

**INSTRUCTIONS AND INFORMATION FOR COMPLETING THE
EVIDENCE OF INSURABILITY – OPTIONAL BENEFITS
ENROLLMENT FORM**

This product is underwritten by LifeWise Assurance Company (LifeWise) also known as we, us or our.

To expedite processing, please print neatly and respond to all questions.

1. Fully complete this form when your plan requires you to be individually underwritten to qualify for insurance or when you are enrolling for Voluntary Life coverage. Specify what coverage you are requesting. If you are unsure, check with your plan administrator.
2. Make sure you have answered all of the questions completely and accurately. Information pertaining to your employer name, address and group number as well as your personal information must be provided. If there are unanswered questions, the underwriting process will not begin.
3. If the amount you or your spouse are applying for is at or below the guaranteed issue, you must complete only Section 1 of this form. If you or your spouse are applying for coverage that is above the guarantee issue amount or 31 days after you are eligible to enroll, then you must complete Sections 1 and 2.
4. Please include your work and home phone number; we may need to request additional information by telephone.
5. Please sign and date where indicated and make a copy of this form for your records. Please send the completed form to your plan administrator or mail or fax us at the address or fax number at the top of this form.

In order to evaluate this application, we are relying on the information you or your spouse have provided. In addition, we may need to request supplemental information from you, your spouse, or your physician(s). Some coverage and amounts may require a brief medical exam, a blood test, urinalysis and/or EKG. We will notify you or your spouse if any additional information is needed.

Caution: If your answers on the application are incorrect or untrue, we may deny benefits or rescind your insurance.

Arizona: Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation on or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a Class 2 misdemeanor.

California: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

New Mexico: 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 is guilty of a crime and may be subject to civil fines and criminal penalties.

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.

All other states: 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.

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Policyholder Information (to be completed by the policyholder)

| | | | | | |
|-----------------------------|---|---|--|----------------------------|--|
| Policy Number | Division Number | Policyholder Name | | | |
| Class | Job Title | Date of Hire (mm/dd/yyyy) | Effective Date (mm/dd/yyyy) | Hours Worked Per Week | |
| Employee's Annual Salary \$ | | Reason For Change | | | |
| Application Type | <input type="checkbox"/> Initial Request | <input type="checkbox"/> Late Applicant | <input type="checkbox"/> Annual Enrollment | Date of Event (mm/dd/yyyy) | |
| | <input type="checkbox"/> Change in Status | <input type="checkbox"/> Increase | | | |

Section 1 – Insured Information (to be completed by the employee)

Coverage Elected

| | | | |
|--|--|--|--|
| Employee Coverage | | Dependent Coverage | |
| <input type="checkbox"/> Basic Life \$ _____ | <input type="checkbox"/> Employee Voluntary Life | <input type="checkbox"/> Spouse Voluntary Life | <input type="checkbox"/> Spouse Voluntary AD&D |
| <input type="checkbox"/> Employee Voluntary AD&D | <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> Child Voluntary Life | <input type="checkbox"/> Child Voluntary AD&D |
| <input type="checkbox"/> Short Term Disability | | | |

Employee Information

| | | | | |
|------------------------|----------------------------|--|--|---------------------------------|
| Employee Name: (Last) | (First) | (MI) | <input type="checkbox"/> Married | <input type="checkbox"/> Male |
| | | | <input type="checkbox"/> Unmarried | <input type="checkbox"/> Female |
| Your Home Address | Street | City | State | Zip |
| Social Security Number | Date of Birth (mm/dd/yyyy) | Home Phone () - | Work Phone () - | |
| Height | Weight | Total Voluntary Life Amount Applied For \$ | Total Voluntary AD&D Amount Applied For \$ | |

Spouse Information (if applicable)

| | | | | | |
|--------------------------------|--------|---|---|----------------------------|----------------------------|
| Spouse Name | Last | First | MI | Date of Birth (mm/dd/yyyy) | Social Security Number - - |
| Spouse's Home Address | Street | City | State | Zip | |
| <i>If different than above</i> | | | | | |
| Height | Weight | Total Spouse Voluntary Life Amount Applied For \$ | Total Spouse Voluntary AD&D Amount Applied For \$ | | |

Child Information (if applicable)

| | |
|--|--|
| Total Child Voluntary Life Amount Applied For \$ | Total Child Voluntary AD&D Amount Applied For \$ |
|--|--|

Beneficiary Designation (Employee is the beneficiary for dependent coverage)

Beneficiary Name(s) Please provide full legal name of beneficiary (Example Helen Louise Jones not Mrs. H.L. Jones)
 Use a separate sheet for additional beneficiaries, if necessary. If more than one beneficiary is named, payment will be made in equal amounts unless otherwise stated in writing.

| | |
|--|--------------|
| <input type="checkbox"/> Primary | Relationship |
| Beneficiary Name: | Percentage |
| <input type="checkbox"/> Primary <input type="checkbox"/> Contingent | Relationship |
| Beneficiary Name: | Percentage |

LWAC Internal Use Only

| | |
|-----------------------------------|-----------------------------------|
| Employee: | Spouse: |
| <input type="checkbox"/> Approved | <input type="checkbox"/> Approved |
| Effective Date: _____ | Effective Date: _____ |
| <input type="checkbox"/> Declined | <input type="checkbox"/> Declined |
| Effective Date: _____ | Effective Date: _____ |
| Initials: _____ Date: _____ | |

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Employee Name:

Social Security Number:

- -

Section 2 – Please complete the following questions to the best of your knowledge and belief

This section is to be completed only if you or your spouse are requesting amounts over the guarantee issue amount, requesting an increase in insurance, or if you are a late enrollee.

If you answer yes to any of the questions, please provide details requested in the box on the next page.

| | Employee | Spouse |
|---|---|---|
| 1. Have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Applicant need not disclose Human Immunodeficiency Virus (HIV) test results. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you confined to a wheelchair for reasons other than paraplegia? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Do you have any condition that prevents or limits activities or are you now pregnant? If yes, provide details including symptoms and describe the limitation(s). If pregnant, please provide expected delivery date. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Within the past 2 years , have you used any controlled substances with the exception of those prescribed by a physician, received medical advice or sought treatment for drug or alcohol abuse, or pled guilty, pled no contest to or been convicted of a felony, misdemeanor, or a charge of operating a motor vehicle under the influence of drugs and/or alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Within the past 2 years , have you been prescribed three or more medications to be taken concurrently for high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Within the past 2 years , have you flown as a student or private pilot, engaged in auto or boat racing, scuba diving, hang gliding, ballooning, flying ultralights, parachuting, mountain climbing or any similar sport or avocation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Within the past 2 years , have you pled guilty to, pled no contest to, or been convicted of 3 or more speeding or other moving violations? If yes, list person's name, type of violation(s), date(s), driver's license number and state of issue. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Within the past 5 years , have you received medical advice or sought treatment for psychosis, internal cancer including melanoma, leukemia, or Hodgkin's disease, ALS, muscular dystrophy, angina, or had heart surgery, heart attack or transient ischemic attack (TIA)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Within the past 5 years , have you ever used barbiturates, amphetamines, cocaine, hallucinogenic drugs or any narcotics except as prescribed by a physician or been advised to reduce your consumption of alcohol or been treated, arrested in connection with alcohol, or been told to have counseling for the use of alcohol or drugs? If yes, provide the frequency of use and date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital name, address and phone number, date of occurrence and driver's license number and issuing state of any arrest. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Within the past 5 years , have you ever pled guilty to, pled no contest to or been convicted of a felony or misdemeanor? If yes, list person's name, reason for arrest(s) and/or are you currently on probation. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Within the past 7 years , have you received medical advice or sought treatment for diabetes, asthma, lung or respiratory disorder, thyroid or other endocrine disease, heart or circulatory disorder, stroke (including TIA), chest pain, high blood pressure, cancer, gastro-intestinal, genitourinary, kidney or liver disease? If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital's name, address and phone number. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Within the past 7 years , have you consistently taken any over the counter medications, natural supplements other than vitamins, or received any therapeutic treatments? If yes, list all over the counter medications including any natural supplements, dosage, condition and date of onset. Please also list therapies and associated conditions and dates treatment received. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Within the past 10 years , have you received medical advice or sought treatment for stroke, congestive heart failure, chronic lung disease including emphysema, diabetes treated with insulin or oral medications, hepatitis (other than type A), cirrhosis of the liver, chronic renal disease including hypertension or failure, systemic lupus or any connective tissue disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Within the past 10 years , have you received medical advice or sought medical treatment for epilepsy, nervous, emotional or mental disorder, paralysis, skin, bone, muscle, back, knee, neck or joint disorder, muscular or neurological disorders, Fibromyalgia, or Chronic Fatigue Syndrome. If yes, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's/hospital's name, address and phone number. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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Employee Name: _____

Social Security Number: _____ - _____ - _____

Section 2 (continued)

| | Employee | Spouse |
|---|---|---|
| 15. Are you currently on any prescribed medications or have any medications been prescribed or have you consulted a medical professional for anything other than the conditions above, or are you currently experiencing any symptoms for which you haven't consulted a medical professional? If yes, provide details including symptoms, dates of occurrence, medications, treatment and medical professional's name, address and phone number. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Details for any "Yes" answers

| Question Number | Name | Detailed Description | Date (mm/dd/yyyy) | Duration | Treatment Received, Medications Taken, and Recovery | Names and Addresses of Physicians and Hospitals |
|------------------------|-------------|-----------------------------|--------------------------|-----------------|--|--|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Please attach additional sheets if you need additional space.

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Employee Name: _____

Social Security Number: _____ - _____ - _____

Notice and Authorization of Exchange of Information

Thank you for enrolling for insurance coverage through LifeWise Assurance Company (“LifeWise”, “we”, “us”, or “our”). As part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person’s insurability. We or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau (Bureau), a nonprofit organization of life insurance companies which operates information exchange in behalf of its members. If you apply to another bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau’s file, you may contact the Bureau and seek a 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 number (617) 426-3660.

We or our reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

By signing below you authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Bureau or other organization, institution or person, that has any records or knowledge of you or your health, including information pertaining to: alcohol and/or chemical dependency; reproductive health (including abortion); sexually transmitted diseases (HIV/AIDS); psychiatric disorders/mental illness; and genetic information to give to us or our reinsurers any such information.

Unless you revoke it, this release will remain valid until the underwriting process is complete, but not to exceed twenty-four (24) months from the date of your signature below.

You understand that you may change your mind and revoke this release at any time. You will do this by letting us know of your decision. Any change will be effective five (5) business days after we receive your written notice at the address listed at the top of this form. You understand that some or all of this information may already have been shared and that LifeWise will not be liable for any information already released.

This authorization is a condition of your enrollment. If you decide not to sign this authorization, we may decline to enroll you in the coverage requested.

Information regarding your insurability will be treated as confidential.

I hereby apply for the insurance coverage indicated on page 1 of this form for which I am eligible and authorize deductions from my wages to cover the cost of insurance.

Date (mm/dd/yyyy)

Your Signature

Date (mm/dd/yyyy)

Your Spouse’s Signature (if applicable)