Life Insurance Changes

To drop dependents:

- Life Insurance Change Form (Page 2)

To add dependents:

- Life Insurance Change Form (Page 2)
- MetLife Enrollment/Change Form (Page 4)

To drop or reduce Life or AD&D insurance:

- Life Insurance Change Form (Page 2)

To add or increase Life or AD&D amounts:

- Life Insurance Change Form (Page 2)
- MetLife Enrollment/Change Form (Page 4)
- MetLife Statement of Health Form (one for each person whose amount you wish to add or increase, including yourself) (Page 7)

Please send completed forms to Kris Akut, Benefits Coordinator.

2022 Life/AD&D Insurance Change Form

Last Name:_____ **First Name:**_____

Moody ID #: _____

My CURRENT Life Insurance is:

☐ Basic $25,000
☐ Optional $_____(*indicate amount*)

☐ Child $10,000
☐ Spouse Optional $_____(*indicate amount*)

I would like my NEW Life Insurance to be:

☐ Drop my Optional Life Insurance

☐ Add or Increase my Optional Life Insurance to $_____(*indicate amount*)*

☐ Decrease my Optional Life Insurance to $_____(*indicate amount*)

☐ Add or Increase Spouse Life Insurance to $_____(*indicate amount*)*

☐ Drop Spouse Life Insurance

☐ Add Child Life Insurance**

☐ Drop Child Life Insurance

I would like to ADD or DROP dependent(s) from my Life Insurance:

☐ **Add**** Name of Dependent:_____Birth date:_____/____/____
☐ **Drop** Relationship to you: _____

☐ **Add**** Name of Dependent:_____Birth date:_____/____/____
☐ **Drop** Relationship to you: _____

☐ **Add**** Name of Dependent: _____Birth date:_____/____/____
☐ **Drop** Relationship to you: _____

☐ **Add**** Name of Dependent: _____Birth date:_____/____/____
☐ **Drop** Relationship to you: _____

My CURRENT AD&D Insurance is:

☐ Basic $25,000
☐ Employee Optional $_____(*indicate amount*)

☐ Family Optional $_____(*indicate amount*)

I would like my NEW AD&D Insurance to be:

☐ Drop my AD&D Insurance

☐ Add or Increase my Employee AD&D Insurance to $_____ (*indicate amount*)***

☐ Decrease my Employee AD&D Insurance to $_____(*indicate amount*)

☐ Add or Increase my Family AD&D Insurance to $_____(*indicate amount*)***

☐ Decrease my Family AD&D Insurance to $_____(*indicate amount*)

Effective Date of Change: 01/01/2022

Signature of Employee:_____ **Date:**_____/_____/_____

* If you are raising your amount of life insurance or applying for the first time, for yourself or your spouse, you must fill out

one **Enrollment/Change Form** and a separate **Statement of Health Form** for each person.
** If you are adding new children to your coverage, you must fill out an **Enrollment/Change Form**.
*** If you are adding or increasing your AD&D insurance, you must fill out an **Enrollment/Change Form**.

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
The Moody Bible Institute of Chicago	145676	145676	0001	0001

Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.

► If you are enrolling during the initial enrollment period, you must also complete a Statement of Health form:
- If you are enrolling for more than $150,000 of Supplemental/Optional Life Insurance
- If you are enrolling for more than $20,000 of Dependent Life Insurance

► If you are enrolling after the initial enrollment period, you must also complete a Statement of Health form.

Term Life Insurance

☒ Basic Life [1]

☐ Supplemental/Optional Life [1]
Enter a multiple of $10,000 up to a maximum of $500,000. $_____

☐ Dependent Spouse Life [1,2]
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000

☐ Dependent Child Life [2]

Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic AD&D

☐ Voluntary AD&D

First select your option
☐ Employee only
☐ Employee + Dependents

Then select your level of coverage
Enter a multiple of $10,000 up to a maximum of $500,000. $_____

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.

[2] Amounts will be subject to state limits, if applicable.

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

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ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: 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 fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under this Group Customer's plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.
I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			TOTAL:	100%

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			TOTAL:	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Employee | Print Name | Date Signed (MM/DD/YYYY)

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Metropolitan Life Insurance Company
Statement of Health Form Instructions

Based on your enrollment, a Statement of Health is required to complete your request for group insurance coverage. Below are instructions for Completing the Statement of Health Form.

A separate Statement of Health form is required for each Proposed Insured / Applicant requesting insurance.

PLEASE USE THE CHECKBOXES TO ENSURE PROPER COMPLETION OF THE FORM.

Information to be Completed by Employer

- ☒ Enter Employer Name
- ☒ Enter Customer Number
- ☒ Enter SOH Reporting Location (if applicable)
- ☒ Enter Employer Address
- ☐ Select type of Insurance
  - ☐ If Life Insurance, **enter the additional amount of insurance**
- ☐ Enter Enrollment Year or year of requested increase (usually current year) for reporting purposes only

Information to be Completed by Proposed Insured / Applicant

The Proposed Insured / Applicant must complete all information located in the boxes at the top:

- ☐ Enter Employee Name and Social Security Number**
- ☐ Enter Relationship of Proposed Insured / Applicant to Employee
- ☐ Enter Proposed Insured / Applicant's
  - ☐ Name
  - ☐ Sex
  - ☐ Date of Birth
  - ☐ Mailing Address
  - ☐ Business Telephone Number
  - ☐ Home Telephone Number
  - ☐ Email Address
  - ☐ State of Birth
  - ☐ Country of Birth

****NOTE: The Employee's Name and Social Security Number must appear on the form.**

Medical Information — must be completed.

- ☐ Complete Question 1.
- ☐ Check "Yes" or "No" for Questions 2–6 (**all parts**).
- ☐ Complete Question 7.
- ☐ Complete the details section if ANY of the questions 2 through 6 were answered "Yes."

Signatures

- ☐ The Employee must always sign and date the **Statement of Health** form.
- ☐ The Proposed Insured / Applicant (if over the age of 18) must sign and date the **Statement of Health** and **Authorization** forms. If the Proposed Insured / Applicant is under the age of 18, his/her personal representative must sign and date the Authorization.

Upon completion, make a copy of the completed form for your records and FAX or MAIL the completed 3-pages to the Statement of Health (SOH) Unit at MetLife.

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

Note: Additional medical information may be required after initial review of completed forms. This information may be in the form of a physical examination, paramedical exam, or Attending Physician Report, in which correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned for completion. For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com.

MetLife®
Metropolitan Life Insurance Company, New York, NY

STATEMENT OF HEALTH FORM

To be Completed by the Employer **-PLEASE PRINT CLEARLY-**

Employer Name	Customer Number	Reporting Location Number	
The Moody Bible Institute of Chicago	**145676**	**145676**	
Employer's Street Address	City	State	Zip Code
820 North LaSalle Boulevard	**Chicago**	**IL**	**60610**

Insurance Requested (To be completed for each Proposed Insured / Applicant)

☐ Basic Life ☐ Supplemental/Optional Life ☐ Group Universal Life ☐ Group Variable Universal Life ☐ Dependent Life

Additional Amount of Life Insurance Subject to Medical Underwriting $_____

☐ Short Term Disability ☐ Long Term Disability

Enrollment Year:_____

To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)

Employee Name (Must Complete) First MI Last			**Employee Social Security Number (Must Complete)**	
Insurance is for ☐ Employee ☐ Spouse ☐ Child	Proposed Insured Name First MI Last		☐ Male ☐ Female	Date of Birth (Mo Day Yr)
Mailing Address	City		State	Zip Code
Business Phone Number ( )	Home Phone Number ( )	E-mail Address	State of Birth	Country of Birth

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Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

1. Height ____ feet ____ inches Weight ____ lbs

	Yes	No
2. Are you now:		
a. pregnant?	☐	☐
b. taking prescribed medications or on a prescribed diet? If "yes," list:_____	☐	☐
c. receiving or applying for any disability benefits including workers' compensation?	☐	☐
3. In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.)_____	☐	☐

5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

	Yes	No		Yes	No
a. chest pain or heart trouble?	☐	☐	h. colitis, Crohn's or any intestinal disorder?	☐	☐
b. high blood pressure, stroke or circulatory disorder?	☐	☐	i. Epilepsy, paralysis or dizziness?	☐	☐
c. cancer or tumors?	☐	☐	j. mental or nervous disorder?	☐	☐
d. anemia, leukemia or other blood disorder?	☐	☐	k. Lyme disease, Epstein-Barr or chronic fatigue syndrome?	☐	☐
e. diabetes?	☐	☐	l. arthritis, carpal tunnel, or any muscle		
insulin treated?	☐	☐	weakness?	☐	☐
f. asthma, tuberculosis, pneumonia, or other			m. kidney or urinary tract disorder?	☐	☐
lung disease?	☐	☐	n. thyroid or other gland disorder?	☐	☐
g. ulcers, stomach or liver disorder?	☐	☐	o. back, neck or spinal disorder?	☐	☐

	Yes	No
6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐

7. Personal Physician:_____ Date and reason for last visit:_____
Address:_____ Phone Number:_____

Give full details for "Yes" answers on the next page.

Make A Copy For Your Records & FAX or MAIL Completed Forms to
the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Give full details for "Yes" answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code

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Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

Fraud Warning:
If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon, and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia and 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 and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Sign Here		Date Here	
	(Employee must always sign) Signed		Date Signed (Mo./Day/Yr.)
	(Proposed Insured if other than Employee and at least 18 years of age) Signed		Date Signed (Mo./Day/Yr.)

GEF02-1a **SOH/NW** **(08/08)**
DEC

Make A Copy For Your Records & FAX or MAIL Completed Forms to
the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, the proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Each proposed insured has a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

_____

Signature of Proposed Insured or
Signature & Relationship of Personal Representative*

_____

Date Signed (Mo./Day/Yr.)

_____

Print Name of Proposed Insured

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.