UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 | MERIDIAN, IDAHO 83680-7777
Phone Number: 800-657-6351
www.unitedheritage.com

Group Insurance Beneficiary Form

Please fill out Sections 1-6 for personal information on the employee.

1. Employee's Full Name	Date of Birth (Month/Day/Yr.)
Address (Including City, State & Zip Code)	Group Number

2. Name of Employer	Employee Job Title	Full-Time Employment (Month/Day/Yr.)	Hours Worked Per Week
Fern Ridge School District #28J			

3. Male ☐ Female ☐	4. Social Security Number	5. Gross Monthly Salary

Your primary beneficiary will receive your death benefit in the event of your death.
The contingent beneficiary will receive your death benefit if the primary beneficiary is no longer living.

	Yes	No		Yes	No
6. Employee Life Insurance	☑	☐			
Dependent Life Insurance	☑	☐	Voluntary STD Plan (cost-see calculator)	☐	☐
Number of Eligible Dependents Including Spouse* _____			Long Term Disability Insurance	☑	☐
Supplemental/Voluntary Group Life Insurance	☐	☐			

☐ Employee Only - Amount Requested $ _____ ($10,000 increments to a max of $300,000)
☐ Spouse - Amount Requested $ _____ ($5,000 increments to a max of $150,000)
☐ Child(ren) - Amount Requested $ _____ ($2,000 increments to a max of $10,000)

**Spouse also includes domestic partner.*

If electing amounts over, Employee - $50,000, Spouse - $25,000 and Child(ren) - $10,000, please complete the attached personal health statement

7. Primary Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Beneficiary			Phone
Contingent Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Contingent Beneficiary			Phone

8. Unless otherwise provided herein, Beneficiaries designated to share proceeds shall share equally and the share of any Beneficiary who does not survive me shall be paid to the Contingent Beneficiary. If no Beneficiary survives me, the payment shall be made according to the terms of the policy, subject to revocation by me by written notice to my employer. I request the insurance provided by my employer's group insurance plan(s), and authorize the required deduction, (if any) from my wages.

United Heritage Life Insurance Company assumes no responsibility for the beneficiary designation complying with any community property laws relating to the designation. Community property states include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Date Signed_____ **Employee Signature**_____

Fern Ridge School District #28J

Generic Supplemental Group Term Life Insurance Enrollment Form

This form is required to be turned in to your HR department.

Name:	**Annual Salary:**	
Title:	**Date of Birth:**	**Age:**
Date of Hire:	**Effective Date:**	
Full Address:		

Supplemental Group Term Life Insurance - Employee

You have the opportunity to enroll in the *Fern Ridge School District #28J* Supplemental Group Term Life Insurance plan. Your election may be made in $10,000 increments, not to exceed 3 times your salary or $300,000, ***whichever is less.*** If you elect an amount that exceeds the guaranteed issue amount of $50,000, you will need to provide evidence of good health that is satisfactory to United Heritage Life before the excess can become effective. The monthly cost, based on your age, is shown below.

Use the rate chart and calculation line below to determine your Monthly cost for this coverage.

Age	Under 24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75 & Over
Rate	$0.04	$0.04	$0.04	$0.06	$0.09	$0.14	$0.23	$0.38	$0.51	$0.80	$1.39	$2.39

_____ ÷ $1,000 = _____ x _____ = $_____
Elected Benefit Amount — Rate Above — Your Monthly Cost

☐ I elect to **ENROLL** in the Supplemental Life plan for $_____ at a Monthly cost of $_____.
Employee Life Amount

☐ I elect to **DECLINE** the Supplemental Life plan.

Note: If you are age 65 or over, your elected benefit and premium will be reduced according to the age reduction schedule in the certificate of insurance. If you are moving from one age bracket to the next, your rate will not change until October 1st, the policy's anniversary date, following your birth date.

Supplemental Group Term Life Insurance - Spouse

If you elect the Supplemental Group Term Life plan for yourself, you may elect Supplemental Life coverage for your Spouse. Your Spouse's election may be made in $5,000 increments to a maximum of $150,000, not to exceed 50% of your approved election. If you elect an amount for your spouse that exceeds the guaranteed issue amount of $25,000, your spouse will need to provide evidence of good health that is satisfactory to United Heritage Life before the excess can become effective.

Supplemental Spouse rates and premiums are based on the Employee's age, not the Spouse's age.

Use the rate chart from above and calculation line below to determine your Monthly cost for this coverage.

_____ ÷ $1,000 = _____ x _____ = $_____
Elected Benefit Amount — Rate Above — Your Monthly Cost

☐ I elect to **ENROLL** in the Supplemental Life plan for $_____ at a Monthly cost of $_____.
Spouse Life Amount

☐ I elect to **DECLINE** the Supplemental Life plan for my Spouse.

SPOUSE

First Name	Last Name	Gender	Date of Birth	Date of Marriage

United Heritage Life Insurance Company (208) 493-6100 or Toll-Free 1-800-657-6351
707 E. United Heritage Ct., Meridian, Idaho 83642-3527 P.O. Box 7777, Meridian, Idaho 83680-7777
http://www.unitedheritage.com

Supplemental Group Term Life Insurance - Child(ren)

If you elect the Supplemental Group Term Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) between the ages of 6 months and 26 years. You may elect in increments of $2,000 to a maximum of $10,000 at the Monthly cost below. Children from 15 days to 6 months are limited to coverage in the amount of $1,000.

Use the rate chart and calculation line below to determine your Monthly cost for this coverage.

Child Life Amount	$2,000	$4,000	$6,000	$8,000	$10,000
Cost per Unit*	$0.40	$0.80	$1.20	$1.60	$2.00

***Unit refers to all children eligible for coverage.**

☐ I elect to **ENROLL** my dependent child(ren) in the Supplemental Life plan for $_____ at the Monthly cost above.

☐ I elect to **DECLINE** the Supplemental Life plan for my dependent child(ren).

CHILD(REN)

First Name	Last Name	Gender	Date of Birth

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Employee Confirmation

I have been given the opportunity to enroll in *Fern Ridge School District #28J* Supplemental Group Term Life Insurance plan. I understand that if I decline now, but later choose to enroll, I will be required to provide evidence of good health and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force. ***Your final payroll deductions may vary slightly pending final enrollment and payroll deduction frequency.***

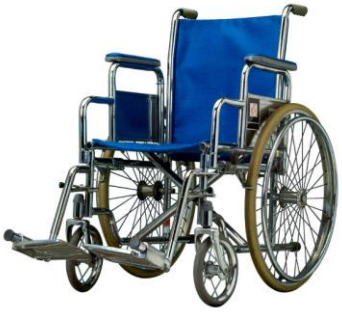
United Heritage Life Insurance Company assumes no responsibility for the beneficiary designation complying with any community property laws relating to the designation. Community Property states include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Signature: _____ **Date:** _____

United Heritage Life Insurance Company (208) 493-6100 or Toll-Free 1-800-657-6351
707 E. United Heritage Ct., Meridian, Idaho 83642-3527 P.O. Box 7777, Meridian, Idaho 83680-7777
http://www.unitedheritage.com

Fern Ridge School District #28J

Generic Voluntary Short Term Disability Enrollment Form



Have you considered how a **sickness, pregnancy, or accidental injury** may prevent you from working for more than a few days? Financially, how might that affect you? Could you afford to stay afloat for a few months if something were to happen?

Your Employer has provided you the opportunity to enroll in a Short Term Disability program that will provide you the financial protection you may need. This benefit replaces a portion of the income you may lose when afflicted by a disability.

Voluntary Short Term Disability

The benefit described below is one your Employer has made available for you as an Employee of Fern Ridge School District #28J.

- **Eligibility**
  All Full-Time Employees working a minimum of **30 hours** per week are eligible.

- **Benefit Payment-** Payment will be paid after the Elimination Period has been met and we have received proof that you have been disabled due to sickness or injury that requires the regular care of a Physician. You will receive a weekly payment based on your pre-disability earnings, not exceeding the maximum weekly benefit.

  - **Benefit as % of Salary - 60%**
  - **Maximum Weekly Benefit - $1,000**

- **Elimination Period**- The number of days that you must be disabled before benefits begin. Your Elimination Period begins on the first day of your disability.

  - **Injury - 7 days**
  - **Sickness - 7 days**

  Benefits will be paid while you are disabled for up to **12 weeks.**

- **Definition of Disability- You** are considered disabled if due to sickness or injury and **are unable to perform some or all of the material and substantial duties of your regular occupation. You must also have at least a 20% loss in pre-disability earnings.** You are also considered disabled if you meet the Definition of Disability above, but are working in any occupation and have at least a 20% loss in Pre-Disability earnings. A loss of a professional occupational license or certification does not, by itself, mean you are disabled. This coverage provides benefits for injury or sickness that occurs when you are off the job. **Occupational injuries and sicknesses are not covered.**

  - ***Regular Occupation***- means the occupation (as it is performed nationally) that you are routinely performing when disability begins. It does not mean the job you are performing for a specific employer or at a specific location.
  - ***Material and substantial duties***- duties that are normally required for the performance of your occupation and cannot be reasonably omitted or changed.

This form is not part of your group's policy or the Certificate of Coverage you have been provided. The policy may contain certain Limitations and Exclusions not stated here. Please see the Certificate of Coverage for specific policy information.

United Heritage Life Insurance Company (208) 493-6100 or Toll-Free 1-800-657-6351
707 E. United Heritage Ct., Meridian, Idaho 83642-3527 P.O. Box 7777, Meridian, Idaho 83680-7777
http://www.unitedheritage.com

Fern Ridge School District #28J

Generic Voluntary Short Term Disability Enrollment Form

Full Name: _____

Full Address: _____

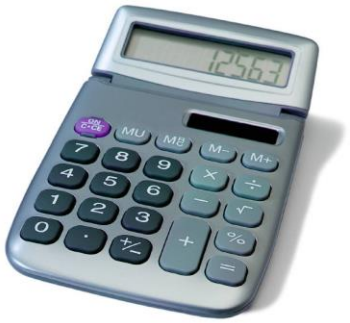
Date of Birth: _____ Occupation: _____

Male/Female: _____

Gross Weekly Earnings: $_____ Hours worked/week: _____

(*Not to Exceed $1,667*)

Date of Employment _____ Social Security Number: ____-____ -_____



Calculating your payroll deduction:

***Example*: Mary Smith -**

- **Age 44**
- **Gross Weekly Earnings $850**
- **Plan: 60% benefit to a maximum of $1,000 Weekly**
- **Mary's rate will be $0.36 per $10 of her weekly benefit**

***Calculation:* $850 X .60 =** $510 **X $0.36 =** $183.60 **/ 10 = $18.36**

To determine Gross Weekly Earnings, divide Gross Monthly Earnings by 4.33

1.	Gross Weekly Earnings* (*Not to Exceed $1,667*)	$_____
2.	By benefit percentage	X .60
3.	Weekly Benefit	= _____
4.	Your Rate (From chart)	X ____
5.	Total	= _____
6.	Divide by 10	/ 10
7.	**Estimated Monthly Premium**	**= $**_____

Age	Rate per $10 of Weekly Benefit
<25	.49
25-29	.47
30-34	.46
35-39	.39
40-44	.36
45-49	.39
50-54	.44
55-59	.50
60-64	.56
65+	.61

Your Pay Cycle	Pay Periods/Year
Bi-Weekly	26
Semi-Monthly	24
Weekly	52

Premium per pay period** _____

***To determine your premium per pay period, multiply line 7 by 12 and divide by the total number of pay periods.*

NOTE: Rates will change on the policy's anniversary date. If you are moving from one age bracket to the next, your rate will not change until the anniversary date following your birth date. ***Your final payroll deductions may vary slightly pending final enrollment and payroll deduction frequency.***

Please complete this enrollment form and return it to your Human Resource Department.

❑	**I would like to ENROLL** in the Voluntary Short Term Disability Insurance offered to me and I authorize the required deduction from my wages. Signature_____ Date_____
❑	**I would like to DECLINE** coverage at this time Signature_____ Date_____

United Heritage Life Insurance Company (208) 493-6100 or Toll-Free 1-800-657-6351
707 E. United Heritage Ct., Meridian, Idaho 83642-3527 P.O. Box 7777, Meridian, Idaho 83680-7777
http://www.unitedheritage.com

Complete the form only if you are electing over the following amounts:
Employee - $50,000
Spouse - $25,000
Child(ren) - $10,000

UNITED HERITAGE LIFE INSURANCE COMPANY
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777
Phone Number: 800-657-6351

PERSONAL HEALTH STATEMENT

Employees must complete this form if they have requested insurance coverage for themselves or any of their family members and are required to show evidence of good health.

For questions about how to complete this form, call United Heritage Life Insurance Company at

1-800-657-6351

Upon Completion:
Send both the Employer and Employee sections of this form to:
United Heritage Life Insurance Company
Group Department
P.O. Box 7777
Meridian, Idaho 83680-7777

Please remember your form can not be processed without your signature and current date.
Please keep a copy of the completed forms for your records

Instructions

Employer's Responsibility

1. Fill out the Employer Section completely. Please note an incomplete form will result in further correspondence that will delay the final time to decision. (Refer to your Policy Contract and employee records.)

2. In Section #1 "Who Requires a Personal Health Statement?" indicate with a check mark all who are required to provide evidence of good health – employee, spouse or child– and for each, check the reason(s) why. Refer to your Policy Contract for coverage amounts, eligibility periods (for late entrant determination) and guarantee issue limits.

3. In Section #2 "Coverage Summary, " complete all coverage amounts for each Enrollee. **Basic Life Coverage amounts are important and must be included for all Enrollees requesting additional Life coverage.** Refer to your policy contract and employee records to determine current coverage amounts, if any.

4. After completing the Employer section, forward the entire form, including both the Employer and Employee Sections, to the employee to complete.

5. No premiums should be deducted on additional amounts applied for until a final decision regarding coverage is received from United Heritage Life Insurance Company's Group Underwriting Department.

Employee's Responsibility

1. Make sure your Employer has already completed the Employer Section of this form in full.

2. The Employer Section clarifies which Enrollees need to show evidence of good health and be listed on this Personal Health Statement. Refer to EMPLOYER SECTION 1 of the form where a box has been marked for each person who is required to fill out a Personal Health Statement – you (the employee), your spouse or child. Enter the names of these individuals on the Personal Health Statement under EMPLOYEE SECTION 1 "Enrollees Requiring Health Evaluation," and fill in the information requested.

3. Answer all questions completely and accurately. Even minor details like height and weight are very important and must be accurate.

4. An enrollee will be responsible to pay for the cost of physical exams, medical tests or medical records retrieval if they are required now or are requested during the underwriting process.

5. YOU, THE EMPLOYEE MUST SIGN THIS FORM IN BOTH AREAS INDICATED (even if you yourself are not applying for coverage). Use your full legal signature, and enter the date signed. Your spouse must sign this form ONLY if using this form to apply for coverage. He or she must use a full legal signature, and enter the date signed.

6. **BOTH THE EMPLOYER AND EMPLOYEE SECTIONS OF THIS FORM MUST BE COMPLETED AND RECEIVED BY UNITED HERITAGE WITHIN 30 DAYS OF THE SIGNATURE DATE.**

7. The medical and personal information you complete on this form will be considered "current" up to 90 days from the date this form is signed. Leaving information blank can result in delays or may result in your file being closed.

EMPLOYER SECTION

Personal Health Statement			
Please print in dark ink. Initial any changes.			
Employer Name:			
Division/Subsidiary Name (If Applicable):			
Mailing Address:			
City:	State:	Zip:	Policy Number:
Benefits Contact Person:	Telephone Number: ( )		E-Mail:
Employee Name:		Employee Social Security Number:	
Date of Hire:	Family Status Change Date:	Employee Base Annual Earnings (BAE): $	

EMPLOYER SECTION 1: Who requires a Personal Health Statement?

Check box for each Enrollee who requires evidence of good health with a Personal Health Statement (PHS), and specify the reason(s) why:

Check all reasons that apply. Identify any Enrollees requiring a Personal Health Statement

EE Employee	❑ **New Hire** Newly eligible employee electing coverage for the first time during eligibility period.	❑ **Over Guaranteed Issue Limit (GI)** Election being made which requires medical underwriting, as it is above the GI benefit amount.	❑ **Opting up to Higher Level of Coverage** e.g. from 1 to 2 times salary or increasing in specified incremental dollar amounts as allowed by the plan.	❑ **Late Entrant** Employee who did not enroll during his/her eligibility periods.	❑ **Add Benefit** Adding a benefit that requires a Personal Health Statement.
SP Spouse	❑ **New Hire** Spouse electing coverage for the first time with a newly eligible employee during eligibility period.	❑ **Over Guaranteed Issue Limit (GI)** Election being made which requires medical underwriting, as it is above the GI benefit amount.	❑ **Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.	❑ **Late Entrant** Spouse did not enroll during his/her eligibility period.	❑ **Add Benefit** Adding a benefit that requires a Personal Health Statement.
CH Child	❑ **New Hire** Child electing coverage for the first time with a newly eligible employee during eligibility period.	❑ **Over Guaranteed Issue Limit (GI)** Election being made which requires medical underwriting, as it is above the GI benefit amount.	❑ **Opting up to Higher Level of Coverage** e.g. from $10,000 to $20,000 in coverage.	❑ **Late Entrant** Child did not enroll during his/her eligibility period.	❑ **Add Benefit** Adding a benefit that requires a Personal Health Statement.

EMPLOYER SECTION 2: Complete for each Enrollee.

Is EMPLOYEE applying for:

- ❑ **Basic Life Insurance**
- ❑ **Basic Dependent Life**
- ❑ **Short Term Disability** If Voluntary, Amt $ _____
- ❑ **Long Term Disability** If Voluntary, Amt $ _____ (Only if Applicable)
- ❑ **LIFE - Additional, Supplemental** *or* **Voluntary** (Complete Table Below)

Be sure to include any Basic Life Coverage as a dollar amount for all Enrollees requesting supplemental life coverage.

Enrollees for Life Coverage	**Current Guarantee Issue (GI) Amount In Force** *(This includes any GI coverage if eligible. This would apply to new hires electing for the first time) If no GI coverage, enter -0-.*	**Initial or Additional Amount Applied For** *(This amount reflects only the amount to be medically underwritten)*	**Total Coverage** *(Combined total of the amount currently in force, if any, and the amount being underwritten)*
Employee:			
Basic Life	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___
Suppl. Life or Voluntary Life	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___
Salary multiples for BAE plans **(BAE-Base Annual Earnings)**	**1x 2x 3x 4 x 5x ___ x Other multiple**	**1x 2x 3x 4 x 5x ___ x Other multiple**	**1x 2x 3x 4 x 5x ___ x Other multiple**
Spouse:			
Basic Life	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___
Suppl. Life or Voluntary Life	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___
Child:			
Basic Life	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___
Suppl. Life or Voluntary Life	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___	$___, ___ ___ ___, ___ ___ ___

EMPLOYEE SECTION

Personal Health Statement **BEFORE MAILING**

Please print in dark ink. Initial any changes

Employee First Name:	MI: Last Name:	
Mailing Address:		
City:	ST:	ZIP:
Social Security Number:	Occupation:	
Can we call you for any additional or missing information?: YES: ❑ NO: ❑	Work Phone: ( )	
E-Mail:	Home Phone: ( )	

• Answer all the questions and DATE and SIGN this form in both areas indicated.
• Keep a copy for your records.
Mail the completed Employer and Employee section to:
United Heritage Life Ins. Co.
Group Department
P.O. Box 7777
Meridian, Idaho 83680-7777

EMPLOYEE SECTION 1: Enrollees Requiring Health Evaluation (This is critical information and if left blank further correspondence will be generated)

List below the names of Enrollees identified in Employer Section I.

First Name, MI, Last Name	ENROLLEES	HEIGHT (ft/in) Required	WEIGHT (lbs) Required	DATE OF BIRTH Required	GENDER
_____	Employee	_____	_____	__ __ - __ __ - __ __	M F
_____	Spouse	_____	_____	__ __ - __ __ - __ __	M F
_____	Child	_____	_____	__ __ - __ __ - __ __	M F
_____	(all eligible children	_____	_____	__ __ - __ __ - __ __	M F
_____	must be listed)	_____	_____	__ __ - __ __ - __ __	M F

EMPLOYEE SECTION 2: Health Questions

Questions 1-11 are to be answered by all Enrollees listed above. **For all "Yes" answers; provide additional details in the sections provided**.

During the past 10 years have you or any of your dependents:	**YES**	**NO**
1. Had or been told to have surgery, been hospitalized, filed for Worker's Compensation, been declined for life, health or disability insurance, or consulted or been examined by any healthcare provider for anything other than normal physical exams or acute illnesses such as cold, flu or sore throat?	❑	❑
During the past 10 years have you or any of your dependents been diagnosed as having or been treated for: (Applies to questions 2-7 only)		
2. Heart disease, stroke, circulatory problems, diabetes, cancer, tumor, or any congenital, digestive, liver, thyroid, kidney, bladder or urinary tract disease or disorder?	❑	❑
3. Asthma, bronchitis, emphysema, allergies, pneumonia or other respiratory condition or disorder?	❑	❑
4. Brain or nervous system problems, epilepsy, depression or any other psychiatric, mental or nervous disorder?	❑	❑
5. Arthritis, rheumatism, back, spine or any other skeletal or muscular disease or disorder?	❑	❑
6. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus?	❑	❑
7. Alcohol or substance abuse or been advised to limit or cease consumption of or seek treatment for the use of alcohol and drugs?	❑	❑
Currently are you or any of your dependents: (Applies to questions 8-11 only)		
8. Pregnant?	❑	❑
9. Taking medication for any condition or disease?	❑	❑
10. Have you or your dependents experienced enlarged lymph nodes or unexplained weight loss?	❑	❑
11. Have you or your dependents had any injury, birth defect, congenital defect, disease or other disorder not mentioned above?	❑	❑

Furnish details here for any "**Yes**" answers on question 1 through 11: *(Use a separate sheet if more room is required.)*

Question Number			
Name of Enrollee			
Medical Condition			
Date Treatment Started			
Duration			
Current Status			
Treatment/Medication			
Names and Addresses of Physicians Consulted			

Furnish details here for any "**Yes**" answers on question 1 through 11: *(Use a separate sheet if more room is required.)*

Question Number			
Name of Enrollee			
Medical Condition			
Date Treatment Started			
Duration			
Current Status			
Treatment/Medication			
Names and Addresses of Physicians Consulted			

Notice: Enrollee is required to notify United Heritage Life Insurance Company in writing of any changes in any enrollee's medical condition between the date that enrollee signs this form and the date coverage is approved.

I hereby certify that the above statements and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statements and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits.

For your protection please be aware any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to civil fines and criminal penalties. This information may be used by the United Heritage Life Insurance Company to decide if the person(s) is/are eligible for coverage.

_____ __ __ - __ __ - __ __ _____ __ __ - __ __ - __ __

EMPLOYEE' S SIGNATURE (required) DATE SIGNED SPOUSE'S SIGNATURE (required only if applying for coverage) DATE SIGNED

EMPLOYEE SECTION 3: Enrollee Authorization

Employee Name – First Name	MI	Last Name	SSN

Authorization to Disclose Protected Health Information
To Be Used To Determine Eligibility for Group Life and/or Disability Income Coverage

I have requested insurance coverage under a Group Life and/or Disability Income Policy issued by United Heritage Life Insurance Company (UHLIC). To properly assess my eligibility for this coverage, UHLIC may require that I authorize disclosure of a copy of my entire medical file to them. This authorization is consistent with the requirements under §164.508(c) of the Standards for the Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), effective April 14, 2003.

I **authorize** any physician, medical or health practitioner, counselor, therapist, hospital, clinic, or other medical or medically-related facility, insurance or reinsurance company, the Medical Information Bureau, Inc., consumer reporting agency or employer that has records or knowledge of me, or my health, or my children, or their health, to disclose to the UHLIC or its representatives, any non-medical information or medical information, including but not limited to x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations and treatment notes, that relates to: 1) Pre-existing or current illnesses, sicknesses, disease, disabilities, disorders, accidents , injuries or any other health conditions; 2) Confinements in hospitals, medical facilities or medical clinics; 3) Outpatient treatment in hospitals, hospital emergency rooms, medical facilities or clinics, or by medical doctors or other health practitioners; 4) Drug abuse, alcohol abuse, or mental health information protected by Federal Law; 5) Counseling or therapy. (All of the foregoing information is called "health information" in the following sections.) **UHLIC will use this information to assess my eligibility and/or claim for insurance or benefits coverage under an existing Group Life and/or Disability Income policy.**

By signing this form I acknowledge that I **understand** the following:

- That any health information used or disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer subject to the privacy protections of HIPAA.
- That my request for coverage may be delayed and/or denied if UHLIC is unable to obtain health information necessary to properly assess its underwriting risk because I do not properly sign, date, and deliver this authorization or any person subject to HIPAA that receives it does not comply with it.
- That if UHLIC denies my request for coverage and this denial is based, in whole or in part, on health information obtained in connection with this authorization, UHLIC will not release this information to me unless otherwise authorized by the person or entity, including my physician or other medical professionals, that disclosed such information to UHLIC unless required by law.
- That, if necessary, UHLIC will send this authorization to persons or entities listed on my Personal Health Statement to receive health information about me. UHLIC will also provide me with written notice of the persons or entities to which UHLIC sends my authorization. I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this authorization or the authorization was granted as a condition for obtaining insurance coverage and UHLIC otherwise has the right to contest the policy or claim under the policy.
- That this authorization will expire two (2) years from the effective date of my coverage or if no coverage has been issued, one (1) year from the date of this application.
- That a photographic copy of this authorization shall be as valid as the original.
- That I am entitled to a signed copy of this authorization.

EMPLOYEE' S SIGNATURE
(required)

__ __ - __ __ - __ __
DATE SIGNED

SPOUSE'S SIGNATURE
(required only if applying for coverage)

__ __ - __ __ - __ __
DATE SIGNED

This section is very important. Your form cannot be processed without it.

Questions? Call 1-800-657-6351