



Beneficial Life
Group Insurance
36 South State Street
Salt Lake City, Utah 84136
Toll-Free (800) 325-7056
www.beneficialgroup.com

Group Supplemental Life Insurance Enrollment Form
(Only to be completed by employees applying for Supplemental Life Coverage)

| | | | | | |
|--|--------------------------|---|---------------|---|----------------------|
| Employer's (Group) Name : | | Please check all that apply New Enrollment: <input type="checkbox"/> G.I.: <input type="checkbox"/> Change: <input type="checkbox"/> | | Supplemental Coverage Amount (Min. of \$20,000): \$ | |
| Employee's Last Name: | | First Name: | | Middle Initial: | Email Address: |
| Street Address: | | City: | | State: | Zip Code: |
| Residential Phone Number: () | Work Phone Number () | Social Security Number: | Date of Birth | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Height: Weight: |
| Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date of Employment: | Occupation: | | Annual Salary: \$ |

PROPOSED INSURED SPOUSE – Only Available if Employee Elects Supplemental Life Coverage
(Complete only if Spouse Supplemental Life is being applied for)

| | | | | | |
|--|--|--|---|-----------------|--|
| Spouse's Last Name: | | Spouse's First Name: | | Middle Initial: | Coverage Amount for Spouse: (Min. \$10,000) \$ |
| Spouse's Social Security Number: | | Spouse's Date of Birth: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Height: | Weight: |
| Has spouse used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If employed, list spouse's occupation: | | Hours per Week: | |

DEPENDENT CHILDREN – Only Available if Employee Elects Supplemental Life Coverage
(Complete only if Supplemental Dependent Life is being applied for, use separate sheet if necessary)

Dependent Coverage Amount: (Please check one) One Unit (\$5,000) Two Units (\$10,000)

| Name: | M <input type="checkbox"/> F <input type="checkbox"/> | Date of Birth: | Height: | Weight: |
|-------|---|----------------|---------|---------|
| | <input type="checkbox"/> <input type="checkbox"/> | | | |
| | <input type="checkbox"/> <input type="checkbox"/> | | | |
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| | <input type="checkbox"/> <input type="checkbox"/> | | | |
| | <input type="checkbox"/> <input type="checkbox"/> | | | |

BENEFICIARY DESIGNATION
Beneficiaries listed below will be the beneficiary for Supplemental Life Coverage only.

| | |
|---|------------------------------|
| Name and address of Employee's Beneficiary (Example, Helen Doe not Mrs. John Doe) | Relationship of Beneficiary: |
| Name and address of Employee's Contingent Beneficiary | Relationship of Beneficiary: |

ANSWER ALL QUESTIONS ON THE REVERSE SIDE AND SIGN FORM WHERE INDICATED

SGTLEA002

PLEASE DETACH THIS NOTICE AND KEEP IT FOR YOUR RECORDS
NOTICE OF DISCLOSURE

Information regarding your insurability will be treated as confidential except that Beneficial Life Insurance Company or its reinsurers may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its member. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Beneficial Life Insurance Company or its reinsurers may also release information in its file to its reinsurers and to other life insurance companies to which you may apply for life or health insurance or to which a claim is submitted.

Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your files. Medical information will only be disclosed to your attending physician. If you question the accuracy of information in the Bureau's file you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone (617) 426-3600.

Complete Questions 1 through 12 with respect to all persons to be insured. Please explain details of any "Yes" answers in item 12.

In the past 5 years has any person to be insured:

1. Consulted or been attended or examined by any doctor or other medical practitioner? YES NO

2. Had an electrocardiogram, x-ray, blood analysis or other medical test? YES NO

Has any person to be insured ever:

3. Been in a hospital or other institution for observation, rest, diagnosis, treatment or surgery? YES NO

4. Used barbiturates or amphetamines, marijuana or any other narcotic, except as prescribed by a doctor? YES NO

5. Been treated or counseled for alcohol or drug use? YES NO

6. Been declined for insurance or been offered coverage other than as applied for? YES NO

7. Been treated for or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or other immune deficiency disorder? YES NO

8. Is any person to be insured now taking, or has taken medication for any purpose in the past 6 months? YES NO

9. Does any person to be insured now have a known sign of any physical or mental disorder, disease or defect not already shown? YES NO

In the past 3 years has any person to be insured?

10. Participated in any hazardous avocations such as motor-boat racing, parachuting, or scuba diving or is such activity contemplated? YES NO

11. Flown as a pilot, student pilot or crew member of any aircraft or is such activity contemplated? YES NO

12. If you have answered "Yes" for any of the above questions, provide details in the following lines. Attach a separate sheet if necessary.

| Question Number | Name of Person | Condition or impairment. Explain nature, severity, frequency, medication or other treatment | Date of Onset | Date and Extent of Recovery | Name and address of each physician, hospital or medical facility | |
|--------------------------------|-----------------|---|---------------|-----------------------------|--|--|
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| | | | | | | |
| Employee's Personal Physician | Street Address: | City: | State: | Zip Code: | Phone Number: () | |
| Spouse's Personal Physician | Street Address: | City: | State: | Zip Code: | Phone Number: () | |
| Dependent's Personal Physician | Street Address: | City: | State: | Zip Code: | Phone Number: () | |

PLEASE BE SURE TO SIGN THE AUTHORIZATION TO OBTAIN INFORMATION SECTION

I represent that the statements and answers given on each side of this form are true, complete and correctly recorded, to the best of my knowledge and belief and I hereby authorize deduction from my wages the contributions, if any, required of me for the insurance. I further understand and agree that upon completion of this enrollment application for group insurance there will be no insurance in force until the Beneficial Life Insurance Company accepts the applicant(s) as insurable risks and the first premium is received by Beneficial Life Insurance Company.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Beneficial Life Insurance Company or its legal representative, any and all of such information.

I UNDERSTAND the information obtained by use of this Authorization will be used by BENEFICIAL LIFE INSURANCE COMPANY to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by BENEFICIAL LIFE INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

If an investigative report is required in connection with my application, I request a personal interview by checking here: **q**
 If you wish to receive a copy of this authorization, please check here: **q**

I KNOW that I or my authorized representative may request to receive a copy of this Authorization. I ACKNOWLEDGE receipt of the Notice of Disclosure of Information and Notice to Proposed Insured. I AGREE this Authorization shall be valid for two and one half years from the date shown below

 Date Signature of Employee Signature of Spouse, if coverage is being applied for

NOTICE TO PROPOSED INSURED

The law requires you to be advised that in connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interview with your neighbors, friends, or others with whom you are acquainted. Such reports are usually part of the process of evaluating risk for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living.

If you wish to be personally interviewed, please check the block in the Authorization to Obtain Information Section of the application. You or your authorized representative are entitled to receive a copy of this authorization form. You have a right to access and correction of the information we collect about you, except that information which relates to a claim or a civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please make such a request, in writing, to the Beneficial Life Insurance Company, Group Underwriting Department, 36 South State Street, Salt Lake City, Utah 84136.