

**Life Insurance Company of North America**  
**Personal Accident Insurance**

**POLICYHOLDER**

**POLICY NO.**  
**OK-961075**

**Hospital Employee Benefit Association Trust**

*Complete the following to enroll:*

Employer Name \_\_\_\_\_

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY STATE ZIP

Employment Date \_\_\_\_\_ Occupation or Job Title \_\_\_\_\_

Dependent Status Change \_\_\_\_\_

Beneficiary Change \_\_\_\_\_

Select Coverage Option:  Employee and Family  Employee Only Total Cost \$ \_\_\_\_\_ /per Month

My Benefit Amount \$ \_\_\_\_\_ (units of \$10,000)

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

My Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
PRINT FULL NAME(S)

You will be your family members' beneficiary unless you tell us otherwise in writing. Benefits will not be paid to your Domestic Partner if he or she is not specifically designated.

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.



**CIGNA Group Insurance**  
Life • Accident • Disability