

## **Evidence of Insurability (EVI) Instructions for Optional Life and Dependent Life through CIGNA Group Insurance**

The following information is required to process your application:

- CIGNA Group Insurance Term Life Insurance Change Form (TL-009320 MN)
- City of Minneapolis Optional/Dependent Group Term Life Enrollment Form

### **CIGNA Group Insurance Term Life Insurance Change Form**

- Page 1:
  - Please complete the employee section.
  - If you are electing dependent life insurance and will be covering a spouse, you must also complete the section below for your spouse.
  - Please do not complete the “I wish to make the following changes to my life insurance coverage” section. Benefits staff will complete based on your elections on the Group Term Life Enrollment Form.
  - Sign and date on the signature line.
- Page 2-3
  - Complete pages 2-3 according to instructions on the form.
  - If you are applying for dependent life insurance and will be covering a spouse, your spouse will also need to complete the applicable sections on pages 2-3.
  - Sign and date page 3. If you are applying for dependent life insurance and will be covering a spouse, your spouse will also need to sign page 3.

### **City of Minneapolis Optional/Dependent Group Term Life Enrollment Form**

- Complete this form and return with the CIGNA Group Insurance Term Life Insurance Change Form
- Incomplete applications may cause a delay in the processing of your request for coverage.

Please keep a copy of the completed application for your records and forward your completed forms to:

City of Minneapolis  
Human Resources – Benefits  
250 S 4<sup>th</sup> St – 100  
Minneapolis, MN 55415-1339



**Term Life Insurance Change Form**  
**Life Insurance Company of North America (LINA)**  
**a Cigna Company (herein called the Insurance Company)**

For info and customer service call 1-800-732-1603.

- The applicant must sign and date this form.
- This form cannot be considered unless received within 30 days of the date it is dated.



**Important:** Please enter all dates in mm/dd/yyyy format.

<b>EMPLOYER USE (MANDATORY DATA NEEDED):</b> In order for the insurance company to process this form, the employer must complete this information.			
<b>EMPLOYER</b>	<u>City of Minneapolis</u>	<b>Policy</b>	<u>FLX-962053</u>
<b>CLASS</b>	<b>LOCATION/PAYCODE #</b>	<b>DATE OF HIRE</b>	<b>ANNUAL SALARY</b>
<b>REASON FOR REQUEST:</b> <input type="checkbox"/> LIFE STATUS CHANGE <input type="checkbox"/> ONGOING ENROLLMENT EVENT <input type="checkbox"/> REINSTATEMENT <input type="checkbox"/> LATE ENTRANT			
	<b>VOLUNTARY EMPLOYEE</b>	<b>VOLUNTARY SPOUSE</b>	
<b>NEW COVERAGE (TOTAL)</b>			
<b>CURRENT COVERAGE</b>			
<b>GUARANTEED COVERAGE PORTION OF REQUESTED INCREASE</b>			
<b>AMOUNT SUBJECT TO MEDICAL EVIDENCE</b>			

Please print (preferably in black ink).

**EMPLOYEE SECTION**

Mr.  Mrs.  Ms. (Check One)

Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Employee ID # \_\_\_\_\_ Sex:  M  F

**COMPLETE IF ELECTING SPOUSE COVERAGE**

I am currently married and my date of marriage is \_\_\_\_\_

Spouse Name (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse Birthdate \_\_\_\_\_ Sex:  M  F

**I WISH TO MAKE THE FOLLOWING CHANGES TO MY LIFE INSURANCE COVERAGE**

**See your life insurance brochure/application for the coverage election options for your plan. When selecting new coverage amounts, please ensure that your election(s) match the amounts, salary multiples or unit increments described in your brochure and/or application.**

**CHECK THE APPROPRIATE BOXES:**

- Increase, decrease or begin coverage on the following individuals as indicated below:**  
 (Complete the medical questions on the next page if you are electing or increasing coverage for yourself or your spouse.)

	<u>Current</u> Voluntary Coverage	<u>New</u> Voluntary Coverage	<u>Total</u> Voluntary Coverage
<input type="checkbox"/> Employee			
<input type="checkbox"/> Spouse			
<input type="checkbox"/> Child(ren)			

**Life Status Change**

If this change is being made due to a Life Status Change, please check one of the following, and provide date of change.

- Marriage  Divorce  Annulment  Legal Separation  Birth or Adoption of a Child  Death of a Spouse or Child  Leave of Absence
- Change in Spouse's Employment  Return to or from Military Duty  Change from full to part-time (or vice-versa)

Date of Life Status Change \_\_\_\_\_

**Cancel coverage on the following individuals:**

- Employee  Spouse  Child(ren) Effective Date of Cancellation \_\_\_\_\_

**Cancel the Automatic Increase Option**

**Name Change: (Current / New Name)**

Employee \_\_\_\_\_ / \_\_\_\_\_

Spouse \_\_\_\_\_ / \_\_\_\_\_

**Reminder:** If you'd like to designate new beneficiaries, please complete a Beneficiary Form.

**ACCEPTANCE / DECLINATION**

I accept the insurance coverage(s) chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the needed amounts from my earnings.



**Sign Here** Signature \_\_\_\_\_ Date \_\_\_\_\_

Month/Day/Year

**Important: You must also sign and date the Agreements and Authorization section.**

**Return to your employer. Be sure to make a copy for your own records.**

**IMPORTANT**  
**Please complete each section that follows if it is needed.**  
**Read the Agreements and Authorization. Sign and date the form in the space provided.**

Complete the employee and spouse info in this section if you (i.e., the Employee) or your spouse are applying for/increasing Life Insurance:  
 (1) exceeding the guaranteed amount, or (2) due to a reinstatement.

**Height and Weight Information**

Employee			Spouse		
Height	ft	in	Height	ft	in
Weight	lbs		Weight	lbs	

**PHYSICIAN SECTION**

**Employee Physician**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Spouse Physician**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please indicate your answers for each question by checking the Yes or No box for the question.**

**SECTION A**

**Within the last 5 years has the proposed insured been:**

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has or may have any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

**Note:** The applicant does not have to disclose the presence of **\*\*bloodborne pathogens** which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as result of performing emergency medical services. See Authorization at **\*\*** for a definition of "bloodborne pathogens" and "emergency medical personnel."

	Employee		Spouse	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION B**

**Within the last 5 years has the proposed insured:**

A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Smoked cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. For how many years has the proposed insured smoked?				
2. Approximately how many cigarettes are, or were, smoked on average per day?				
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C. Used any controlled or illegal drug or other substance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee/Spouse	Medical Condition	Date Occurred	Duration/Treatment Received	Current Status

**Caution:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**Important:** You must also sign and date the Agreements and Authorization section.

**Fold and staple this page to conceal health questions.**  
**Return application to your employer. Be sure to make a copy for your own records.**

## ◆ ◆ ◆ AGREEMENTS AND AUTHORIZATION ◆ ◆ ◆

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical info.
- (3) I may need to take medical tests and report the results to the Insurance Company.
- (4) I must report any change in my health that happens before the insurance is effective.
- (5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

**Authorization.** I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB), Veterans Administration or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me or my children to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved.

This authorization shall be valid for a period of 26 months from the date signed, and a photographic copy shall be as valid as the original. This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as result of performing emergency medical services.) \*\*The term bloodborne pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. The pathogens include, but are not limited to Hepatitis B virus (HBV), the Hepatitis C virus (HCV) and the Human Immunodeficiency (HIV) virus. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)



**Sign Here**

\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Month/Day/Year*

\_\_\_\_\_  
*Spouse's Signature*  
*(If applying for insurance for your spouse)*

\_\_\_\_\_  
*Month/Day/Year*

**Notice:** Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.



**CITY OF MINNEAPOLIS  
OPTIONAL/DEPENDENT GROUP TERM LIFE ENROLLMENT FORM**

Employee Name (Last, First, MI) \_\_\_\_\_

Employee ID \_\_\_\_\_

Effective Date \_\_\_\_\_

Listed below are the optional and dependent life insurance coverage options. Once the Benefits Department is notified by the insurance company of your approved application, the appropriate paycheck deduction changes will be made. When making your selection, note the number to the right of each choice (1) and write this number on the 'Option Code' line to the far right.

**YOUR OPTIONS**

City Optional Life

- CIGNA Group Ins. 1x Annual Salary B-Tax (1)
- CIGNA Group Ins. 2x Annual Salary B-Tax (2)
- CIGNA Group Ins. 3x Annual Salary B-Tax (3)
- CIGNA Group Ins. 4x Annual Salary B-Tax (4)
- CIGNA Group Ins. 5x Annual Salary B-Tax (5)
- CIGNA Group Ins. 1x Annual Salary A-Tax (6)
- CIGNA Group Ins. 2x Annual Salary A-Tax (7)
- CIGNA Group Ins. 3x Annual Salary A-Tax (8)
- CIGNA Group Ins. 4x Annual Salary A-Tax (9)
- CIGNA Group Ins. 5x Annual Salary A-Tax (10)
- Waive (W)

**Option Selected**

Option Code: \_\_\_\_\_

B-Tax=Pre-tax deductions  
A-Tax=After-tax deductions

City Dependent Life

You must be enrolled in Optional Life in order to enroll in Dependent Life.

- CIGNA Group Ins. \$5,000 A-Tax \$1.60 (1)
- Waive \$0.00 (W)

Option Code: \_\_\_\_\_

<b>City Dependent Life DEPENDENT(S) TO BE COVERED</b>

Please fill in percent of benefit for primary and contingent beneficiaries. Beneficiaries are considered to be primary unless specified as contingent (CON). The contingent is entitled to the life insurance benefit only in the event the primary beneficiary(s) is deceased at the time of payment. The total of all primary percentages must equal 100% and the total of all contingent percentages must equal 100%.

<b>Dependent/Beneficiary Info</b>	%	%	RELATIONSHIP	DOB	SEX
DEPENDENT/BENEFICIARY NAME	BEN	CON	RELATIONSHIP	DOB	SEX

Some of the requested information on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13. The data requested allows Benefit staff to verify eligibility and enroll you and your dependents in health plan(s) and allows the plan provider(s) the ability to establish an enrollment record for you and your dependents. You are not required to provide this information, however, failure to do so may result in ineligibility and non-enrollment. This form may be available to City and plan provider employees or agents, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, or to others through subpoena or pursuant to Federal and State law

By my signature below, I authorize the deductions necessary (pre-tax or after-tax as applicable) to ensure coverage under my plan choices as indicated above.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## Optional Life Insurance Age-Based Rates

You may elect 1, 2, 3, 4 or 5 times your annual earnings. Coverage amounts and monthly costs that display on your enrollment materials are based on your current year salary and age. As a result, premiums may be greater than those shown on your enrollment materials. Complete the premium calculation formula below for your monthly optional life insurance premium. (Negotiated Union contract pay changes **effective for January 1<sup>st</sup>** may change the amount of coverage and premium deduction during the year.)

Dependent Life insurance is \$1.60 per dependent unit (family) per month and covers a legal spouse and dependent children to age 19 for \$5,000.00 each. (Newborns 14 days to 6 months are covered for \$500.00.) You must elect Optional Life insurance in order to enroll in Dependent life coverage.

Optional CIGNA Group Term Life Insurance	
Your Age as of January 1	COST OF COVERAGE PER \$1,000 OF LIFE INSURANCE
Less than age 25	\$0.060
Age 25 but less than 30	\$0.060
Age 30 but less than age 35	\$0.080
Age 35 but less than age 40	\$0.090
Age 40 but less than age 45	\$0.108
Age 45 but less than age 50	\$0.180
Age 50 but less than age 55	\$0.330
Age 55 but less than age 60	\$0.430
Age 60 but less than age 65	\$0.695
Age 65 but less that age 70	\$1.270
Age 70 and over	\$2.060

### EXAMPLE OF PREMIUM CALCULATION:

Employee age 41 with an annual salary of \$36,000, enrolled for 2 times their annual salary in coverage.

$\$36,000 \times 2 = \$72,000$  of coverage, divided by  $\$1000 = 72$   
 Rate for age 41 is  $\$.108 \times 72$  (thousands) =  $\$ 7.78$  per month

Your Salary \$ \_\_\_\_\_ x (1, 2, 3, 4 or 5) = \$ \_\_\_\_\_ (rounded to next \$1000), divided by \$1000 = \$ \_\_\_\_\_ (thousands) x rate from chart = \$ \_\_\_\_\_ estimated monthly premium.

Pre-tax premium deductions can result in an IRS required imputed income calculation that may decrease tax savings that normally occur with pre-tax premium deductions. In general you will do better with pre-tax deductions if you are under age 60 with less than 3 times your salary in coverage. Pre-tax enrollments cannot be changed until the end of the year.

Increases are subject to Evidence of Insurability application and insurance carrier approval.