**Life Insurance Company of North America**

# Personal Accident Insurance

**POLICYHOLDER:**
**INDIANA UNIVERSITY**

**POLICY No.**
**OK-980032**

*Complete the following to enroll. Please print.* CAMPUS LOCATION _____

Full Name: _____ Date of Birth: ___/ ___ / ___ Social Security #_____- ____- _____

ADDRESS: _____
Street City State Zip

1. Select Coverage Option (Select one): ❑ Employee Only - OR - ❑ Employee and Family

2. Select Benefit Amount: $_____ Indicate Monthly Cost: $_____ / per month (see chart below)

| Benefit Amount | Monthly Cost For Employee Only Coverage | Monthly Cost For Employee and Family Coverage* |
|---|---|---|
| $30,000 | $.60 | $.90 |
| $60,000 | $1.20 | $1.80 |
| $90,000 | $1.80 | $2.70 |
| $120,000 | $2.40 | $3.60 |
| $180,000 | $3.60 | $5.40 |
| $240,000 | $4.80 | $7.20 |
| $300,000 | $6.00 | $9.00 |
| $350,000 | $7.00 | $10.50 |
| $400,000 | $8.00 | $12.00 |
| $450,000 | $9.00 | $13.50 |
| $500,000 | $10.00 | $15.00 |

* For Employee and Family Coverage, benefits for family members will be a percentage of the Benefit Amount selected.

PRIMARY BENEFICIARY(IES):

| Name | DOB | SSN | Address | Relationship | % |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

CONTINGENT BENEFICIARY(IES):

| Name | DOB | SSN | Address | Relationship | % |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

*The Employee will be the family member's beneficiary unless otherwise indicated 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, the effective date of coverage will be delayed until I return to work.

Employee Signature _____ Date _____/_____/_____

**CIGNA Group Insurance**
**Life - Accident - Disability**

UHRS
07/04