTN: INDIVIDUAL UNDERWRITING
200 SW MARKET STREET
P.O. Box 1271, M/S E8L
PORTLAND, OR 97207

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 794-5390

PRIVACY NOTICE

We, at LifeMap Assurance Company, 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. Access to your information is limited within our organization to those persons who must have the information to provide services to you, or to conduct our business. Even if you are no longer a LifeMap member, we protect the confidentiality of your personal information as if you were.

Marketing

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

Accessing and Correcting your Personal Information

You may request a copy of your personal information to review it for completeness and accuracy. Send your privacy inquiry to the address below as your request must be in writing. Please include your name, address, and policy number and have your signature notarized. This is for your protection so we may prove your identity.

Where required by law we will correct or amend the personal information we maintain. If we do not agree that the records are incorrect, you can request we add a rebuttal statement to your file.

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:

LifeMap Privacy Official
P.O. Box 1271, Mailstop E12P
Portland, OR 97207