Group Select
Case Submission Application

Cigna Group Insurance
Life • Accident • Disability

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York

Cigna.

UNDERWRITING COMPANY

☒ Life Insurance Company of North America ☐ Cigna Life Insurance Company of New York ☐ Connecticut General Life Insurance Company
☐ Cigna Behavioral Health, Inc. (for Life Assistance Program and Employee Assistance Program)

Attachments for Case Submission

☒ Confirmed Sold Proposals ☒ Prior Carrier Contract/Booklet(s)
☒ Binder Check equal to first month's premium *(100% Employer Paid coverages only)*

Attachments for Customer Review *(provided by your Sales Rep as applicable)*

☒ Appointment of Claim Fiduciary * ☒ ADEA Notice ☐ Life Assistance Program Agreement *
☒ Disclosure of Producer Compensation Practices ☒ Limited Agency Agreement ☐ Employee Assistance Program Agreement *
*** signature required** ☒ Privacy Notice ☐ Cigna Absence Assistant *

To assure operational readiness and accurate set-up of your contract/agreement(s) you MUST provide the information requested below.

EMPLOYER INFORMATION - SECTION 1
To be completed for all coverages

EMPLOYER FULL LEGAL NAME *Please include exact abbreviations, punctuation and /or capitalization.*			COMPANY TAX ID #
City of Gahanna			
STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CONTACT	TITLE	PHONE	PHONE EXT. / FAX
E-MAIL			

AFFILIATED COMPANIES

Please complete the following information if there are employees working for an affiliated company and they are eligible for coverage.

AFFILIATE NAME (1)	TAX ID #	SEPARATE BILLING GROUP? ☐ Yes ☐ No	NUMBER OF EMPLOYEES
STREET ADDRESS	CITY	STATE	ZIP CODE
CONTACT NAME	PHONE	PHONE EXT.	
E-MAIL			

If more space is needed for additional affiliates, billing groups or contacts, please provide the information requested above on the attached Additional Notes page.

GENERAL PLAN AND COVERAGE INFORMATION - SECTION 2
To be completed for all coverages

If policy effective date and/or anniversary date varies by coverage(s) please identify here.

Policy Effective Date **1/1/2013** Policy Anniversary Date **1/1**

Employee Eligibility, Waiting Period & Earnings Definition(s)

Please select an eligibility description either for all employees (Class 1 box) OR for each class as appropriate. All classes standardly exclude temporary or seasonal employees.

Class 1	Minimum Hours ☐ Full-time _____ ☐ Part-time _____ *if applicable*	Includes: ☐ All Employees **OR** ☐ Salaried ☐ Union ☐ Hourly ☐ Non-Union	Other Description: (i.e.: Pres., V.P., CFO specific job titles)
Class 2	Minimum Hours ☐ Full-time _____ ☐ Part-time _____ *if applicable*	☐ Salaried ☐ Union ☐ Hourly ☐ Non-Union	Other Description: (i.e.: Pres., V.P., CFO specific job titles)
Class 3	Minimum Hours ☐ Full-time _____ ☐ Part-time _____ *if applicable*	☐ Salaried ☐ Union ☐ Hourly ☐ Non-Union	Other Description: (i.e.: Pres., V.P., CFO specific job titles)

Are there any union employees part of the eligible class? ☐ Yes ☐ No Do you provide coverage for retirees? ☐ Yes ☐ No

Is there any level of coverage provided to a special group of employees outside of the current plan parameters or to a population that is not actively at work?

☐ Yes ☐ No If yes, describe in the space provided below.

(It is required that Cigna have a list of these individuals on file. The list should include Employee Name, Gender, Date of Birth and Coverage Amount).

Please utilize the attached Additional Notes page to identify any additional classes or if eligibility differs by coverage.

GENERAL PLAN AND COVERAGE INFORMATION - SECTION 2 *(Continued)*
To be completed for all coverages

Active Service Definition

An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.
2. **Applicable only to Life and Accident Coverage.** The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days. An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.
2. **Applicable only to Disability Coverage.** The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

Do you have anyone who is not actively at work due to disability and are now in the waiver waiting period? ☐ Yes ☐ No

If Yes, these employees should apply for waiver immediately with the previous carrier.

Eligibility Waiting Period Time employee must work before becoming eligible for insurance coverage.

☐ No Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 month ☐ 3 months
☐ Other _____

Class Specific Waiting Period *Complete only* if Eligibility Waiting Period is different by class.

Class 1 ☐ No Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 month ☐ 3 months
☐ Other _____

Class 2 ☐ No Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 month ☐ 3 months
☐ Other _____

Class 3 ☐ No Waiting Period ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 month ☐ 3 months
☐ Other _____

Individual Effective Date Date employee is eligible for insurance coverage once eligibility waiting period has been satisfied.

☒ On the date eligibility waiting period is satisfied (standard)
☐ First of the month on or after completion of the eligibility waiting period
☐ On the day following completion of the eligibilty waiting period

Cigna standard is to not provide dual coverage for married couples.

Class Change Effective Date *Complete only* if more than one class.

☒ Date of Change (standard) ☐ First of the month following Date of Change ☐ Anniversary Date
☐ Other _____

Earnings Change Effective Date Date an employee's amount of insurance resulting from a change in the Employee's earnings will take effect

☒ Date of Change (standard) ☐ First of the month following Date of Change ☐ Anniversary Date ☐ Not Applicable
☐ Other _____

Age band changes

☒ Policy Anniversary (standard) ☐ Date of Change ☐ First of the month following Date of Change ☐ Jan 1 ☐ Not Applicable
☐ Other _____

Benefit Reduction Effective Date

☒ Date of Change (standard) ☐ First of the month following Date of Change ☐ Anniversary Date ☐ Not Applicable
☐ Other _____

Continuation of Insurance *Allows insurance to be continued if an employee is no longer in active service. Premium payment is required. If applicable to your plan, please indicate maximum duration for each leave type listed.*

FML Leave ☐ The later of approved FML leave or the leave period required by state law (would include Military Caregiver Leave).
☐ Other _____

Approved Unpaid Leave of Absence *

☒ End of the Month in which the leave began (standard) ☐ End of the Month following the month the leave began
☐ None ☐ Days _____ ☐ Weeks _____ ☐ Months _____

Layoff*

☒ None (standard) ☐ Days _____ ☐ Weeks _____ ☐ Months _____
☐ End of the Month in which the layoff began ☐ End of the Month following the month the layoff began

**These continuation options are not applicable to Disability Coverages*

If any other Leave Types apply to your plan, please define (i.e.: Sabbatical, Military) and indicate maximum timeframes in the space provided below.

GENERAL PLAN AND COVERAGE INFORMATION - SECTION 2 *(Continued)*
To be completed for all coverages

Covered Earnings Definition Same definition for All Classes and Coverages(s) [x] Yes [ ] No *If No, define below as applicable:*

[x] Basic Earnings Only - Standard Wage or Salary as reported by the Employer; excluding commissions, overtime, bonuses or any additional extra compensation.

[ ] Basic Earnings Including [ ] Bonus [ ] Commissions [ ] Overtime [ ] Incentive Pay [ ] Other: _____

Bonus and/or Commissions averaged over [ ] 12 months [ ] 24 months [ ] 36 months

[ ] W2 Basic Earnings Including [ ] Bonuses [ ] Schedule K [ ] Pre-Tax Contributions [ ] Other: _____

LIFE PLAN COVERAGE INFORMATION

Beneficiary Maintenance [ ] Paper [ ] Electronic *(if electronic, agreement will be provided for signature)*

Life Plan Section 125 [ ] Yes [ ] No

Do you allow Employees to make election changes at any time throughout the year? [ ] Yes [ ] No

Medical Underwriting is required for an Employee if they are a late entrant. Does this match your administrative practice? [ ] Yes [ ] No

If No, what amount of Guaranteed Coverage is provided? _____

Are Domestic Partners Covered? [ ] Yes [ ] No If Yes [ ] Same Gender [ ] Opposite Gender **If state mandated** [ ] Registered [ ] Full

If Domestic Partners are covered, does Cigna need to provide you with an affidavit? [ ] Yes [ ] No

If No, please provide Cigna with the affidavit that will be utilized.

Calculation of Spouse Premium is based on [ ] Spouse Age [ ] Employee Age

Spouse coverage ends when the Spouse reaches age 70. Does this match your administrative practice? [ ] Yes [ ] No

If No, please provide the age that spouse coverage will end. ____ ***Please note that the Spouse will have the same benefit reduction schedule as the Employee.***

Maximum Age for Dependent Child Benefits ____

Full-time Student Status Required? [ ] Yes [ ] No If Yes, please provide maximum child age without student requirement. ____

Is Financial Dependency for Child Benefits Required? [ ] Yes [ ] No

Rounding for Times Salary Plans - Salary is multiplied first then rounding occurs [ ] Yes [ ] No

If No, please describe: _____

Rounding for Increment Units Plans [ ] Rounding Up [ ] Rounding Down [ ] Nearest

ACCIDENT PLAN COVERAGE INFORMATION

Beneficiary Maintenance [ ] Paper [ ] Electronic *(if electronic, agreement will be provided for signature)*

Domestic Partner Covered [ ] Yes [ ] No If Yes [ ] Same Gender [ ] Opposite Gender **If state mandated** [ ] Registered [ ] Full

Secure Travel [ ] Yes [ ] No

Must Voluntary Accident amount match the Voluntary Life Election? [ ] Yes [ ] No

If Yes, Is it an independent election or automatic match? [ ] Independent Election [ ] Automatic Match

If Disability Coverage was not purchased please proceed to Section 4.

DISABILITY PLAN COVERAGE INFORMATION

Short Term Disability Coverage Only

Weekly disability benefits are based on the number of days in a normally scheduled work week. They will be prorated if payable for any period less than a week. Do your employees work a 5 or 7 days work week? ☐ 5 Day Work Week ☐ 7 Day Work Week

Your response impacts the daily benefit amount. Benefits will be prorated on a 5 or 7 day basis. *If your hours of operation include weekends or shift work schedules it is recommended that you select 7 day work week.*

Self Insured Disability Plans Only

Does the Maximum Benefit Period include the Benefit Waiting Period? ☐ Yes ☐ No

Benefit Waiting Period is based on ☐ Calendar Days ☐ Business Days

Who is responsible for payment of ancillary costs? ☐ Employer ☐ Employee ☐ Other: _____

Statutory Coverage Information

Do you have Employees working in statutory states? ☐ Yes ☐ No *If Yes, please check the boxes below to indicate coverage type.*

Is Cigna providing any statutory coverages? ☐ Yes ☐ No

Your Cigna Sales Representative will generate a separate quote if not already provided. We may also provide additional state required application forms for policy issuance.

☐ California

☐ New York
Number of males _____
Number of females _____

☐ New Jersey*
Number of males _____
Number of females _____
**Please provide prior carrier DP1 if available.*

☐ Rhode Island

☐ Puerto Rico

☐ Hawaii Hawaii DOL Number: _____
Hawaii Address: _____
_____
Number of males _____
Number of females _____

DISABILITY CLAIMS STRUCTURE & ADMINISTRATIVE CLAIMS REPORTING

Claim Structure Set-Up

Is it necessary to provide claims reporting by department or division? ☐ Yes ☐ No *If Yes, list desired reporting location(s) below.*

Note: Employees will be required to identify their location when reporting claim.

Reporting Location(s) *(i.e., Hourly, Salary, Union, Non-Union, Location, Region, Sales, Manufacturing)*

Claim Reporting Set-Up *On-line Reporting access is provided for all Disability Coverage.*

Primary contact will have full administrator access to reporting functions and ability to delegate access functions. *(MUST be an Employee of the Company).* Name an alternate administrator contact below, if needed.

ALTERNATE ADMINISTRATOR *(Must be an Employee - can delegate access to other users and has full access to reporting functions)*

ADDRESS	CITY	STATE	ZIP CODE
PHONE	EMAIL		

a. **Any additional users to be set-up during implementation for online reporting access?** ☐ Yes ☐ No
If Yes, please provide list that includes Name, Address and Email.

b. **Can these users access reports for all locations?** ☐ Yes ☐ No
If No, you must also specify applicable reporting locations by user.

c. **Select day for posting of Weekly STD Status Reports** ☐ M ☐ T ☐ W ☐ TH ☐ F
STD Closed claims will appear for 2 weeks.

d. **LTD Reports will be posted on the first day of each month** *LTD Closed claims will appear for 2 months.*

e. **Employee Name appears on claim reports. Please select an additional identifier if needed.**
☐ EE Social Security Number ☐ EE ID Number

f. **Is there any other Company Name the Employee could use when reporting a claim?** ☐ Yes ☐ No
If Yes, please list the Company Names: _____

g. **Please provide Employer contact for Eligibility Verification.** ☐ **Primary contact identified on page 1.**
☐ **Other contact name:** _____ **Other contact e-mail:** _____

h. **If Cigna Healthcare is your medical provider, should outreach letters be sent to Employees?** ☐ Yes ☐ No

DISABILITY PLANS - EMPLOYER CONTRIBUTION, TAX AND YEAR-END REPORTING INFORMATION - SECTION 3

I. Exemption from Social Security/Medicare Taxes

Select appropriate reason if your disability plan is exempt from Social Security and Medicare taxes:

☐ Religious Institution ☐ Charitable Institution ☐ Other *(Specify)* _____

Indicate if Plan is issued to a union, a creditor, or an association which is exempt from Social Security taxation if the employer is neither a party to the contract or a contributor to plan costs: ☐ Union ☐ Creditor ☐ Professional Association

II. Employee Contribution Percentages

Short Term Disability

☐ All employees contribute _____ % of disability policy premium on a post-tax basis.
☐ Employees contribute on a pre-tax basis (considered 100% employer contributions).
☐ Employer contributes 100% of cost.
☐ Contribution percentage varies by benefit, plan or division.

Is this a Tax Choice Plan? ☐ Yes ☐ No
Is this a STD gross up plan? ☐ Yes ☐ No

Long Term Disability

☐ All employees contribute _____ % of disability policy premium on a post-tax basis.
☐ Employees contribute on a pre-tax basis (considered 100% employer contributions).
☐ Employer contributes 100% of cost.
☐ Contribution percentage varies by benefit, plan or division.

Is this a Tax Choice Plan? ☐ Yes ☐ No
Is this a LTD gross up plan? ☐ Yes ☐ No

III. Tax Reporting of Self-Insured Benefits (Does not apply to "advice to pay")

☐ Benefits are paid from a trust (e.g. 501(c)(9) trust) which bears an insurance risk. Indicate the address where the ASO tax reimbursement check should be sent:

Attention: _____
Mailing Address: _____

IV. Address to which tax reports should be sent (All tax reports will be sent to the primary contact unless indicated otherwise below.)

Attention: _____
Mailing Address: _____

☐ Reporting should be to multiple addresses. Provide address information on the attached Additional Notes page. Include suffix/division code, coverage code, employee post-tax contribution percentage, federal EIN and employer address.

V. Services Short Term Disability Policy

☐ W2 Services ☐ W-2 Services with Employer FICA Depositing Service *(This service is not available on 100% Employee Paid Disability Plans. Also, if not previously confirmed selecting this option may require a rate review.)*

☐ List of Payments Only *(Employer will prepare and report W-2's)*

Services Long Term Disability Policy

☐ W2 Services ☐ W-2 Services with Employer FICA Depositing Service *(This service is not available on 100% Employee Paid Disability plans.)*

☐ List of Payments Only *(Employer will prepare and report W-2's)*

If W-2 services are selected, please review the attached Limited Agency Agreement for complete disclosure of terms and conditions. Annual Wage and Tax Statement, Form- W-2 will be mailed to the Employees home address unless otherwise specified.

LIFE ASSISTANCE PROGRAM INFORMATION - SECTION 4

☐ Life Assistance Program "LAP". ☐ 3 visit clinical sessions ☐ 5 visit clinical sessions

☐ Full Employee Assistance Program "EAP" (*includes up to 3 clinical sessions and Employer Service hours of 10 per 1,000 employees)*

Until the LAP or EAP Agreement is finalized and executed, all services provided by Cigna Behavioral Health, Inc. shall be in accordance with the terms of Cigna Behavioral's standard LAP or EAP Agreement. Employer shall reimburse Cigna Group Insurance for Cigna Behavioral LAP or EAP services through the agreed upon combined product and LAP or EAP services rate.

The parties agree to negotiate in good faith the terms of the definitive LAP or EAP Agreement, and to execute such Agreements as soon as practicable. Once the LAP or EAP Agreement is finalized, that agreement will supersede this Application and will apply retroactively to the effective date of Cigna Behavioral's administration of the LAP or EAP services.

By signing this Application, Employer indicates acknowledgement of and agreement with this arrangement.

CIGNA ABSENCE ASSISTANT - SECTION 5

☐ Cigna Absence Assistant

Cigna Absence Assistant Service Agreement must be executed prior to the Absence Assistant Orientation Meeting. Upon receipt of a signed agreement, Cigna will schedule an orientation meeting to provide the client with Cigna Absence Assistant Resource Guide for Managing FMLA and ADA. The client will also be given access to MD Guidelines™ Leave of Absence Advisor, a web-based compliance database of federal and state job-protect leave laws and FML & ADA 101 Brainshark training tutorial for managers and supervisors. Once the orientation process is completed, the client can refer FMLA leave or ADA accommodation case requests for consultative guidance and recommendation.

ERISA PLAN INFORMATION - SECTION 6

Please note: Please refer to the attached ERISA Coverage Worksheet to determine whether a policy is issued in conjunction with ERISA. In general, any group insurance policy issued to an employer to insure employees, or to a labor union to insure union members, is subject to ERISA.

Does your Company file annual ERISA reports? ☐ Yes ☐ No *If Yes, please complete the following information.*

ERISA PLAN NAME	ERISA PHONE NUMBER

ERISA PLAN NUMBER(S)

	☐ Life _____	☐ Acc _____	☐ STD _____	☐ LTD _____
PLAN OF BENEFITS IS FINANCED BY	☐ Employer ☐ Employees ☐ Employer & Employees	☐ Employer ☐ Employees ☐ Employer & Employees	☐ Employer ☐ Employees ☐ Employer & Employees	☐ Employer ☐ Employees ☐ Employer & Employees

PLAN YEAR ENDS ☐ Calendar Year ☐ Policy Year (Anniv) ☐ Fiscal Year (*provide fiscal year date*) _____

PLAN ADMINISTRATOR

☐ Employer ☐ Other - *If other, please provide*

Name _____

Address _____

AGENT FOR LEGAL PROCESS

☐ Same as Plan Administrator ☐ Other - *If other, please provide* _____

PREMIUM AND BILLING INFORMATION - SECTION 7

Premium Administration

CIGNA Easy Bill? ☐ Yes (Census Required) ☐ No Is there a TPA? ☐ Yes (Hold Harmless Agreement Required) ☐ No

Complete information below for on-line billing platform.

a. Please provide Employer Billing Contact. ☐ **Primary contact identified on page 1.** ☐ **Other contact name:** _____

Other contact e-mail: _____ **Other contact phone:** _____

b. Please list each desired billing location(s) _____

c. Will we receive payment from each Billing Location? ☐ Yes ☐ No, assumes one payment will be remitted from the billing contact noted above in letter a.

If Yes, please provide contact information of each billing location on the attached Additional Notes page.

VOLUNTARY ENROLLMENT INFORMATION - SECTION 8

Enrollment Event ☐ Yes Event Start Date _____ * End Date _____ ☐ No

* Please indicate the last day the employee is allowed to sign the enrollment application/EVI

Date Enrollment Materials needed _____ **Printed Brochures required?** ☐ Yes ☐ No

If Yes, please provide distribution instructions including physical address, contact name, phone number and quantity needed by class on a separate page.

Combine Enrollment Brochures for Voluntary Life and Voluntary Accident Coverages? ☐ Yes ☐ No

Please note Medical Underwriting Status Report will be sent to Primary Contact.

THIS SECTION TO BE COMPLETED BY PRODUCER/GENERAL AGENT

COMMISSION INFORMATION - SECTION 9

Writing Agent currently appointed with Cigna Group Insurance in group situs state? ☒ Yes ☐ No

If applicable, our Central Licensing Department will provide appointment package for completion.

PRODUCER/GENERAL AGENT COMPANY NAME				COMMISSION TAX ID #	
Assured Partners of Ohio,LLC dba Group Benefits Agency				**80-0786940**	
PRODUCER NAME *(WRITING AGENT)*				TITLE	
Carrie Christine				**Senior Account Executive**	
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE	EMAIL
1105 Schrock Rd, Suite 500	**Columbus**	**OH**	**43229**	**614-545-2904**	**cchristine@groupbenefitsagency.com**
LICENSING CONTACT NAME AT PRODUCER/GENERAL AGENT OFFICE				PHONE	EMAIL
Kara Chapin				**614-545-2941**	**kchapin@groupbenefitsagency.com**
DAY TO DAY PRODUCER CONTACT NAME				PHONE	EMAIL
Lana Hartpence				**614-545-2925**	**lhartpence@groupbenefitsagency.com**

IS PRODUCER A GENERAL AGENT? ☐ Yes ☒ No *If Yes, please provide Sub-Producer Contact Information*

SUB-PRODUCER COMPANY/CONTACT NAME			PHONE	PHONE EXT.
EMAIL	STREET ADDRESS	CITY	STATE	ZIP CODE

Please continue to complete this section on next page.

COMMISSION INFORMATION - SECTION 9 *(Continued)*

COMMISSION PAID TO ☐ Individual ☒ Corporation ☐ N/A *(no commission paid)*

☒ Life	☒ Accident	☐ STD	☐ LTD
☒ Standard Blanket Commission	☒ Standard Blanket Commission	☐ Standard Blanket Commission	☐ Standard Blanket Commission
☐ Case Specific Commission _____ %	☐ Case Specific Commission _____ %	☐ Case Specific Commission _____ %	☐ Case Specific Commission _____ %

Utilize this space to identify any other commission arrangements not specified above.

(If Split Commission complete Second Producer Information below)

SECOND PRODUCER INFORMATION *(For split commissions)*

Writing Agent currently appointed with Cigna Group Insurance in group situs state? ☐ Yes ☐ No

SECOND PRODUCER COMPANY NAME				COMMISSION TAX ID #
SECOND PRODUCER NAME *(WRITING AGENT)*				TITLE
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE / EMAIL
LICENSING CONTACT NAME AT SECOND PRODUCER OFFICE				PHONE / EMAIL
DAY TO DAY SECOND PRODUCER CONTACT NAME				PHONE / EMAIL

COMMISSION PAID TO ☐ Individual ☐ Corporation ☐ N/A *(no commission paid)*

☐ Life	☐ Accident	☐ STD	☐ LTD
☐ Standard Blanket Commission	☐ Standard Blanket Commission	☐ Standard Blanket Commission	☐ Standard Blanket Commission
☐ Case Specific Commission _____ %	☐ Case Specific Commission _____ %	☐ Case Specific Commission _____ %	☐ Case Specific Commission _____ %

If more space is needed for additional contact information, please provide on the attached Additional Notes page.

EMPLOYER & PRODUCER REPRESENTATIVE SIGNATURE

We acknowledge receipt of this Implementation Kit. We confirm the accuracy of the proposal from the insurance company named above and hereby accept the terms and conditions of the proposal and any attachments or modifications made to the proposal.

We confirm the accuracy of the plan and coverage identification information contained in Section 2 and agree to the premium billing information contained in Section 7. We hereby request the issuance of insurance policies on the basis of this coverage and premium billing information.

If applicable, we authorize LINA Benefit Payments, Inc. to perform the tax-related services related to our disability benefits described in Section 3.

We confirm the appointment of our producer identified in Section 9 above and authorize payment of compensation as described therein.

We acknowledge receipt of the Privacy Notice.

We understand that the following insurance policies are to be issued to the Group Insurance Trust for Employers in the

PUBLIC ADMINISTRATION 9111-9721 Industry. SIC Code **9199**

TRUST ISSUED POLICY TYPE ☒ **Life** ☐ **Accident** ☐ **STD** ☐ **LTD**

We hereby adopt the above-named trust as co-settlor and subscribe to that trust for the purpose of participation in these policies, which shall only cover our eligible employees, and, if applicable, retirees and dependents. We confirm the appointment of Wilmington Trust Company as Trustee, and of Life Insurance Company of North America ("LINA") as trust administrator. We appoint LINA, in its capacity as trust administrator, to represent us in dealings with the Trustee related to the insurance trust. We understand that, in the event the policy(ies) are terminated for any reason, we will cease to be a participant in the insurance trust. We understand that no benefits are provided by the trust other than the benefits described in the insurance policy(ies).

Authorized Employer Representative *(please print name here)*	Authorized Employer Representative *(please sign name here)*
Date _____	
Carrie A. Christine	
Authorized Producer Representative *(please print name here)*	Authorized Producer Representative *(please sign name here)*
Date _____	

CIGNA INTERNAL USE - TO BE COMPLETED UPON RECEIPT OF COMPLETED AND SIGNED DOCUMENT

Assigned Policy Number(s) _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

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Cigna Group Insurance
Life • Accident • Disability

ADDITIONAL NOTES