Life Administrative Handbook

Aetna Life Coverage





Dear Plan Sponsor:

Welcome! We're pleased you've chosen Aetna and look forward to working with you.

At Aetna,[‡] we want you to know. By providing information and tools that are accessible, simple and clear, we're committed to giving you what you need to make better decisions for your business and your people.

To that end, this handbook provides a summary of the administrative information you'll need to help you administer your Aetna plan. It is important that you understand the provisions of the plan, particularly the need to submit timely and accurate data and other information described in the handbook. The Customer Service Information sections, immediately following this letter, contain phone numbers and addresses for the Aetna departments you will need to contact.

As you read through this handbook, you may come across terms or references that do not apply to the plan of benefits you have selected. The actual terms of your group plan are detailed in the plan documents we have already provided to you.

Thank you for choosing Aetna. It's our privilege to serve you.

Sincerely,

Aetna

[‡]Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).

Table of Contents

Customer Service Information	.3
Inquiries	. 3
Life Insurance Service Center	
Evidence of Insurability	
Forms and supplies	
Enrollment forms.	
All forms, other than enrollment forms	
	. 4
Life Insurance and Accidental Death &	,
Personal Loss Insurance	. 4
Enrollment	. 5
What is an annual benefits election period?	
What are the enrollment requirements for	
contributory/noncontributory coverage?	. 5
Probationary period	
Active-at-Work rule	. 6
When are employees considered Late Enrollees?	. 6
Duplicate coverage	
How do I enroll new employees?	
How do I complete an Enrollment/Change Request form? .	
Explaining the Enrollment/Change Request form	
When should changes be submitted?	
How should changes be submitted?	
More information on terminations or cancellations	
Aetna's Privacy Notice	
Confidentiality Notice	
	• •
Beneficiaries	13
How to assign coverage	
What if an employee wants to assign his or	
her Life Insurance and/or AD&PL coverage?	
What is the process for assigning coverage?	13
What will Aetna do when it receives the	
assignment forms?	
When does the assignment become effective?	13
How to complete an Assignment of	
Group Coverage form	13

beneficiary designations and changes	_
Who can designate or change beneficiaries?	2
When can employees designate beneficiaries?	2
Can employees change beneficiaries?	2
What if an employee does not designate	
a beneficiary?	
What if the beneficiary dies before the employee?	2
What is the process of designating a beneficiary?	2
What if a beneficiary designation	
is incomplete or contains errors?	2.
Addressing employee questions	
about designating beneficiaries	
Individual beneficiaries	
Multiple beneficiaries	
The beneficiary is the employee's estate	
The beneficiary is a trust	
The beneficiary is charity, hospital or church	2
Additional information helpful to employees	2
selecting beneficiaries	
The beneficiary resides in a community property state. The beneficiary is the employer	
The beneficiary is a citizen of a blocked country	
The beneficiary is an animal	
The beneficiary is a minor	
Beneficiary changes made by an individual acting	2
as an agent under a durable power of attorney	2
Addressing employee concerns about beneficiary	_
issues that may arise after death	2
The claim is disputed	
The claim is denied	
Evidence of Insurability	27
When is Evidence of Insurability required	
for a timely enrollee?	
When is Evidence of Insurability required for	
late enrollees?	
Is evidence required for a change in family status? $\ldots\ldots$	
How do I complete an Evidence of Insurability form?	2
When is evidence required for employees who	
already have coverage?	2
Evidence of Insurability reports provided by the	
Medical Underwriting Department	2

Table of Contents (continued)

Premium Waiver	. 45
Premium Waiver – disability claims	45
Premium Waivers for permanently and	
totally disabled employees	
Non-Premium Waiver – disability claims	
Disabilities – general information	
Disability claims – employer's role and responsibilities	46
Disability claims – employee responsibilities $\ldots \ldots$	46
Disability claims – submitting notice of claim for disability benefits	46
Completing a Life Insurance Continuation form	46
Attending Physician's Statement form	
Accelerated Death Benefit	. 53
What is ADB?	
What is the definition of terminal illness under ADB?	53
How much is payable?	53
More information	53
Accidental Death & Personal Loss	.89
AD&PL death benefits	89
AD&PL death claims	89
AD&PL and other losses	89
AD&PL limitations	90
AD&PL claims	90
How do I complete an Accidental	
Dismemberment Claim form?	
Physician's Statement	
Investigating a claim	91
Life Conversion	. 95
When should an employee apply for a life conversion policy?	95
How does Premium Waiver affect life conversion?	
Can employees convert to an individual policy when the policy discontinues?	0.5
	95
What happens if a person dies during the 31-day life conversion application period?	96
How does the employee apply for a policy	
of individual insurance?	96

Portability	101
Who is eligible?	101
What is the application process?	101
f elected, when does portability take effect?	101
What coverage may be ported?	
What if there is a death during portability?	101
What happens when portability ceases?	101
Continuation	106
Can coverage be continued if an employee is	404
away from work due to disease or injury?	106
If an employee is laid off, is eligible for severance pay or on a leave of absence,	
can coverage be continued?	107
Can coverage be continued for handicapped	107
dependent children?	107
The Family and Medical Leave Act (FMLA)	
State-required continuation	
Life Claims	109
When an employee or dependent dies	109
Completing the life claim process	109
Proof of Death form	110
Investigating a claim	111
Aetna Beneficiary Solutions™	115
What is Aetna Beneficiary Solutions?	
Financial counseling and investment services	
Free Web-based legal information and	
discounted legal services	115
Bill Payment	
Understanding and paying your List Bill	116
What is a List Bill?	
How do I read my List Bill?	
How do I pay my List Bill?	
Understanding and paying your Summary Bill	
How do I read my Summary Bill?	
How do I complete my Summary Bill?	122

Customer Service Information

In this chapter and throughout this handbook, we will continuously make reference to, and refer you back to, the provisions of your policy, in order for you to determine which benefits and limitations apply to you. Policy is defined as the legal document or contract issued by the insurance company (insurer) to the policyholder that sets forth the terms and conditions of the insurance.

This chapter provides information and instructions for contacting Aetna when you have a question or a problem with your Group Policy. It also provides instructions and guidance for ordering additional forms when needed.

Important: When contacting Aetna, please be prepared to give the person assisting you certain information specific to your Group Policy. For example, be prepared to provide your policy's control, suffix and account number whenever you make a call. If you are calling in regard to an employee matter, be prepared to provide the employee's Social Security number. Having this information readily available will help avoid delays in customer service.

- *Contact your Aetna service representative when you have a question regarding renewing your group plan. Otherwise, direct all calls, except for claims or benefits questions, to the Customer Service Unit at the toll-free number listed on your billing statement.
- **Please note that this number is for your group benefits administrator or an individual who has the authority to act on behalf of your company. The number is not to be released to employees. Employee claims and benefits questions should be directed to the toll-free number shown on the employee's ID card.

Inquiries

For questions or problems concerning your billing statement (for example, Summary Statement or List Bill Statement) or any other aspect of the administration, or for which a specific address or phone number has not been provided, contact the following in the order of presentation:

- Your servicing Aetna claims office (if it involves a claims issue).
- Your Aetna representative.*
- The Customer Service Unit or contact name as it appears on your billing statement.**
- Or if you prefer, you can write to the Aetna Plan Sponsor Services location that services your Group Policy.

Aetha – Pian Spo	onsor Services		
Mailing Address:			
Enrollment/Changes:	Phone:		
Emonnero changes.	Fax:		
Control:	Suffix:	Account:	
Aetna – Marketir	ng		
Marketing Office:			
Service Representative		Phone:	
		Fax:	

Customer Service Information (continued)

Life Insurance Service Center

Life Insurance PW and ABD claims

Please send all Group Disability forms (for example, Premium Waiver and Death Benefit Only/Aetna Investigates Disability) and any proof of disability to:

Aetna Life Insurance Company P.O. Box 14548 Lexington, KY 40512-4548

Life and AD&PL claims

Please send all Proof of Death forms and Accidental Death and Personal Loss claim forms to:

Aetna Life Insurance Company P.O. Box 14549 Lexington, KY 40512-4549

If you have questions concerning the filing of a life or dismemberment claim or simply need to check on the status of a claim, call the Life Insurance Service Center or fax us at the following toll-free numbers:

1-800-523-5065 (phone) 1-800-238-6239 (fax)

Evidence of Insurability

Please send all Evidence of Insurability Statements to:

Aetna Life Insurance Company Medical Underwriting Department P.O. Box 83641 Lincoln, NE 68501-3641 OR

Fax to: 1-800-792-9710

If you have questions, call us toll-free at 1-800-660-9913.

Forms and supplies

The necessary forms will be provided to you by your Aetna representative.

When you need additional forms required for the administration of your Group Policy, order forms as follows.

Enrollment forms

To order additional enrollment forms, please call your Aetna representative.

All forms, other than enrollment forms

If the form number is GR-50000 to GR-59999, please order additional copies from your Aetna representative.

If the form number is GR-60000 to GR-69000, please order additional copies using the Customer Request form and the special return envelope. A copy is shown on the following pages. When using this form, be sure to include your Group Policy's control number, along with a copy of the form being requested.

If the form number begins with the letters "GC," please order additional copies and envelopes through the claim office or your Aetna representative using form GC-634. When using this form, be sure to include your Group Policy's control number, along with a copy of the form being requested.

Contact your Aetna representative when you have a question related to the renewal of your Group Policy. Otherwise, direct all calls, except for claims or benefits questions, to the Customer Service Unit at the number listed on your billing statement.

Please note that this number is for the group benefits administrator or someone who has the authority to act on behalf of the policyholder. This number is not for release to the policyholder's covered employees.

Life Insurance and Accidental Death & Personal Loss Insurance

This handbook covers Aetna's Group Term Life Insurance and Accidental Death & Personal Loss (AD&PL) Insurance and the different benefit features that may be included under your Aetna Group Policy.

Unlike health insurance, where much of the claims work is handled by the provider of services, Life Insurance and AD&PL Insurance requires much more detail and attention from you, as the policyholder, in order to ensure accurate and timely benefits changes and claims submissions. As such, this handbook provides information on the different forms Aetna will require to support a benefit change or claim submission and gives details and instructions for completing those forms.

This handbook will also help you in administering your Group Policy.

This handbook should be used as a reference guide and does not replace or supersede the benefits described in your Group Policy. Please refer to your Group Policy for Policy-specific information.

If you have questions regarding any of the information covered in this chapter, please call Aetna's Life Insurance Service Center at 1-800-523-5065.

Enrollment

For most companies, enrollment and benefit change activity constitutes the biggest piece of the administration process. As such, Aetna recommends that you familiarize yourself with these sections. Pay particular attention to the information that must be included on an Enrollment/Change Request form in order to prevent potential claim problems caused by delayed enrollment or missing information.

What is an annual benefits election period?

The annual benefits election period is the time of year when your employees can evaluate their benefit needs and select the coverage that best meets their needs for the following year.

What are the enrollment requirements for contributory coverage/noncontributory coverage?

For contributory coverage:

Aetna requires that at least 20 percent of all eligible employees must enroll for Life Insurance and at least 20 percent of all eligible employees must enroll for Accidental Death and Personal Loss coverage.

For noncontributory coverage:

Aetna requires that 100 percent of all eligible employees be enrolled for all noncontributory coverages. If dependent coverage is included under the policy and employees do not contribute toward the cost of dependents' benefits, dependent coverage cannot be refused.

Aetna reserves the right to audit payroll records to ensure that participation requirements are being met. If the participation requirements are not met, Aetna has the right to cancel your Group Policy by giving you advance written notice. If your Group Policy is cancelled, your employees may be eligible to convert their coverage to a policy of individual insurance. Please refer to the Life Conversion chapter of this handbook for details concerning conversion and to your Group Policy for the specific terms regarding Aetna's rights to cancel coverage.

Probationary period

As the employer, you have the discretion to decide whether or how long newly hired employees (or if you choose to, existing employees) must wait in order to be eligible for coverage under the active group coverage. This is called the probationary period. If employees are required to serve a probationary period, it must be applied equally to all employees in that class.

If you select a probationary period, the eligibility date under the Group Policy is the day after the employee finishes serving his/her probationary period. In order to be

eligible for coverage, the employee must sign and return the Enrollment/Change Request form within 31 days of the eligibility date. Otherwise, the employee will be treated as a "Late Enrollee." If the employee is a Late Enrollee, coverage will be subject to the requirements outlined in the Late Enrollees section that follows.

If the employee elects coverage before the end of his/her probationary period, coverage will take effect on the eligibility date. Otherwise, coverage will take effect on the date the employee returns the signed Enrollment/Change Request form, provided it is within 31 days of the eligibility date.

Examples:

- 1. ABC Company imposes a three-month probationary period. Jim Smith is hired on January 1, and fills out an Enrollment/Change Request form for the group Life coverage immediately. Since Jim must first serve his probationary period, his eligibility date under the Group Policy is April 1. Jim's coverage under the Group Policy will not become effective until April 1.
- 2. ABC Company imposes a three-month probationary period. Jim Smith is hired on January 1, making his eligibility date April 1. On April 24, he gives his signed Enrollment/Change Request form to you. Jim can be covered, since he signed and returned his enrollment form to you within 31 days of his eligibility date. His coverage becomes effective on April 24.
- 3. ABC Company imposes a three-month probationary period. Jim Smith is hired on January 1, making his

Enrollment (continued)

eligibility date April 1. On May 19, he gives his signed Enrollment/Change Request form to you. Since Jim did not enroll within 31 days of his eligibility date, he is subject to the Late Enrollee requirements outlined in the effective date of coverage section of his Group Policy.

Active-at-Work rule

If an employee is away from work because of illness or injury on the date group Life coverage would otherwise take effect, such coverage will not take effect until the employee returns to work for one full day. Dependent coverage will usually take effect when the employee's coverage takes effect if, by then, the employee has enrolled for dependent coverage. New dependents not enrolled within 31 days of the dependent's eligibility date will be subject to Late Enrollee requirements.

When are employees considered Late Enrollees?

When employees do not elect coverage within the 31-day period from their eligibility date, they and their dependents are considered Late Enrollees.

To avoid being considered a Late Enrollee, the Enrollment/Change Request form must be:

 Signed by the employee no later than 31 days after the annual benefits election date or hire date.

Unless this condition is met, the enrollee will be considered late and will need to submit Evidence of Insurability. Please

see the Evidence of Insurability chapter for more information. In addition, some policies do not allow for late enrollment and require a Late Enrollee to wait until the next annual benefits election period to enroll for coverage. Please refer to the effective date of coverage section of your Group Policy for specifics.

Example:

The "annual benefits election date" is November 1. To qualify:

- The Enrollment/Change Request form must be signed by the employee (or made by phone*) on or before December 1.
- The Enrollment/Change Request form must be received by Aetna on or before January 1.
- If the request is received January 2 or later, the employee is considered a Late Enrollee and enrollment will not be accepted.

If the state mandates an annual benefits election period that is greater than 31 days, the mandated enrollment period will be used for the initial enrollment of a member.

Duplicate coverage

Your Group Policy may not allow individuals to be covered both as an employee and as a dependent. In addition, no person may be covered as a dependent of more than one employee, except where required by state law. Your Aetna representative can provide you with more specific information about what your Group Policy provides with respect to duplicate coverage. You may also refer to the eligibility section of your Group Policy's Summary of Coverage.

How do I enroll new employees?

Enrollment can be made an integral part of the hiring process for new employees. By providing enrollment materials and benefits literature to your employees when they first begin work, you are allowing them to make informed benefits decisions. This also helps prevent potential claims problems caused by delayed enrollment or missing information.

Note: The Enrollment/Change Request form is used for adding new employees, terminating employees and making changes to existing elections. A sample form is shown later in this chapter.

If you choose to make enrollment a part of the hiring process, you should provide the following to new hires:

1. Enrollment/Change Request

form – Many states have laws that govern the information that may be collected on an enrollment form. As such, it may be necessary to use more than one enrollment form for your workforce. All enrollment forms must be approved by each Department of Insurance prior to use. Therefore, in many cases custom employer enrollment forms cannot be accepted by Aetna. The use of custom enrollment forms for full-risk and self-insured business requires advance approval of the forms by Aetna

*In this example, if the request is received by Aetna by phone during December, the caller must confirm on a recorded phone call that the member did sign and return the form to the employer by December 1. and, when required by the state in which the business is written, state filing of the proposed enrollment forms with the appropriate regulatory authority. Your Aetna service representative will ensure you are given the appropriate enrollment forms. A sample with instructions is shown later in this chapter.

- 2. Booklet/Certificate Your Group Policy's Booklet/Certificate contains a detailed description of the Policy's benefits and limitations. If you offer a choice of more than one policy of benefits, employees should be given a copy of each Booklet/Certificate.
- 3. Privacy Notice The Privacy Notice describes certain aspects of Aetna's insurance privacy policy. This privacy policy applies to individuals who are covered under an Aetna group insurance policy. For your convenience in providing this policy to your employees, a copy of Aetna's privacy policy appears on page 10.

How do I complete an Enrollment/Change Request form?

The Enrollment/Change Request form is used to enroll new subscribers process changes in family status such as the birth of a child or marriage or change Policy coverage.

Enrollment/Change Request forms vary according to state and the Policy selected. Your Aetna representative can provide you with these correct forms.

Most Enrollment/Change Request forms have three parts:

- 1. Aetna copy.
- 2. Employee copy.
- 3. Employer copy.

It is very important that we receive the required information detailed below on each Enrollment/Change Request form. As the employer, you are responsible for making sure all Enrollment/Change Request forms are properly completed by your employees before calling, mailing or faxing them to us. If any of the required information is missing, it may lead to a delay in enrollment or potential claims problems.

If you have any questions, call your Aetna representative, whose phone number is on your billing statement.

Explaining the Enrollment/ Change Request form

A sample of the Life and AD&PL/AD&PL Enrollment/Change Request form appears at the end of this chapter. The following explains what information is needed in each section of the Enrollment/Change Request form.

Effective date

This is the date the employee's coverage will take effect. For example, if an employee starts work on February 1 and has to serve a two-month probationary period, the effective date should be shown as April 1.

Employee hire date

Fill in the date the employee was hired.

Employee Social Security number

Fill in the employee's SSN. This is necessary to process any future transactions, including claim payment.

Section A: Transaction information

1. Enrollment

Indicate if the Enrollee is a New Enrollee or Rehire.

Requested employee coverage

Check the box(es) for which the employee elects coverage.

Requested dependent coverage

If your Policy has dependent coverage, and the employee elects dependent coverage, check the box(es) that apply for dependent coverage.

2. Termination

Check this box if the transaction being requested is to terminate or cancel coverage for an employee. Please see the "More Information on Terminations or Cancellations" section in this chapter for further details.

3. Change

Check the box that applies to the change requested. Please see the "How to Submit Changes" section in this chapter for further details.

Section B: Employer information

1. Employer name

If not already pre-printed, please add.

2. Control, suffix and account number If not already pre-printed, please add.

Enrollment (continued)

3. Plan number

The plan number reflects the combination of benefits offered under your Group Policy. It details the employees eligible for a particular Policy, the particular benefits covered under each Policy, the plan numbers and basic administrative instructions. If your Group Policy offers more than one combination of benefits, please contact your Aetna representative for the appropriate plan number.

4. SFO (Servicing Field Office)

This information will be pre-printed on your Enrollment/Change Request form.

5. Employer address

The employer's primary business location.

6. Claim office code

The claim office assigned to the Enrollee. Your Aetna representative will provide you with this code.

7. Customer code (optional)

Provide an identifying customer code for the employee (only if you had elected to provide this information).

Section C: Employee information

1. Employee name

The employee should list his/her full name (last, first, middle initial). Do not use nicknames.

2. Birth date

The employee should list his/her date of birth.

3. Employee's sex

Show "M" for male and "F" for female.

4. Telephone numbers

The employee should list his/her home and work phone numbers.

5. Employee home address

The employee should list his/her home address (street, city, state, zip code).

6. Employee coverage amounts

The employee should list his/her annual earnings in whole dollars. Also fill in the amounts of insurance requested for each benefit covered or elected.

7. Beneficiary designation

The employee should list the full name of the beneficiary, the beneficiary's Social Security number and the relationship to the employee. This is necessary to determine to whom benefits will be paid in case of death. If additional space is needed, use the Special Remarks space. Please refer to the Beneficiaries chapter for the appropriate beneficiary terminology.

Section D: Covered dependents

(Complete only if dependent coverage is offered under your Policy and dependent coverage is elected.)

Dependents

Check the box if dependent coverage is being refused.

Transaction type

Show "A" for adding new coverage for an employee or dependent.

Show "C" for changing dependent coverage.

Show "R" to remove a dependent.

Dependent name

The employee should list the dependents' full name (last, first, middle initial). Do not use nicknames.

Social Security number

Fill in the Social Security number of each dependent, if available.

Relation code

Use the following abbreviations to indicate the relationship of each dependent to the employee:

W = Wife

H = Husband

D = Daughter

S = Son

O = Other (Use the Special Remarks section to indicate the relationship, if any, to the covered employee and to provide details of the parent-child relationship.*)

Birth date

The employee must list his/her date of birth and the birth dates of all dependents.

Students age 19 or older

Indicate "yes" if the employee is enrolling a child over the age of 19. Dependent children over age 19 who are not attending school are generally not eligible for coverage.

*If your Group Policy permits employees to cover dependent children who are not their own biological, adopted or stepchildren, it will be necessary to have the employee complete a Special Dependent form. For example, the completion of a Special Dependent form would be required if the employee were attempting to enroll a niece, nephew or grandchild. If the employee is attempting to cover a dependent child who is not his/her own biological, adopted or stepchild, the Special Dependent form shown later in this chapter should be completed and attached to the Enrollment/Change Request form. If the Special Dependent form is not submitted with the Enrollment/Change Request form, a copy will be sent to the employer for completion by the employee. Answers to the questions on the form will be used to determine if the child is eligible for the coverage.

Insurance amount(s)

Fill in the insurance amounts for the benefits elected.

Acknowledgments

Employee's signature

The employee must sign and date the form.

Employee's e-mail address This is optional.

Employer's signature

The employer must sign and date the form.

When should changes be submitted?

You should use the Enrollment/Change Request form to:

- Add, change or remove dependents
- Change beneficiary information
- Change Social Security number
- Change Plan number
- Change earnings amounts
- Change insurance amounts
- Terminations or cancellations

How should changes be submitted?

You will need to check the box in the "Change" section of the form (section A #3) that corresponds to the change being requested. Then the portion of the form that relates to the change should be filled out. For example, to increase the benefit amount, check the "Increase/Decrease Benefit Amount" box and fill out all the pertinent information in section 6 of the form.

The following information should also be filled out when submitting any change:

Section A: Effective date of transaction

This is the effective date of the change.

Section B: Employer information Employer name

If not already pre-printed, please add.

Control, suffix and account number If not already pre-printed, please add.

Section C: Employee information: Employee's Social Security number List employee's Social Security number.

Employee's name

The employee should list his/her full name (last, first, middle initial). Do not use nicknames.

Certification

The employee and the employer must sign and date the form.

More information on terminations or cancellations

When processing a termination or cancellation, please use the date the employee's employment terminates or the date the employee cancels his/her coverage. For purposes of credit transactions (crediting premium), the effective date will be limited to 60 days from the date your request is received by Aetna.

The date the employee terminates or cancels coverage can be either:

 The date the employee ceases active work, is no longer in an eligible class or cancels coverage. ■ The last day of the billing cycle during which the employee ceases active work, is no longer in an eligible class or cancels coverage. For example, if your next billing due date is November 1 and an employee's last day of work is October 23, you have the option of extending that employee's benefits through October 31, the end of the current billing cycle.

Please provide the reason for terminating or canceling coverage on the Enrollment/ Change Request form in section D – Special Remarks.

Note: Any continuation will begin on the day following the date of termination or cancellation of coverage, regardless of which option is elected. All terminations or cancellations under your Policy must be reported the same way. Aetna will process the termination or cancellation as of the date you specify.

Note: There is an important distinction between canceling an employee's coverage and terminating an employee's coverage. The cancellation box should only be checked when the employee cancels his/ her coverage, but remains active at work; for example, an employee who remains in your employment but cancels his/her coverage because he or she has opted to become covered under the spouse's Group Policy. The termination box should only be checked when the employee ceases employment or becomes a member of a class of employees not eligible for coverage. This distinction is important because an employee who terminates employment or who rejoins an eligible class within one year of termination will typically not be required to again serve any probationary period of your Group Policy.

Enrollment (continued)

Aetna's Privacy Notice

The Notice of Aetna's Privacy Practices describes Aetna's privacy policy. Aetna distributes the required notices to members as required by law. This notice is required by the federal HIPAA Privacy Rule and also by individual state Gramm-Leach-Bliley Privacy Regulations. The notice may differ based on the insured product. If your Policy includes insured coverages, you may obtain copies of product-specific versions of the Notice of Aetna's Privacy Practices, which are available on our website at www.aetna.com/about/information_ practices.html.

These privacy notices are not applicable to employees in self-funded benefits plans. Instead, plan sponsors may be obligated to develop and provide employees in self-funded benefits plans with their privacy notice. Please consult your counsel and/or consultants to develop any such required privacy notice.

Additional privacy information

While not a formal part of the employee Booklet/Certificate, the following confidentiality notice is included along with employee Booklet/Certificate to comply with state requirements.

Confidentiality notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or Life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or Life Insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payers (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your policy), other insurers, third-party administrators, vendors, consultants, government authorities and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network

providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third-party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and Life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies

addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our website at www.aetna.com.

Your right of access and correction

In general, you have a right to learn the nature and substance of any information Aetna has in its files about you. You may also have a right of access to such files, except information that relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment or deletion of personal information. This can be done in states that provide such rights and that grant immunity to insurers providing such access. If you request any health information, Aetna may elect to disclose details of the information you request to your (attending) physician. If you wish to exercise this right or if you wish to have more detail on our information practices, please contact:

Aetna
Executive Regulatory & Resolution Team,
RT11
151 Farmington Avenue
Hartford, CT 06156

	Requested Employee Coverage	Requested Dependent Coverage	it Coverage	2. Te	2. Termination (Cancel)		Change ('Provide explanation in Section D, Special Remarks.) Add Depondent(s)	in Section D, Special Remarks.)
Effective Date (MM/DD/YYYY) Date of Hire (I/M/DD/YYYY)	□ AD&PL/AD&D □ Supplemental Life □ Supplemental AD&PL/AD&D	☐ Basic Dependent AD&PL/AD&☐ Supplemental Dependent Life☐ Supplemental Dependent AD&☐ Supplemental Dependent AD&	Basic Dependent AD&PL/AD&D Supplemental Dependent Life Supplemental Dependent AD&FL/AD&D		* Employee must be enrolled for dependent(s) to have coverage. Effective Date (MMDD/YYYY)	earolled for e coverage.	Remove Dependent(s) Other Increase/Decrease Benefit Amount* Effective Date (MM/DD/YYYY)	s) □ Other* cnefit Amount*
Employer Information								
1. Employer Name • Full Name of Business or Organization	altion				2. Control No.	Suffix	Account 3. Piz	3. Plan Number 4, SFO
5. Employer Address (Streel, CRy, State, ZIP Code) - Primary Location of B. C. Employee Information - Please Print all Information	5. Employer Address (Street, City, State, ZIP Coos) - Primary Location of Business or Organization 2. Employee Information - Please Print all Information						6. Claim Office Dode 7. Customer Code (Optional)	stomer Code (Optional)
1 Employee Social Security Number 2. Empl	2. Employee Name (Last, First, MJ.)		3, Brithdate	3, Brithdate (MM/DD/YYYY)	4 Sex 5. Telephone Numbers Horne (Numbers ()	- Work (0
6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)	o., Civ, State, ZIP Code)				7. Employee	7. Employee Annual Earnings \$	8. Occupation/Title	
erage Amounts (Based or	9. Employee Coverage Amounts (Based on the requirements of your Plan, you may have to submit evidence of good health.)	nay have to submit evide	nce of good health.)					
	Supplemental Life Amount		Basic AD&I	Basic AD&PUAD&D Amount			Supplemental ADSPL/AD&D Amount	uni
esignation - If more than or	10. Beneficiary Designation - If more than one beneficiary, use Special Remarks.	Dependent cover	Dependent coverage Beneficiary is always the Employee.	ays the Emplo	уее.			
Full Beneficiary Name (First, Middle, Last)					Social Security Number of Beneficiary	r ol Beneficiary	Retationship to Employee	суве
ependents (Complete	 D. Covered Dependents (Complete only if Dependent Coverage is offered under your Plan.) 	ered under your Plan.)		his box if ye	Check this box if you are refusing coverage for your dependents.	overage for y	our dependents.	- 4
Dependent Name (First, Middle Initial, Last)	Social Security Number (If dependent has no SSN, write "None")	umber Relation. no SSN, write Code	Birthdate MM / DD / YYYY	Student Age 19 or Older Yes No	Basic Dependent Amount	Supplementa Amount	Supplemental Dependent Anount Anount Anount Anount	Supplemental Dependent ount AD&PLAD&D Amount
	3		1 1		69	49	\$	50
	•		1 1		60	₩.	*	8
			1 1		89	49	9	60
	•	•	1 1		S	6 0	65	69
Certification - Signatures Required	omeni with the ciglements and a	Employee's E-mail Address:	! Address:	thorization	dife doed adi no	is form		
below signifies my agre	My signature below signifies my agreement with the statements and authorization under Certification and Authorization on the back of this form.	umorization under C	ertification and At	Thorization	on the back of the	18 torm.		, in
1. Employee Signature (Hequired)		Late	Z. Employe	2. Employer Signature (Hequired)	dniradi		Ö	Date

Beneficiaries

How to assign coverage

Assignment

Assignment is the process by which a covered employee transfers his/her incidents of ownership under the Group Policy to another individual, individuals, trust or organization. Please note that Aetna's policy prohibits assignments unless you (the policyholder) agree to it.

What if an employee wants to assign his or her Life Insurance and/or AD&PL coverage?

- Call the Life Insurance Service Center toll-free at 1-800-523-5065 to request the appropriate assignment forms.
- Advise the employee that he or she may wish to discuss assignment tax implications and legal issues with an attorney or tax advisor prior to completing the assignment.

What is the process for assigning coverage?

- Work with the employee (assignor) to complete four copies of the assignment forms that Aetna sends you.
- Make sure the assignee completes and dates the four forms in the Release by Assignee sections.
- Sign the four forms in the appropriate sections.
- Return the four completed forms to Aetna.

What will Aetna do when it receives the assignment forms?

- Review the forms for proper completion and execution.
- Contact the employer or employee to resolve any problems.
- Register and place on file properly completed and executed assignments.
- Aetna will return three executed copies to you. Retain one and give two to the employee for record keeping.

By placing the assignment on file, Aetna assumes no responsibility for the validity, sufficiency or effect of the assignment.

When does the assignment become effective?

The assignment becomes effective on the date the designated assignee accepts the assignment.

How to complete an Assignment of Group Coverage form

The employee must fill out the form and must follow these instructions whether the employee (the assignor) elects to assign his/her coverage to a single assignee or to multiple assignees. A sample form is shown later in this chapter.

When completing the appropriate forms, it is important that the assignee(s), assignor and the employer complete all four forms, as Aetna cannot accept photocopies.

Once the assignment has been registered by us and returned to you, it is essential that you mark the employee's file to show that the rights have been assigned. In the event that the employee dies while an assignment is in effect, the registered Assignment of Group Coverage form should be submitted with the Proof of Death form.

Beneficiaries (continued)

Front side:

- 1. Print the insured's full name (do not use nicknames or abbreviations).
- 2. Write in the insured's Social Security number.
- 3. Print the assignor's full name (do not use nicknames or abbreviations).
- 4. Print the assignee's full name (do not use nicknames or abbreviations). If the assignee is a trust, enter the name of the trust, the trust agreement date and the trustee(s).
- 5. Include the assignee's relationship to the assignor, if any. If not related, indicate "none."
- 6. Write in the assignee's Social Security number (not necessary for a trust).
- 7. Provide the assignee's home address (street, city, state and zip code). If the assignee is a trust, enter the trustee's address. Repeat steps 4–7 if more than one assignee.
- 8. Provide the six-digit control number.

- 9. If the assignor is covered under more than one Group Policy, list the other Aetna control numbers if the assignor is assigning benefits under all group life policies.
- 10. Provide the full name of the policyholder.
- 11. Provide the city/town and state where the assignor is at the time he or she completes the form, plus the day, month and year. Be sure to use a current date.
- 12. A disinterested person must witness the assignor's signature. (A disinterested person is defined as someone who has no interest in the assignment.)
- 13. The signature of the assignor.

Reverse side:

Release by assignee

A disinterested person must witness the assignee's signature. (A disinterested person is defined as someone who has no interest in the assignment.)

1. The form must be signed and dated by the assignee.

Consent by contract holder

This section must be completed by you, the employer.

- 1. Provide the full name of the employer.
- 2. Include the date the employer completes this section.
- 3. The person authorized to complete the form for the employer must provide his/her signature and must print his/her full name next to the signature.
- 4. Provide the title of the person who completes this section.

Consent by insurer and acknowledgement of recording Aetna will complete this section.

Designation of beneficiary by assignee

- 1. It is recommended that the assignee name a beneficiary at the time this form is executed. If the assignee does not name a beneficiary, Aetna may still register the form. If the assignee decides to designate a beneficiary later, Aetna will furnish the Designation of Beneficiary by Assignee forms to be completed.
- 2. A disinterested person must witness the assignee's signature. (A disinterested person is defined as someone who has no interest in the assignment.)
- 3. The assignee must provide his/her signature.

page 1 of 2



Assignment of Group Coverage Aetna Life Insurance Company

Name of Person Insured	
Social Security Number	

Mail all four originally signed copies to:

Aetna Life Insurance Company Attn: Consumer Services 151 Farmington Avenue Hartford, CT 06156-7318

To be executed in quadruplet - May be used for Group Life Coverage with or without Paid-Up Values, Group Accidental Death and Dismemberment, and Group Plans providing Accident Coverage. May also be used for individual policies provided on a group basis such as policy forms GR-42645, GR-37, GR-159 and GR-1072. If the employee lives in a community property state, and if the employee's spouse is not an assignee, said spouse should assent in writing to the assignment.

Aetna makes no representation that this assignment form is sufficient for purposes of an employee's personal tax or estate planning. Prior to making any assignment, employees should review this form with their own legal counsel. NO ONE SHOULD COMPLETE THIS FORM IF HE OR SHE HAS EXECUTED A PREVIOUS ASSIGNMENT WHICH HAS BEEN ACCEPTED BY AETNA IN CONNECTION WITH ANY OF THE ABOVE-MENTIONED COVERAGES AND WHICH IS

I, the undersigned,	, hereby irrevoc	ably assign	n, transfer, and	set over as a
	Assignor	,	4 2211-1-1	200 2121 222
gift to				V2-7:047
Assignee	Family Relationship, if any		Social Security	Number
Street Address	City or Town, State		-1-	
limited to all my right, title, claim, interest a payable on account of my death or the de	cessors or assigns of said assignee all my inci and benefit, present or future, in and to any G ath of any of my dependents under Contract N act or contracts between the Contractholder, r	roup Insura No.(s)		
and the Insurer, namely, Aetna Life Insural issued by the Insurer or any succeeding Ir	ance Company or one of its affiliated Compani nsurer to the Contractholder, its successors o issued by the Insurer or any succeeding Insu	es, and ur assigns,	in replacement	thereof, and
administrator should the assignee predection individual contract of life insurance in according to make to the Contractholder any contract or contracts; (3) the sole and excitor assignment, could be exercised by me sole and exclusive right to demand, collections.	of the foregoing, this assignment shall vest in ease me: (1) the sole and exclusive right to e ordance with any conversion privilege contains ontributions which may be required to maintain clusive right to exercise any and all other rights e under the contract or contracts, or which ma ct, and receive any and all proceeds of the content to the right of the assignee to designate an	xercise the ed in the co my insura s, privilege by be grant atract or co	e privilege of ob- ontract or contra ance in force un s, and options ted by the Insur- ontracts, subject	otaining an racts; (2) the order the which, but for rer; (4) the t, however, to
nor the Insurer shall be obliged to inquire with knowledge of the terms thereof. The	e as trustee, or is subject to any condition or a into the terms of such trust, condition or agree Contractholder and the Insurer may rely sole ther instrument affecting this assignment of m	ement, and y upon the	they shall not signature of the	be chargeable ne assignee to
take effect until the Contractholder and the	ain a provision against assignments, it is unde e Insurer execute waivers thereof, and that af	er such ex		ent chall not
become effective as of the date of accepta	ance by the Assignee, as indicated on the rev	0,000,000,		
It is further understood that neither the Co	entractholder nor the Insurer assumes respons		ny kind or degr	signment shall
It is further understood that neither the Co validity, sufficiency or effect of this assign	ontractholder nor the Insurer assumes response ment.	sibility of a	ny kind or degr day of	signment shall
	ontractholder nor the Insurer assumes responsi ment. o set my hand at	sibility of a		signment shall

Assignment of Group Coverage - Single page 2 of 2

under which the assignor's benefits are p will not be effective unless the Contracth hereby agree to release the Contractho iability of any kind that might arise as a c	n on the reverse side hereof. It is my understanding or	nment, and that the assignment to me eration of their grant of such consent, d assigns from any obligation or ereby release each of them from any
Vitness	Assignee	Date
he assignment set forth on the reverse s	assignee of the above " Release By Assignee ," the side hereof and agrees to waive any prohibition a ent and waiver shall be effective only with respect	gainst assignments contained in the
Contractholder		Date
Ву	Title	
nsurer Sy	Title	
A copy of this assignment has been place Insurer	ed diffice by the mound.	
À	Title	
Registrar		Date
is assignee, I hereby designate one*, of	of the assignment set forth on the reverse side he f the following as the beneficiary under the contra g payable by reason of death of the person insure	ct or contracts set forth in said
child per stirpes. Myself, if I survive the insured, otherw Myself, if I survive the insured, otherw Other,		
child per stirpes. Myself, if I survive the insured, otherw Myself, if I survive the insured, otherw Other, under Trust Agreement dated NOTE: If assignee wishes to make an forms on request. It is my understanding and desire that this previously made under said contract or contracts; that if the Designation is to a total sayment to and receipt by the trustee(s)	rise in equal shares to my surviving children. rise to my estate. In other Designation of Beneficiary, the Insuration of Series and Insurer shall not be chargeable with known shall fully discharge all liability of said Insurer to the Insurer income benefits if the contract or contract or survivor income benefits if the contract or contr	er will promptly furnish proper and all designations of beneficiary ge as provided in said contract or wledge of the terms thereof and the the extent of such payment; and that
child per stirpes. Myself, if I survive the insured, otherw Myself, if I survive the insured, otherw Other, under Trust Agreement dated NOTE: If assignee wishes to make an forms on request. It is my understanding and desire that this previously made under said contract or contracts; that if the Designation is to a total and receipt by the trustee(s) his Designation will not affect the payment.	rise in equal shares to my surviving children. rise to my estate. In other Designation of Beneficiary, the Insuration of Series and Insurer shall not be chargeable with known shall fully discharge all liability of said Insurer to the Insurer income benefits if the contract or contract or survivor income benefits if the contract or contr	er will promptly furnish proper and all designations of beneficiary ge as provided in said contract or wledge of the terms thereof and the the extent of such payment; and that

page 1 of 2



I, the undersigned,

Assignment of Group Coverage

Aetna Life Insurance Company

Name of Person Insured	
Social Security Number	

, hereby irrevocably assign, transfer, and set over as a gift to

Mail all four originally signed copies to:

Aetna Life Insurance Company Attn: Consumer Services 151 Farmington Avenue Hartford, CT 06156-7318

To be executed in quadruplet - May be used for Group Life Plans with or without Paid-Up Values, Group Plans providing benefits for Accidental Death and Dismemberment, and Group Accident Plans. May also be used for individual policies provided on a group basis such as policy forms GR-42645, GR-37, GR-159 and GR-1072. If the employee lives in a community property state, and if the employee's spouse is not an assignee, said spouse should assent in writing to the assignment.

Aetna makes no representation that this assignment form is sufficient for purposes of an employee's personal tax or estate planning. Prior to making any assignment, employees should review this form with their own legal counsel. NO ONE SHOULD COMPLETE THIS FORM IF HE OR SHE HAS EXECUTED A PREVIOUS ASSIGNMENT WHICH HAS BEEN ACCEPTED BY AETNA IN CONNECTION WITH ANY OF THE ABOVE-MENTIONED COVERAGES AND WHICH IS CURRENTLY IN FORCE.

Assignee	Family Relationship, if any	Social Security	Number
Street Address	City or Town		
Assignee	Family Relationship, if any	Social Security	/ Number
Street Address	City or Town		
Assignee	Family Relationship, if any	Social Security	/ Number
Street Address	City or Town	-	
Aetna Lite insurance Company or one of its attilia	ited Companies, and under any contract or co	ontracts issued by the Ins	surer or any
succeeding Insurer to the Contractholder, its succeeding Insurer to the Contractholder, its succeeding Without limiting in any way the generality of the for of the last surviving assignee should the assignee obtaining an individual contract of life insurance in the right to make to the Contractholder any contricontracts; (3) the sole and exclusive right to exercicely be exercised by me under the contract or codemand, collect, and receive any and all proceed subject further to the right of the assignee to designee the terms that the terms to of the terms thereof. The Contractholder and the waiver, or to any other instrument affecting this assignment is as	cessors or assigns, in replacement thereof, all planter pursuant to the conversion privilege pregoing, this assignment shall vest in the asses predecease me. (1) the sole and exclusive a accordance with any conversion privilege or butions which may be required to maintain moise any and all other rights, privileges, and o contracts, or which may be granted by the Insulation of the contract or contracts, subject, however gnate and to change the beneficiary as provious tees or is subject to any condition or agreement, and the linsurer may rely solely upon the signature of	nd under any individual of contained in such contra- signees or in the survivor e right to exercise the pri- contained in the contract of y insurance in force under ptions which, but for this urer; (4) the sole and exce er, to the terms of the co- ded in the contract or cor- ment, neither the Contract y shall not be chargeable the assignees to any re-	or in the estate vilege of or contracts; (2) or the contract or assignment, lusive right to ntract and atracts.
succeeding Insurer to the Contractholder, its succentracts issued by the Insurer or any succeeding Without limiting in any way the generality of the foof the last surviving assignee should the assignee obtaining an individual contract of life insurance in the right to make to the Contractholder any contricontracts; (3) the sole and exclusive right to exercicely be exercised by me under the contract or codemand, collect, and receive any and all proceed subject further to the right of the assignee to designee that the contract of the suspense as the linear shall be obliged to inquire into the terms of the terms thereof. The Contractholder and the	cessors or assigns, in replacement thereof, all planter pursuant to the conversion privilege pregoing, this assignment shall vest in the asses predecease me: (1) the sole and exclusive in accordance with any conversion privilege or butions which may be required to maintain moise any and all other rights, privileges, and of contracts, or which may be granted by the Insulation of the contract or contracts, subject, however gnate and to change the beneficiary as proving the subject to any condition or agreed of such trust, condition or agreement, and the insurer may rely solely upon the signature of essignment of my insurance under the contract rovision against assignments, it is understood waivers thereof, and that after such execution	nd under any individual of contained in such contrained in such contrained in the survivore right to exercise the prior ontained in the contract of y insurance in force under ptions which, but for this urer; (4) the sole and except, to the terms of the coded in the contract or cornent, neither the Contract y shall not be chargeable of the assignees to any ret tor contracts.	or in the estate vilege of or contracts; (2) or the contract or assignment, lusive right to intract and attracts. Atholder nor the ewith knowledge lease, receipt or all not take effectively.
succeeding Insurer to the Contractholder, its succentracts issued by the Insurer or any succeeding Without limiting in any way the generality of the foof the last surviving assignee should the assignee obtaining an individual contract of life insurance in the right to make to the Contractholder any contrict contracts; (3) the sole and exclusive right to exercicely be exercised by me under the contract or could be exercised by me under the contract or codemand, collect, and receive any and all proceed subject further to the right of the assignee to design of the terms thereof. The Contractholder and the waiver, or to any other instrument affecting this as In the event the contract or contracts contain a pruntil the Contractholder and the Insurer execute very	cessors or assigns, in replacement thereof, at glinsurer pursuant to the conversion privilege pregoing, this assignment shall vest in the asses predecease me: (1) the sole and exclusive in accordance with any conversion privilege of butions which may be required to maintain mucise any and all other rights, privileges, and of contracts, or which may be granted by the Institute of the contract or contracts, subject, however, gnate and to change the beneficiary as provious testes or is subject to any condition or agreed of such trust, condition or agreement, and the Insurer may rely solely upon the signature of sesignment of my insurance under the contract covision against assignments, it is understood waivers thereof, and that after such executions indicated on the reverse side.	and under any individual of contained in such contrained in such contrained in the survivore right to exercise the privontained in the contract of y insurance in force under ptions which, but for this urer; (4) the sole and excer, to the terms of the conded in the contract or connent, neither the Contract y shall not be chargeable of the assignees to any relation to the transport of the this assignment shall be of any kind or degree for	or in the estate vilege of or contracts; (2) or the contracts; (2) or the contract or assignment, lusive right to ntract and attracts. It will be the with knowledge lease, receipt or all not take effective the validity,
succeeding Insurer to the Contractholder, its succentracts issued by the Insurer or any succeeding Without limiting in any way the generality of the for the last surviving assignee should the assignee obtaining an individual contract of life insurance in the right to make to the Contractholder any contrict contracts; (3) the sole and exclusive right to exercicely demand, collect, and receive any and all proceed subject further to the right of the assignee to design this assignment is made to the assignees as truinsurer shall be obliged to inquire into the terms of the terms thereof. The Contractholder and the waiver, or to any other instrument affecting this as In the event the contract or contracts contain a pruntil the Contractholder and the Insurer execute was of the date of acceptance by the Assignees, as It is further understood that neither the Contracthols sufficiency or effect of this assignment.	cessors or assigns, in replacement thereof, at glinsurer pursuant to the conversion privilege pregoing, this assignment shall vest in the asses predecease me: (1) the sole and exclusive in accordance with any conversion privilege of butions which may be required to maintain mucise any and all other rights, privileges, and of contracts, or which may be granted by the Institute of the contract or contracts, subject, however, gnate and to change the beneficiary as provious testes or is subject to any condition or agreed of such trust, condition or agreement, and the Insurer may rely solely upon the signature of sesignment of my insurance under the contract covision against assignments, it is understood waivers thereof, and that after such executions indicated on the reverse side.	and under any individual of contained in such contrained in such contrained in the survivore right to exercise the privontained in the contract of y insurance in force under ptions which, but for this urer; (4) the sole and excer, to the terms of the conded in the contract or connent, neither the Contract y shall not be chargeable of the assignees to any relation to the transport of the this assignment shall be of any kind or degree for	or in the estate vilege of or contracts; (2) or the contract of assignment, lusive right to ntract and attracts. Atholder nor the ewith knowledge lease, receipt or all not take effective the validity,
succeeding Insurer to the Contractholder, its succentracts issued by the Insurer or any succeeding Without limiting in any way the generality of the for the last surviving assignee should the assignee obtaining an individual contract of life insurance in the right to make to the Contractholder any contricontracts; (3) the sole and exclusive right to exerciculd be exercised by me under the contract or ordemand, collect, and receive any and all proceed subject further to the right of the assignee to designee the terms to the terms that the contract or contract further to the right of the assignees as truinsurer shall be obliged to inquire into the terms of the terms thereof. The Contractholder and the waiver, or to any other instrument affecting this as in the event the contract or contracts contain a pruntil the Contractholder and the Insurer execute was of the date of acceptance by the Assignees, as It is further understood that neither the Contractholder.	cessors or assigns, in replacement thereof, at glinsurer pursuant to the conversion privilege pregoing, this assignment shall vest in the asses predecease me: (1) the sole and exclusive in accordance with any conversion privilege of butions which may be required to maintain mucise any and all other rights, privileges, and of contracts, or which may be granted by the Institute of the contract or contracts, subject, however, gnate and to change the beneficiary as provious testes or is subject to any condition or agreed of such trust, condition or agreement, and the Insurer may rely solely upon the signature of sesignment of my insurance under the contract covision against assignments, it is understood waivers thereof, and that after such executions indicated on the reverse side.	nd under any individual of contained in such contrained in such contrained in the survivore right to exercise the privontained in the contract of y insurance in force under ptions which, but for this urer; (4) the sole and excer, to the terms of the content, neither the Contract or content, neither the Contract y shall not be chargeable if the assignees to any relation to contracts.	or in the estate vilege of or contracts; (2) or the contract of assignment, lusive right to ntract and attracts. Atholder nor the ewith knowledge lease, receipt or all not take effective the validity,

Assignment of Group Coverage - Multiple page 2 of 2

the Contractholder and the insurer, their employees consequence of the assignment. In particular, we have insurance benefits assigned to us or of any term	bition against their assignment, and that the hereto. In consideration of their grant of sur- , agents, and assigns from any obligation or ereby release each of them from any liabilit	ch consent, we hereby agree to release r liability of any kind that might arise as a ry for any failure to notify us of changes in
Witness	Assignee	
Witness	Assignee	Date
Witness	Assignee	
Consent by Contractholder In consideration of the execution by the assignees of assignment set forth on the reverse side hereof and contract or contracts. This consent and waiver shall	agrees to waive any prohibition against ass	signments contained in the subject
Contractholder		Date
Ву	Title	1
In consideration of the execution by the assignee of set forth on the reverse side hereof and agrees to w contracts. This consent and waiver shall be effective has been placed on file by the Insurer.	aive any prohibition against assignments co	ontained in the subject contract or
By	Title	
Ву	Title	
Registrar		Date
Designation of Beneficiary By Assignees Effective on the date of our acceptance of the assign assignees, we hereby designate one*, of the following to receive any sum becoming payable by reason of spouse of the surviving assignees named in the foregoing In equal shares to the surviving assignees named stirpes. In equal shares to the surviving assignees named other, Other,	ng as the beneficiary(ies) under the contract death of the person insured: of said person insured, if he or she survives assignment and the descendants of any de ed in the foregoing assignment and the des	et or contracts set forth in said assignments to the insured, otherwise in equal shares to eceased assignee, per stirpes. cendants of any deceased assignee, per
——————————————————————————————————————		, as Trustee unde
Trust Agreement dated *NOTE: If assignees wish to make any other Des request.	signation of Beneficiary, the Insurer will	promptly furnish proper forms on
It is our understanding and desire that this Designat made under said contract or contracts; that this Des Designation is to a trust, the Insurer shall not be cha trustee(s) shall fully discharge all liability of said Insu- payment of survivor income benefits if the contract of	ignation is subject to change as provided in argeable with knowledge of the terms thered	said contract or contracts; that if the of and the payment to and receipt by the this Designation will not affect the
beneficiary designation.	Assignee	
	Assignee	
beneficiary designation.	Assignee	

page 1 of 2



I, the undersigned,

Assignment of Group Coverage Aetna Life Insurance Company

Name of Person Insured	
Social Security Number	

, hereby irrevocably assign, transfer, and set over for

Mail all four originally signed copies to:

Aetna Life Insurance Company Attn: Consumer Services 151 Farmington Avenue Hartford, CT 06156-7318

To be executed in in quadruplet- May be used for Group Life Coverage with or without Paid-Up Values, Group Accidental Death and Dismemberment, and Group Plans providing Accident Coverage. May also be used for individual policies provided on a group basis such as policy forms GR-42645, GR-37, GR-159 and GR-1072. If the employee lives in a community property state, and if the employee's spouse is not an assignee, said spouse should assent in writing to the assignment.

Aetna makes no representation that this assignment form is sufficient for purposes of an employee's personal tax or estate planning. Prior to making any assignment, employees should review this form with their own legal counsel. NO ONE SHOULD COMPLETE THIS FORM IF HE OR SHE HAS EXECUTED A PREVIOUS ASSIGNMENT WHICH HAS BEEN ACCEPTED BY AETNA IN CONNECTION WITH ANY OF THE ABOVE-MENTIONED COVERAGES AND WHICH IS CURRENTLY IN FORCE.

	Assignee			
				and to the
Street Address	City	or room o core	State	
successors or assigns of said assignee all my limited to all my right, or future, in and to my in a contract or contracts between the Contract	nsurance under Contract Nun nolder, namely,	nber(s)		
and the Insurer, namely, Aetna Life Insurance issued by the Insurer or any succeeding Insurunder any individual contract or contracts issucontained in such contract or contracts.	rer to the Contractholder, its s	successors or a	ssigns, in replace	ment thereof, and
Without limiting in any way the generality of the right to exercise the privilege of obtaining an incontained in the contract or contracts; (2) the maintain my insurance in force under the contrights, privileges, and options which, but for the which may be granted by the Insurer; (4) the state contract or contracts, subject, however, to designate and to change the beneficiary as privileges.	individual contract of life insur- right to make to the Contract tract or contracts; (3) the sole his assignment, could be exer- sole and exclusive right to de to the terms of the contract and	rance in accord holder any con- and exclusive roised by me ur mand, collect, d subject furthe	lance with any con tributions which m right to exercise a nder the contract o and receive any ar	oversion privilege ay be required to any and all other or contracts, or and all proceeds of
If this assignment is made to the assignee as nor the Insurer shall be obliged to inquire into with knowledge of the terms thereof. The Cor any release, receipt or waiver, or to any other contracts.	the terms of such trust, cond ntractholder and the Insurer n	ition or agreem	nent, and they shall upon the signature	Il not be chargeable of the assignee to
In the event the contract or contracts contain take effect until the Contractholder and the Inspecome effective as of the date of acceptance	surer execute waivers thereo	f, and that after	such execution th	
It is further understood that neither the Contra validity, sufficiency or effect of this assignment		mes responsib	ility of any kind or	degree for the
IN WITNESS WHEREOF, I have hereunto se	t my hand at	, this	day of	, 20
Signed and delivered in the presence of:	Assignor			

19

Assignment of Group Coverage – Viatical

pag

Consent by Contractholder In consideration of the execution by the assignee of the above "Release By Assignee," the Contractholder hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. Contractholder By Title Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer By Title Date	Consent by Contractholder In consideration of the execution by the assignee of the above "Release By Assignee," the Contractholder hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. Contractholder By Title Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer Title	under which the assignor's be will not be effective unless the I hereby agree to release the liability of any kind that might	ent set forth on the reverse side hereof. It is my understate enefits are provided contain a prohibition against their as a Contractholder and the Insurer consent thereto. In contractholder and the Insurer, their employees, agents arise as a consequence of the assignment. In particular y me of changes in the insurance benefits assigned to me aid benefits in force.	signment, and that the assignment to me nsideration of their grant of such consent, s, and assigns from any obligation or r, I hereby release each of them from any
In consideration of the execution by the assignee of the above "Release By Assignee," the Contractholder hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. Contractholder By Title Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. By Title	In consideration of the execution by the assignee of the above "Release By Assignee," the Contractholder hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. Contractholder By Title Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. By Title	Witness	Assignee	Date
Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer By	Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer By	In consideration of the execu the assignment set forth on the	tion by the assignee of the above "Release By Assigned he reverse side hereof and agrees to waive any prohibition."	on against assignments contained in the
Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer Title	Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer Title	Contractholder		Date
Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer Title	Consent by Insurer and Acknowledgment of Recording In consideration of the execution by the assignee of the above "Release By Assignee," the Insurer hereby consents to the assignment set forth on the reverse side hereof and agrees to waive any prohibition against assignments contained in the subject contract or contracts. This consent and waiver shall be effective only with respect to said assignment and to no other. A copy of this assignment has been placed on file by the Insurer. Insurer Title	Ву	Title	2
		assignment set forth on the re subject contract or contracts. A copy of this assignment ha Insurer	everse side hereof and agrees to waive any prohibition a This consent and waiver shall be effective only with res s been placed on file by the Insurer.	gainst assignments contained in the
		assignment set forth on the re subject contract or contracts. A copy of this assignment ha Insurer	everse side hereof and agrees to waive any prohibition a This consent and waiver shall be effective only with res s been placed on file by the Insurer.	gainst assignments contained in the pect to said assignment and to no other.
		assignment set forth on the re subject contract or contracts. A copy of this assignment ha Insurer By	everse side hereof and agrees to waive any prohibition a This consent and waiver shall be effective only with res s been placed on file by the Insurer.	gainst assignments contained in the pect to said assignment and to no other.



Funeral Home Beneficiary Designation

Aetna Life Insurance Company

Aetna Life Insurance Company Attn: Consumer Services 151 Farmington Avenue, RE52 Hartford, CT 06156-7318

Group Policyholder			Group Policy(ies)	
Name of Employee			Employee Social Security Number	
death, Aetna Life Insura the following funeral hon	nce Company may pa ne but only to the ext in this space may not	ay an amount not to exceed ent that such funeral home p	that from any sum becoming paya that from any sum becoming paya toward funeral so tovides these services. fit and should not exceed \$10,000	ervices provided by
uneral Home	and company.			
Address				
		ayable to the following secon	ndary beneficiary(ies). (If more tha	an one named, the
Name of Beneficiary	Relationship	Social Security Number	Address of Beneficiary	Percentage
Name of Beneficiary	Relationship	Social Security Number	Address of Beneficiary	Percentage
Unless otherwise expres uch beneficiary would he eneficiary(ies), if any, wo rescribed in said Group The foregoing Beneficiar insurance under said Group of this Beneficiary Designand Dismemberment cover	ave received if such tho survive me. If no Policy(ies). y Designation shall e oup Policy(ies). nation refers only to G verage, this designati	beneficiary had survived me secondary beneficiary survi xtend to any insurance whic froup Life Insurance coverage on shall apply to both policies	hereby designated predeceases in , shall be payable equally to the reves me, I request that said remain h may be in effect on my life in regree and I am also insured for Groups unless otherwise expressly state	ne, the share which emaining secondary der be payable as placement of my o Accidental Death ed above. This
Unless otherwise expressuch beneficiary would he peneficiary would he peneficiary (ies), if any, worescribed in said Group. The foregoing Beneficiar nsurance under said Grand Dismemberment con Beneficiary Designation. The right to change this which I may be insured a	ave received if such tho survive me. If no Policy(ies). y Designation shall e oup Policy(ies). nation refers only to G verage, this designation shall not apply to cov	beneficiary had survived me secondary beneficiary survi xtend to any insurance whice froup Life Insurance coverage on shall apply to both policie erage, if any, under a Group ciary is reserved in accordange of beneficiary is requeste	, shall be payable equally to the reves me, I request that said remains the may be in effect on my life in repayable and I am also insured for Group is unless otherwise expressly state Accident policy bearing the prefix acce with the terms of the group policy.	ne, the share which emaining secondary der be payable as placement of my o Accidental Death ed above. This c ACC.
Unless otherwise expressuch beneficiary would honeficiary would honeficiary would honeficiary (ies), if any, worescribed in said Group. The foregoing Beneficiar nsurance under said Group of this Beneficiary Designand Dismemberment con Beneficiary Designation. The right to change this which I may be insured a signed at	ave received if such tho survive me. If no Policy(ies). y Designation shall e oup Policy(ies). nation refers only to G verage, this designation shall not apply to cov	beneficiary had survived me secondary beneficiary survi xtend to any insurance whice froup Life Insurance coverage on shall apply to both policie erage, if any, under a Group ciary is reserved in accordange of beneficiary is requeste	, shall be payable equally to the reves me, I request that said remain h may be in effect on my life in rep ge and I am also insured for Group s unless otherwise expressly state Accident policy bearing the prefix ace with the terms of the group pol	ne, the share which emaining secondary der be payable as placement of my o Accidental Death ed above. This k ACC.
Unless otherwise expressuch beneficiary would honeficiary would honeficiary would honeficiary (ies), if any, worescribed in said Group. The foregoing Beneficiar nsurance under said Group of this Beneficiary Designand Dismemberment con Beneficiary Designation. The right to change this which I may be insured a signed at	ave received if such tho survive me. If no Policy(ies). y Designation shall e oup Policy(ies). nation refers only to G verage, this designation shall not apply to cov	beneficiary had survived me secondary beneficiary survi xtend to any insurance whice froup Life Insurance coverage on shall apply to both policie erage, if any, under a Group ciary is reserved in accordange of beneficiary is requeste	, shall be payable equally to the reves me, I request that said remains the may be in effect on my life in repayable and I am also insured for Group is unless otherwise expressly state Accident policy bearing the prefix acce with the terms of the group policy.	ne, the share which emaining secondary der be payable as placement of my o Accidental Death ed above. This c ACC.
Unless otherwise expressuch beneficiary would horeneficiary (ies), if any, worescribed in said Group The foregoing Beneficiar Insurance under said Group If this Beneficiary Designand Dismemberment con Beneficiary Designation The right to change this which I may be insured a	pave received if such tho survive me. If no Policy(ies). The policy (ies) and Policy (ies) artion refers only to Goverage, this designation hall not apply to cover designation of beneficat the time such change.	beneficiary had survived me secondary beneficiary survi xtend to any insurance whice froup Life Insurance coverage on shall apply to both policie erage, if any, under a Group ciary is reserved in accordange of beneficiary is requested	, shall be payable equally to the reves me, I request that said remain h may be in effect on my life in rep ge and I am also insured for Group s unless otherwise expressly state Accident policy bearing the prefix nce with the terms of the group pol d. day of	ne, the share which emaining secondary der be payable as placement of my o Accidental Death ed above. This c ACC.
Unless otherwise expressuch beneficiary would horeneficiary (ies), if any, worescribed in said Group The foregoing Beneficiar insurance under said Group If this Beneficiary Designand Dismemberment consending properties of the right to change this exhich I may be insured a signed at	pave received if such tho survive me. If no Policy(ies). Ty Designation shall ecup Policy(ies). The pour Policy(ies) pation refers only to Goverage, this designation shall not apply to cover designation of benefits at the time such change. Witness peen placed	beneficiary had survived me secondary beneficiary survived me secondary beneficiary survived me secondary beneficiary survived me steed to any insurance which shall apply to both policie erage, if any, under a Group ciary is reserved in accordance of beneficiary is requested this this on file.	, shall be payable equally to the reves me, I request that said remain h may be in effect on my life in rep ge and I am also insured for Group s unless otherwise expressly state Accident policy bearing the prefix nce with the terms of the group pol d. day of	ne, the share which emaining secondar der be payable as placement of my o Accidental Death ed above. This k ACC. licy(ies) under
Unless otherwise expressuch beneficiary would horeneficiary (ies), if any, worescribed in said Group The foregoing Beneficiar insurance under said Group If this Beneficiary Designand Dismemberment consensive properties of the right to change this which I may be insured a signed at	pave received if such tho survive me. If no Policy(ies). Ty Designation shall ecup Policy(ies). The pour Policy(ies) pation refers only to Goverage, this designation shall not apply to cover designation of benefits at the time such change. Witness peen placed	beneficiary had survived me secondary beneficiary survived me secondary beneficiary survived me secondary beneficiary survived me steed to any insurance which shall apply to both policie erage, if any, under a Group ciary is reserved in accordance of beneficiary is requested this this on file.	, shall be payable equally to the reves me, I request that said remain h may be in effect on my life in rep ge and I am also insured for Group is unless otherwise expressly state Accident policy bearing the prefix nce with the terms of the group pol d. Signature of Insured	ne, the share which emaining secondar der be payable as placement of my o Accidental Death ed above. This k ACC. licy(ies) under
Unless otherwise expressuch beneficiary would honeficiary (ies), if any, worescribed in said Group The foregoing Beneficiar Insurance under said Group If this Beneficiary Designand Dismemberment con Beneficiary Designation If the right to change this which I may be insured a Witness Insured at Hartford, Connecticut, the Insurer Aetna Life Insu	pave received if such tho survive me. If no Policy(ies). Ty Designation shall ecup Policy(ies). The policy (ies) pation refers only to Goverage, this designation shall not apply to covered designation of beneficat the time such change. Witness pent has been placed is	beneficiary had survived me secondary beneficiary survived me secondary beneficiary survived me secondary beneficiary survived me steed to any insurance which shall apply to both policie erage, if any, under a Group ciary is reserved in accordance of beneficiary is requested this this on file.	, shall be payable equally to the reves me, I request that said remain h may be in effect on my life in rep ge and I am also insured for Group is unless otherwise expressly state Accident policy bearing the prefix nce with the terms of the group pol d. Signature of Insured	ne, the share which emaining secondar der be payable as placement of my o Accidental Death ed above. This k ACC. licy(ies) under
Unless otherwise expressuch beneficiary would horeneficiary (ies), if any, worescribed in said Group The foregoing Beneficiar nsurance under said Group If this Beneficiary Designand Dismemberment con Beneficiary Designation The right to change this which I may be insured a signed at	pave received if such tho survive me. If no Policy(ies). Ty Designation shall ecup Policy(ies). The policy (ies) pation refers only to Goverage, this designation shall not apply to covered designation of beneficat the time such change. Witness pent has been placed is	beneficiary had survived me secondary beneficiary survived me secondary beneficiary survived me secondary beneficiary survived me steed to any insurance which shall apply to both policie erage, if any, under a Group ciary is reserved in accordance of beneficiary is requested this this on file.	, shall be payable equally to the reves me, I request that said remain h may be in effect on my life in rep ge and I am also insured for Group es unless otherwise expressly state o Accident policy bearing the prefix nice with the terms of the group pol d. day of Signature of Insured	ne, the share which emaining secondary der be payable as placement of my o Accidental Death ed above. This e ACC. licy(ies) under



Creditor Designation of Beneficiary Aetna Life Insurance Company

Aetna Life Insurance Company Attn: Consumer Services 151 Farmington Avenue, RE52 Hartford, CT 06156-7318

			Group Contract Nun	nber(s)
Employee's Name			Social Security Num	her
Linployee's Name			Social Security Num	ibei
Subject to the terms of the a death be payable to the follo		Contract(s), I request that any sum beco y, as interest may appear:	ming payable by rea	ison of my
Name of Creditor		Address		
by me and any amounts ex	pended by said creditor I authorized to accept the	unpaid balance of any indebtedness no for funeral and other expenses incident t affidavit of the creditor as sufficient prod	o my last illness and	death. Aetna
	if any, shall be payable	to the following secondary beneficiary(is	es). (If more than on	e named, the
Name of Beneficiary		Address of Beneficiary		
Social Security Number	Relationship			
Name of Beneficiary		Address of Beneficiary		
Social Security Number	Relationship			
The foregoing Designation on Insurance under said Group If this Designation of Benefi	of Beneficiary shall exter contract(s). ciary refers only to a Gro	nd to any insurance which may be in effective Life Insurance contract and I am also	o insured for Group A	Accidental
The foregoing Designation of insurance under said Group of this Designation of Beneficenth and Dismemberment	of Beneficiary shall exter contract(s). ciary refers only to a Gro coverage, this designat		o insured for Group A	Accidental ated above.
The foregoing Designation of insurance under said Group of this Designation of Benefic Death and Dismemberment This Designation of Benefic I hereby agree not to make	of Beneficiary shall exter o Contract(s). ciary refers only to a Gro t coverage, this designat diary shall not apply to co any change in beneficial itor, but this Designation	oup Life Insurance contract and I am also ion shall apply to both policies unless of verage, if any, under a Group Accident of ry which will affect the interest of said con of Beneficiary is otherwise subject to ch	o insured for Group A herwise expressly sta contract bearing the editor beneficiary wit	Accidental ated above, prefix ACC, hout the
The foregoing Designation of insurance under said Group of this Designation of Benefic Death and Dismemberment This Designation of Benefic I hereby agree not to make written consent of said cred contracts in effect at the tim	of Beneficiary shall exter of Contract(s). ciary refers only to a Grot coverage, this designation shall not apply to color, but this Designation be such change of beneficiary shall not alue, and nothing herein	oup Life Insurance contract and I am also ion shall apply to both policies unless of verage, if any, under a Group Accident of ry which will affect the interest of said cro of Beneficiary is otherwise subject to choosing is requested. t apply at any time after my Paid-up Insu- shall restrict in any way my right to surre	o insured for Group A herwise expressly sta contract bearing the editor beneficiary wit range as provided in	Accidental ated above, prefix ACC, hout the the contract come subject to
The foregoing Designation of insurance under said Group of this Designation of Benefic Death and Dismemberment This Designation of Benefic I hereby agree not to make written consent of said cred contracts in effect at the time. The designation of said creasurender by me for cash valuon or at any time after terministics.	of Beneficiary shall exter of Contract(s). ciary refers only to a Grot coverage, this designatiary shall not apply to coany change in beneficialitor, but this Designation is such change of beneficiary shall not alue, and nothing herein mination of my employments.	oup Life Insurance contract and I am also ion shall apply to both policies unless of verage, if any, under a Group Accident of ry which will affect the interest of said cro of Beneficiary is otherwise subject to choosing is requested. t apply at any time after my Paid-up Insu- shall restrict in any way my right to surre	o insured for Group A herwise expressly sta contract bearing the editor beneficiary wit range as provided in trances, if any, become ender such Paid-up I	Accidental ated above, prefix ACC, hout the the contract of the subject to insurances.
The foregoing Designation of insurance under said Group of this Designation of Benefic Death and Dismemberment This Designation of Benefic I hereby agree not to make written consent of said cred contracts in effect at the time. The designation of said creasurender by me for cash value on a surrender by the surr	of Beneficiary shall exter o Contract(s). ciary refers only to a Gro coverage, this designat iary shall not apply to co any change in beneficial itor, but this Designation ie such change of benefi ditor beneficiary shall no alue, and nothing herein mination of my employm	oup Life Insurance contract and I am also ion shall apply to both policies unless of overage, if any, under a Group Accident or which will affect the interest of said crop of Beneficiary is otherwise subject to choosing is requested. It apply at any time after my Paid-up Insurant restrict in any way my right to surrement.	o insured for Group A herwise expressly sta contract bearing the editor beneficiary wit lange as provided in trances, if any, becon ender such Paid-up I	Accidental ated above, prefix ACC, hout the the contract of the subject to insurances
The foregoing Designation on surance under said Group of this Designation of Benefic Death and Dismemberment This Designation of Benefic hereby agree not to make written consent of said cred contracts in effect at the time. The designation of said cressurrender by me for cash value or at any time after terms of the surrender by the designation of said cressurrender by me for cash value or at any time after terms of the surrender by the surrende	of Beneficiary shall exter of Contract(s). ciary refers only to a Grot coverage, this designatiary shall not apply to company change in beneficial itor, but this Designation be such change of beneficiary shall not alue, and nothing herein mination of my employments.	oup Life Insurance contract and I am also ion shall apply to both policies unless of overage, if any, under a Group Accident or which will affect the interest of said crop of Beneficiary is otherwise subject to choosing is requested. It apply at any time after my Paid-up Insurant restrict in any way my right to surrement.	o insured for Group A herwise expressly sta contract bearing the editor beneficiary wit range as provided in trances, if any, become ender such Paid-up In day of	Accidental ated above, prefix ACC, hout the the contract of the subject to insurances.
The foregoing Designation of nsurance under said Group of this Designation of Benefic Death and Dismemberment This Designation of Benefic hereby agree not to make written consent of said cred contracts in effect at the time. The designation of said creasurender by me for cash was upon or at any time after tension of a triplicate at	of Beneficiary shall exter of Contract(s). ciary refers only to a Gro t coverage, this designat- iary shall not apply to co- any change in beneficial itor, but this Designation ite such change of benefi- ditor beneficiary shall not alue, and nothing herein mination of my employm	oup Life Insurance contract and I am also ion shall apply to both policies unless of overage, if any, under a Group Accident or which will affect the interest of said crit of Beneficiary is otherwise subject to choosing is requested. It apply at any time after my Paid-up Insurant restrict in any way my right to surrement.	o insured for Group A herwise expressly sta contract bearing the editor beneficiary wit lange as provided in trances, if any, becon ender such Paid-up I day of drances Group C	Accidental ated above, prefix ACC, hout the the contract of the subject to a surances a consurances.
The foregoing Designation of surance under said Group of this Designation of Benefic Death and Dismemberment This Designation of Benefic hereby agree not to make written consent of said cred contracts in effect at the time. The designation of said creesurender by me for cash valuon or at any time after tension of the contracts of the contracts of the first of the designation of said creesurender by me for cash valuon or at any time after tensions. Signed in triplicate at	of Beneficiary shall exter of Contract(s). ciary refers only to a Grot coverage, this designation shall not apply to color, but this Designation be such change of beneficiary shall not alue, and nothing herein mination of my employments. Witness	oup Life Insurance contract and I am also ion shall apply to both policies unless of overage, if any, under a Group Accident or which will affect the interest of said crit of Beneficiary is otherwise subject to choosing is requested. It apply at any time after my Paid-up Insurant restrict in any way my right to surrement.	o insured for Group And the wise expressly statement on the contract bearing the editor beneficiary with lange as provided in the contract of	Accidental ated above, prefix ACC, hout the the contract to me subject to nsurances, 20

Beneficiaries (continued)

Beneficiary designations and changes

Who can designate or change beneficiaries?

- Employees with Life Insurance and/or Accidental Death and Personal Loss coverage have the right to name the beneficiary(ies) of their choice. A beneficiary is the person who receives benefits when an insured dies.
- Beneficiary changes made by an individual acting as an agent under a durable power of attorney.
- Covered dependents cannot designate beneficiaries. Benefits are always payable to the insured employee or his/her estate.

The guidelines for changing a beneficiary using a Durable Power of Attorney are found on page 26.

When can employees designate beneficiaries?

Employees can first designate a beneficiary(ies) at enrollment or at any time thereafter.

Can employees change beneficiaries?

Employees have the right to change their named beneficiaries at any time by following the instructions shown in this section.

What if an employee does not designate a beneficiary?

If an employee has not designated a beneficiary at the time of the employee's death, Life Insurance benefits will be paid in accordance with the Beneficiary section of your Group Policy.

What if the beneficiary dies before the employee?

If a named beneficiary is not alive at the time of the employee's death, Life Insurance benefits will be paid in accordance with the Beneficiary section of your Group Policy.

What is the process for designating a beneficiary?

Employees can designate a beneficiary on the Enrollment/Change Request form or submit a written request to you or to Aetna's corporate headquarters. In any event, the beneficiary designation should include:

- The employee's signature and date signed.
- The full name of the beneficiary or organization (no nicknames).
- The relationship of the beneficiary to the insured (for example, spouse, trust, charity).
- The beneficiary's date of birth.
- The beneficiary's Social Security number or tax identification number.

What if a beneficiary designation is incomplete or contains errors?

If any of the above information is missing, the intended beneficiary may not receive the insurance benefits. You should check the form to make sure it is completed correctly, and if not, please contact your employee to obtain any missing information.

Addressing employee questions about designating beneficiaries

Employees should be advised to contact an attorney with any legal questions they may have. They may also contact the Life Insurance Service Center with any other questions. In addition, Aetna suggests the following guidelines for properly identifying and naming different types of beneficiaries. This information may be helpful to your employees so that their wishes are carried out.

Beneficiaries (continued)

Individual beneficiaries

When naming an individual as the beneficiary, an employee must include all the information requested above and make sure that the name and the relationship of the person is clear. For example:

Intended Beneficiary	Proper Terminology
Spouse	Jane L. Doe – Wife
Husband	John L. Doe – Husband
Child	John L. Doe Jr. – Son
Fiancée	Mary K. Smith – Fiancée
Friend	Mark A. Jones – Friend

Multiple beneficiaries

When naming more than one person as beneficiary, include all the information requested above in addition to the specific percentages for each beneficiary. All the beneficiaries' percentages added together should equal 100 percent.

Employees may designate primary and contingent beneficiaries. Beneficiaries will receive the benefit upon the employee's death. If the primary beneficiary is not alive at the employee's death, the benefit will be payable to the contingent beneficiary. As shown in the examples that follow, primary and contingent beneficiaries need to be clearly stated in order to avoid discrepancies. For example:

Intended Beneficiary	Proper Terminology
Jane L. Doe, Wife – Primary Children – Secondary	Jane L Doe, Wife – Primary Jeff Doe, Son – Contingent 50% Lucy Doe, Daughter – Contingent 50%
John L. Doe, Husband – Primary Children of Marriage – Secondary	John L. Doe, Husband – Primary Michael S. Doe, Son – Contingent 50% Kevin M. Doe, Son – Contingent 50%
Parents – Primary Joe & Peg C. Doe, Children – Secondary	Esther M. Doe, Mother – Primary 50% George M. Doe, Father – Primary 50% Joe A Doe, Son – Contingent 50% Peg C. Doe, Daughter – Contingent 50%
Spouse and Children – equally	Jane L. Doe, Wife – Primary John L. Doe Jr., Son – Primary Janet L. Doe, Daughter – Primary
Children of John L. Doe	John L. Doe Jr., Son – Primary 50% Janet L. Doe, Daughter – Primary 50%

The beneficiary is the employee's estate

When naming the estate as the beneficiary, include reference to the specific will and date the will was executed. For example:

Intended Beneficiary	Proper Terminology	
Estate	The Estate of John L. Doe	

Aetna requires a certified copy of the Letters of Testamentary issued by a probate court when there is a will. If there is no will, a "Letter of Administration" issued by the probate court is required.

If the estate is not going through formal probate administration and the amount involved is small, the individual who is settling the estate may obtain the right to the proceeds by complying with the applicable small estate procedure under state law.

The beneficiary is a trust

When naming a "trust" as the beneficiary, the employee should make sure it is a legally established trust. The employee should consult a lawyer for guidance on this issue. If an employee names a trust as beneficiary, at his/her death, a copy of the trust documents will need to be provided. Benefits will be issued to the trustee designated in the trust document.

The beneficiary is a charity, hospital or church

When naming a charity, hospital or church as the beneficiary, include the entity's full name and address. For example:

Intended Beneficiary	Proper Terminology
Charity	American Cancer Society P.O. Box 999 Anywhere, CT 00000
Hospital	Hartford Mercy Hospital 100 Wells Rd Anywhere, CT 00000
Church	St. Marks Church 100 Holy Rd. Anywhere, CT 00000

Additional information helpful to employees selecting beneficiaries

The beneficiary resides in a community property state

In community property states, the employee's spouse may have a legal right to a portion of the Life Insurance benefit, up to a maximum of 50 percent of the benefits. If the employee names someone other than the spouse as beneficiary, and the spouse does not sign the spousal consent section of the beneficiary form, then the spouse has the right to contest the beneficiary designation and payment may be delayed pending a resolution of the spouse's claim to benefits.

Currently, the following states are community property states: Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Wisconsin and Washington.

The beneficiary is the employer

State law generally prohibits an employee from naming his/her employer as beneficiary. However, if the employer is a charity, the beneficiary designation should indicate the beneficiary as a charity after the organization's name.

The beneficiary is a citizen of a blocked country

If the beneficiary is a citizen or resident of a "blocked country" as determined by Presidential Order, Life Insurance benefits cannot be released to the foreign resident, unless the Department of Treasury, Foreign Assets Control Division, permits the release of the benefit. In the meantime, Aetna will maintain the benefits in a blocked bank account.

The beneficiaries or their representatives, who are citizens and residents of blocked countries, may write to the following address for additional details:

Office of Foreign Assets Control U.S. Department of the Treasury 1500 Pennsylvania Avenue, NW Washington, DC 20220 202-622-2490

The beneficiary is an animal

Employees should be advised that they cannot name an animal as beneficiary, since the animal is not capable of negotiating a draft. Arrangements for the care of an animal can be made through a friend, trust or will.

The beneficiary is a former spouse

Several states have laws under which the designation of a spouse as a Life Insurance beneficiary will be automatically revoked upon divorce (that is, "revocation by divorce" laws). For claims arising under an ERISA-governed policy, a state law

that purports to automatically revoke a beneficiary designation will be pre-empted by ERISA and Aetna will pay benefits in accordance with a validly executed beneficiary designation. For policies that are not governed by ERISA, there is no pre-emption of the state "revocation by divorce" law. In this situation, Aetna will review the state's revocation by divorce statute to determine if it is applicable. Claims will be paid in accordance with the terms of the Group Policy and results of that review.

If a former spouse disputes a claim based on the terms of a domestic relations order, then Aetna will need to review the order to ascertain its effect on the claim determination.

The beneficiary is a minor

When a minor child is the beneficiary, the minor does not have the legal capacity to provide a valid release of benefits. Benefits can be distributed only upon receipt of a valid release. Aetna may pay the proceeds for the benefit of the minor if in receipt of:

- A copy of the court order appointing a guardian of the minor's estate (property) and a release by the guardian; and
- A copy of a court order authorizing release; or
- Proof that the child has attained legal age in his/her state of residence; or
- Any other documentation providing a legal release (that is, state statute).

Beneficiaries (continued)

Beneficiary changes made by an individual acting as an agent under a durable power of attorney

The general rule is that the right to designate a Life Insurance beneficiary may only be exercised by the covered employee. However, in some limited circumstances, a third party other than the covered employee may be able to properly execute a beneficiary designation.

For example, if the covered employee has assigned all their rights under the Policy to an assignee, then the assignee, not the covered employee, is the only party that can make or change the beneficiary designation. (For more information, refer to the Beneficiary Assignment section.)

Another example is where the covered employee has designated a person (called an "agent") to act on his/her behalf pursuant to a power of attorney (POA). Whether an agent can make (or change) a beneficiary designation on behalf of the covered employee depends on the applicable state law. If the state POA law specifically permits an agent under a POA to designate a beneficiary on behalf of the

covered employee and the POA contains language giving the agent such authority, then a beneficiary designation executed by the POA may be valid. If, however, the applicable state POA law does not specifically allow an agent to execute beneficiary designations under a POA, then the agent can not legally designate a beneficiary (or change an existing beneficiary designation) on behalf of the covered employee.

If you receive a beneficiary designation which has been executed by an agent on behalf of the covered employee, please send a copy of the POA to the address for submitting Proof of Death claims (as shown in the Customer Service Information chapter of this handbook) for review.

Addressing employee concerns about beneficiary issues that may arise after death

Certain situations may occur after the death of the insured. Aetna will rely on the following guidelines and procedures for managing the situations described in the next column.

The claim is disputed

In the event a claim is made by someone other than the beneficiary and that claim appears to lack merit, Aetna will send the individual a letter putting him/her on notice that the claim must be supported on a legal or factual basis within a specified period of time or the payment will be made to the beneficiary of record.

If the claim is substantiated, or it is unclear who is legally entitled to the proceeds, an attempt will be made to obtain an agreement of the parties regarding distribution, or the proceeds may be paid into court pursuant to an interpleader action. If the parties are in the process of negotiating an agreement, the interpleader action will be deferred for a reasonable period of time.

The claim is denied

A review of the denied claim may be requested. The request must be submitted in writing within 60 days after the receipt of the denial. The reason for requesting the review must be included and submitted to Aetna.

Evidence of Insurability

There are circumstances when the employee and/or dependent(s) must submit evidence of good health, referred to as Evidence of Insurability (EOI) in order to be covered under the Group Policy. Aetna requires Evidence of Insurability for late enrollees, elections exceeding the guarantee issue amount or under certain circumstances, subsequent benefit increases after initial enrollment.

When is Evidence of Insurability required for a timely enrollee?

Evidence guidelines for timely enrollees:

- Evidence underwriting for Life Insurance is based on the dollar amount of coverage being requested. Medical Evidence is not needed for amounts under the Guaranteed Issue limit. An Evidence Statement is required for any amount which exceeds the Guaranteed Issue limit. In addition, medical information in the form of questionnaires and attending physician's reports may be required based on the medical history provided on the Evidence application. All requests for additional medical information on timely enrollees, such as an attending physician's report, will be at Aetna's expense.
- Enrollees who have exceeded the nonmedical examination maximum will be asked to undergo a paramedical examination, again at Aetna's expense.

When is evidence required for late enrollees?

A "Late" enrollee is an individual who:

- Does not enroll for coverage when initially eligible (within 31 days of completing their probationary period).
- Cancels or freezes coverage and then requests an opportunity to re-enroll or increase coverage at a later date.
- Requests an increase in coverage greater than the Annual Benefits Election rules (one times annual earnings or one unit of coverage).

Evidence of Insurability guidelines for late enrollees

Evidence underwriting is based on the dollar amount of coverage being requested. Any employee or dependent that is late in applying for benefits must complete an Evidence of Insurability Statement. He or she must submit this form for any coverage amount and be approved for that amount before insurance can become effective.

All requests for additional medical information, such as an attending physician's report or a paramedical examination, will be at the enrollee's expense.

Is Evidence of Insurability required for a change in family status?

Employees who are not currently insured for Supplemental Life coverage and undergo a family status change may add Supplemental Life Insurance in the amount or benefit increment (if Policy is based on flat dollar amounts) as indicated in the Policy—without evidence. This request for coverage must be made within 31 days of the family status change. Amounts requested above the Policy stated salary multiple or benefit increment will be subject to evidence and must be medically underwritten. The employee must be approved before the additional coverage would become effective.

Employees who are currently insured for Supplemental Life coverage and undergo a family status change may increase their Supplemental Life coverage up to the Policy's Guaranteed Issue Limit without evidence provided the request is made within 31 days of the family status change.

Evidence of Insurability (continued)

Qualifying events for family status change

- 1. Change in legal marital status
 - Marriage
 - Death of spouse
 - Divorce
 - Legal separation
 - Annulment
- 2. Change in the number of dependent children
 - Birth of child
 - Death of child
 - Placement for or finalized adoption
- 3. Change in employment status (for employee and/or spouse)
 - Commencement or termination of spouse's employment
 - Employee goes from part time to full time
 - Employee goes from full time to part time
 - Employee's job is eliminated

How do I complete an Evidence of Insurability form?

Follow the instructions on the Evidence form, making sure that all the information in Section A (the Plan Sponsor/ Employer) is completed. You must provide the current amount of coverage, the requested increase amount and the resulting total amount of coverage for each individual for whom coverage is being requested. The application will not be processed without the Authorized Representative's signature.

A sample form is shown later in this chapter.

Give the form to the employee for his/her submission to Aetna. Instruct the employee that all the information in Section B (the employee's section) must be completed, signed by the employee and spouse (if dependent coverage is requested) and dated. In order to expedite the processing of the Evidence of Insurability statement, all information on the form must be completed. If any information is missing, Aetna will return the form to the employee to complete the missing information.

When is evidence required for employees who already have coverage?

Subsequent annual benefits election periods allow individuals who already have Life benefits to change coverage options under their Policy, when permitted to do so. Employees can increase their current Life coverage by units or multiples of salary, whichever is applicable, up to the Guaranteed Issue Limit stated in the Policy without Evidence of Insurability. An election that results in insurance amounts in excess of the Guaranteed Issue Level is subject to EOI.

Employees and dependents without current Life coverage who wish to enroll will be subject to late enrollee rules for any amount elected.

Contributory AD&PL coverage does not require Evidence of Insurability to enroll.

Evidence of Insurability reports provided by the Medical Underwriting Department:

You may wish to receive a Customer Report tracking the Evidence of Insurability statements submitted by your employees. This report can be provided in alphabetical order or Social Security order. It will show the date the application was received, who is applying for coverage, the benefit being requested and status of the application (pending, approved, denied, etc.).

You can elect to receive one of two types of reports.

- Weekly reports can be produced. If a weekly report is chosen, no individual letters (that is, approval, denial or pending additional information) will be provided to the customer. The employee will receive requests for additional information and denial letters.
- Monthly reports If requesting a monthly report, the plan sponsor will receive the report, and both the plan sponsor and the employee will receive individual letters of approval, denial and pending additional information.

Approval letters are mailed to the employer only. An additional cost will apply, per letter, if a copy is mailed to the employee.



Evidence of Insurability Statement Life Coverage

Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Plan Sponsor

Complete Section A in its entirety. Be sure that:

Please Print

- All items are completed.
 The Control Number, Suffix and Account numbers are provided (A1).
- The Employee/Member's Social Security Number is provided (A2).
 Both the Employee/Member's and your name and address are shown in the spaces provided (A3 and A4).
- The telephone number of your authorized representative (A5), Employee/Member's date of hire (A6) and Employee/Member's home and work telephone numbers (A7) are provided.
- Your Employee/Member's and your E-mail addresses are provided (A8 and A9).
- Employee/Member's Annual Earnings is completed (A10)
 You check the appropriate box(es) for individual(s) requesting Life coverage. Provide the current amount of coverage, requested additional amount of coverage, resulting total amount of coverage and Guarantee Issue amount for each individual for whom coverage is being requested (A11).
- · You check the reason for requested life coverage (A11).
- Section A is signed by your Authorized Representative (A12).

Give the form to your Employee/Member for his/her confidential submission to Aetna.

Aetna will advise you of its coverage decision. Employee/Member will be notified directly if coverage is denied.

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Complete Section B. Be sure that:

- · All items are completed.
- . Only the names of individuals requesting coverage at this time are listed (B1).
- Height and Weight must be provided or this form will be returned unprocessed for your completion (B1).
- The appropriate boxes regarding dependent child coverage are checked, if applicable (B2a, B2b, and B2c).
- . Complete dates and details are given for all conditions checked in B3g, (B4).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company Medical Underwriting Department P.O Box 83641 Lincoln, NE 68501-3641

OR

Fax to: 1-800-792-9710

If you have any questions, call us toll-free at

1-800-660-9913

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety and signed, it will be returned unprocessed for your completion.

EOI GR-67829 (12-07) A-POD

Make a copy for your records.

PH Sign Req'd Page 1 of 4

Evidence of Insurability Statement – Life Coverage

page 2 of 4

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company, Medical Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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. Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna

Page 2 of 4

Evidence of Insurability Statement – Life Coverage

page 3 of 4



Evidence of Insurability Statement Make a copy for your records. Mail the original to: Life Coverage Aetna Life Insurance Company

Aetna Life Insurance Company Medical Underwriting Department P.O. Box 83641

Lincoln, NE 68501-3641

	trol Number	Suffix	Account	2. Employee/Memb	er Social Security Num	ber			
Plan	Sponsor Name &	Address		4. Employee/Membe	er Name & Address				
TTN				-					
ame									
treet				Street					
ity			State ZIP Code	City			State	Ü	ZIP Code
	Sponsor - Author		6. Employee/Member Date of Hire (миссолуч	LL A A	r Telephone Numbers	Hon)	
Plan.	Sponsor E-mail a	address		9. Employee/Member	r E-mail Address	11011	10 1	1	
Ac Re Gi	Iditional Amesulting Total uarantee Iss ason for Rec ☐ Salary	esting an Amount in Ex	verage? \$_ Coverage requested? \$_ Int if Approved (a + b)? \$_ Irance? \$_		Voluntary Life \$ \$ \$ \$ ge in Increments r (Please explain)	\$ \$ \$ Life	e Event/	\$ _ \$ _ \$	Life
	rtify the above info	Manager Company			4 - 1 - Ma		Date	Signed	
an S	rtify the above info	zed Representative Signature			ive Name (Please print)	ms can	not be n	roces	sed
an S	rtify the above info ponsor - Authoriz	zed Representative Signature	Plan Sponsor - etion - Please print. All questions esting Coverage at this Time Shou	s must be answere		ms <u>can</u>	not be p	roces	sed.
En S	rtify the above info ponsor - Authoriz	zed Representative Signature	tion - Please print. All questions	s must be answere			Height (fl		sed. Weight (lbs.)
En S	rify the above info ponsor - Authoriz nployee/Mem Only the Nam oyee:	zed Representative Signature	esting Coverage at this Time Shou Relationship Bri	s must be answere	ed. Incomplete for				
En S	nify the above info ponsor - Authoriz nployee/Mem Only the Nam oyee:	zed Representative Signature	esting Coverage at this Time Shou Relationship Bri	s must be answere	ed. Incomplete for				
En S	rify the above info ponsor - Authoriz nployee/Mem Only the Nam oyee:	zed Representative Signature	esting Coverage at this Time Shou Relationship Bri	s must be answere	ed. Incomplete for				
En me mplooou	rify the above info ponsor - Authoriz nployee/Mem Only the Nam oyee: se: (ren):	zed Representative Signature ber: Complete this Sec les of Individual(s) Requ	esting Coverage at this Time Shou Relationship Bri	s must be answere Id be Listed Hhdate (MM/DD/YYYY)	ed. Incomplete for	Sex	Height (fi	, in).	
an S En me mplo moou nilde	rify the above info	ber: Complete this Secures of Individual(s) Requirements of Indivi	esting Coverage at this Time Shou Relationship Self Self endent children are listed about live in your household? If no, in depend solely on you for supp	in the street in	Birthplace (City/State) 4 if additional specific additional speci	Sex	Height (fi	, in).	
Enr Enremple	rify the above info	ber: Complete this Secures of Individual(s) Requirements of Indivi	esting Coverage at this Time Shou Relationship Self Self endent children are listed about live in your household? If no,	in the street in	Birthplace (City/State) 4 if additional specific additional speci	Sex	Height (fi	, in).	

Evidence of Insurability Statement – Life Coverage

page 4 of 4

3.	following questions are	checked "Vee"				your knowledge and belief. If any of the
	Yes No	CHECKED TES	you <u>must</u> provid	ue details in Nu	IIIDEI 4 DEIOW.	
a.						emplications or problems.
b.						ing tobacco)? If yes, who
C.			nt medical, surgi	ical or diagnost	ic procedures recommended or c	contemplated: If yes, When:
d.	Individual: Individual:	vears has any	individual been c	or procedure.	Reason for pospital, clinic, sanatorium, rehabilit	
	If yes, Who:	- Joans Had arry	V	Vhy:	When:	ent from any doctor, practitioner or
е	in the past 7 counselor fo lf yes, Who:	rany condition	other than minor	examined, mon illnesses (cold Why:	itored or received medical treatment, flu, etc.)? When:	ent from any doctor, practitioner or
f.					complete the following information	
,,	Name of Individual	and the second second second second	/ledication		osage/Frequency	Diagnosis
				3=		
g.	Within the past 10 years the following? If yes, cl					ent (other than minor illnesses) for any of
		the same of the same of the same of the	Cancer	4 40001100 111 14	☐ Immune System Disorder	☐ Nervous System
	☐ Arthritis		Carpal Tunnel S	Syndrome	☐ Intestine/Stomach/Ulcer	☐ Paralysis/Paresis
	☐ Asthma/Emphysema		Chest Pain		☐ Kidney/Bladder	Reproductive System
	Back/Spine/Neck		Chronic Fatigue		Liver/Spleen/Pancreas	Skin Disorder
	☐ Blood Disorder/Bleed ☐ Blood Pressure/Hype		」Diabetes/Metab]Ears/Eyes	OOIIC	☐ Lungs/Breathing ☐ Lupus	☐ Stroke☐ Substance Abuse (Alcohol/Drug)
	☐ Blood Vessels/Circula		☐ Epilepsy/Seizur	re	☐ Mental/Emotional Condition	☐ Substance Abuse (Alcohol/Drug) ☐ Throat/Tonsils/Swallowing
	☐ Bones/Joints		Esophagus/Dig		Multiple Sclerosis	☐ Thyroid/Pituitary/Adrenal
	Brain		Heart		☐ Muscular Condition	☐ Tumor/Growth
	Virus). The virus is fou into the bloodstream, if In the space below, de needed.	and in some hu can damage t escribe all cond	man body fluids he body's defer ditions checked	s of infected p nses against d in 3g above a	eople, most notably in semen a isease, resulting in life-threatenir nd provide additional informatio	ng diseases. There is no known cure. In for questions 2a-c and 3a-f, if
	*AIDS (Acquired Immu Virus). The virus is fou into the bloodstream, if In the space below, de needed.	ind in some hu can damage t	man body fluids he body's defer	s of infected p nses against d	eople, most notably in semen a isease, resulting in life-threatenir nd provide additional informatio Treatments	nd blood. If the AIDS virus finds its wing diseases. There is no known cure.
Queston. Ce Ae covil has and info Au hos and ack will sig	*AIDS (Acquired Immu Virus). The virus is fou into the bloodstream, if In the space below, de needed. **Name Of Individual *Check here if you are provider iffication: I certify the that of any material characteristication are retained a copy of the content of	and in some huse can damage to escribe all conditions and disposis allowers and the condition work and deputs on this formation condition obtained se of determine that I have reached and I have reached a	Date of Onset Date o	Details/ Symptoms Details/ Symptoms Pate attachment. For are complete fided which ta ent shall become by services and accumulation requires and ac	eople, most notably in semen a isease, resulting in life-threatening and provide additional information. Treatments Received and true to the best of my known ke place between the time the same a part of my request for grate law, false statements may fits payable. I understand that in including any preexisting concurrements. My signature indicuracy, cospitals and other health care call Information Bureau; You a livice, treatment or supplies (incompared to the content of the content	nd blood. If the AIDS virus finds its wang diseases. There is no known cure. In for questions 2a-c and 3a-f, if Full Recovery Date Towledge and belief. I will inform a form is completed and the time roup coverage and I acknowledge the result in the denial of claims or in material conditions which are disclosed on addition limitations, fraud provisions ates that I have reviewed all institutions, insurers, medical or are authorized to provide Aetna Life cluding those related to mental illnes requested. (Minnesota residents arminal offender or a crime victim.) I ting investigation. This information for twelve (12) months from the data
Ques No.	*AIDS (Acquired Immu Virus). The virus is fou into the bloodstream, if In the space below, de needed. **Name Of Individual *Check here if you are provider iffication: I certify the that of any material characteristication are retained a copy of the content of	ind in some huse can damage to escribe all conditional information and can depth and information condition obtained se of determinity at the condition obtained se of determinity at the condition condition condition condition condition condition condition condition obtained se of determinity at the condition condition condition condition condition condition condition condition obtained se of determinity at the condition condition condition condition condition obtained se of determinity at the conditional condition condition obtained se of determinity at the conditional condition condition condition obtained se of determinity at the conditional con	Date of Onset Date o	Details/ Symptoms Details/ Symptoms Pate attachment. For are complete fided which ta ent shall become by services and accumulation requires and ac	eople, most notably in semen a isease, resulting in life-threatening and provide additional information. Treatments Received and true to the best of my known ke place between the time the same a part of my request for grate law, false statements may fits payable. I understand that in including any preexisting concurrements. My signature indicuracy, cospitals and other health care call Information Bureau; You a livice, treatment or supplies (incompared to the content of the content	result in the denial of claims or in mit conditions which are disclosed on indition limitations, insurers, medical or are authorized to provide Aetna Life cluding those related to mental illnes requested. (Minnesota residents are minal offender or a crime victim.) I ting investigation. This information for twelve (12) months from the date shown on "Page 2 of 4" of this for that a photographic copy of this



Evidence of Insurability Statement Life and Disability Coverage

Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Plan Sponsor

Complete Section A in its entirety. Be sure that:

Please Print

- All items are completed.
- The Control Number, Suffix and Account numbers are provided (A1).
- The Employee/Member's Social Security Number is provided (A2).
- Both the Employee/Member's and your name and address are shown in the spaces provided (A3 and A4).
- The telephone number of your authorized representative (A5), Employee/Member's date of hire (A6) and Employee/Member's home and work telephone numbers (A7) are provided.
- Your Employee/Member's and your E-mail addresses are provided (A8 and A9).
- . Employee/Member's Annual Earnings is completed (A10)
- You check the appropriate box(es) for individual(s) requesting Life coverage. Provide the current
 amount of coverage, requested additional amount of coverage, resulting total amount of coverage and
 Guarantee Issue amount for each individual for whom coverage is being requested (A11).
- · You check the reason for requested life coverage (A11).
- You check the appropriate Disability box(es) and provide current and requested amounts of coverage (A11)
- Section A is signed by your Authorized Representative (A12).

Give the form to your Employee/Member for his/her confidential submission to Aetna.

Aetna will advise you of its coverage decision. Employee/Member will be notified directly if coverage is denied.

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Verify that your name, address and Social Security Number as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Complete Section B. Be sure that:

- · All items are completed.
- . Only the names of individuals requesting coverage at this time are listed (B1).
- Height and Weight must be provided or this form will be returned unprocessed for your completion (B1).
- The appropriate boxes regarding dependent child coverage are checked, if applicable (B2a, B2b, and B2c).
- . Complete dates and details are given for all conditions checked in B3g, (B4).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company Medical Underwriting Department P.O Box 83641 Lincoln, NE 68501-3641

OR

Fax to: 1-800-792-9710

If you have any questions, call us toll-free at:

1-800-660-9913

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety and signed, it will be returned unprocessed for your completion.

EOI GR-67853 (12-07) A-POD

Make a copy for your records.

PH Sign Req'd Page 1 of 4

Evidence of Insurability Statement – Life and Disability Coverage

page 2 of 4

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetha Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company, Medical Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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. Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents. Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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 mittigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna

Evidence of Insurability Statement – Life and Disability Coverage

page 3 of 4



Evidence of Insurability Statement Life and Disability Coverage Make a copy for your records. Mail the original to: Aetha Life Insurance Company Medical Underwriting Department

P.O. Box 83641

Control Number	Suffix	print. Account	2. Employee/Mem	ber Social Security Numl	ber			
					1			
Plan Sponsor Name & Address			4, Employee/Memb	er Name & Address				
ATTN:								
Name								
Street			Street					
City	State	ZIP Code	City			State	Z	IP Code
Plan Sponsor - Authorized Rep. Telepho	one Number 6. Employe	ee/Member Date of Hire (мино	www. 7 Employee/Memb	er Telephone Numbers) -	Н	ome ()	2
Plan Sponsor E-mail address	1		9. Employee/Memb	er E-mail Address				
Employee/Member's Annua	al Earnings \$							
☐ Life* ☐ Employee ☐ Spouse	/Member Basic Li	Child(ren)		ental, Optional or Vo Employee/Member Supplemental, Optional or Voluntary Life	5	pouse Life	c	Child(ren) Life
. Current Amount of Life Ins	surance Coverage	?	\$				\$	J.Prich
. Additional Amount of Life	Insurance Covera	ige requested?	\$	\$	\$		\$_	
5 W = X 11/2 C	A							
 Resulting Total Life Insura 	nce Amount If Ap	proved (a + b)?	\$	\$	\$		2	
d. Guarantee Issue Amount Reason for Requested Cove	of Life Insurance?	i that apply).	\$	\$	\$		\$_	ATT ALL
Reason for Requested Cove Salary Increase Requesting an Am	of Life Insurance? erage (indicate al ☐ Change in Multount in Excess of oyee/Member On	i that apply). tiple □ Late Appli Plan's Guaranteed Is	\$cant	\$e in Increments [\$	e Event/Sta	\$ _	Change
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employed)	of Life Insurance of Life Insurance of Life Indicate all Change in Multiount in Excess of Coyee/Member On Current Amour	i that apply). tiple ☐ Late Appli Plan's Guaranteed Is ly): or \$ or	\$ cant	\$	\$	Event/Sta	\$ _	Change
Guarantee Issue Amount Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employed) Short Term Disability: Long Term Disability:	of Life Insurance? erage (indicate al Change in Multi ount in Excess of oyee/Member On Current Amour	i that apply). tiple □ Late Appli Plan's Guaranteed Is lly):	\$ cant	\$e in Increments [er (Please explain)	\$	Event/Sta	\$ _	Change
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employed) Short Term Disability: Long Term Disability: 1. I certify the above information is co	of Life Insurance? erage (indicate al Change in Multiount in Excess of oyee/Member On Current Amour Current Amour	i that apply). ithat apply). Ciple □ Late Appli Plan's Guaranteed Is it\$ or it\$ or	\$ cant	\$	\$	e Event/Sta	\$ _	Change
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employers) Short Term Disability: Long Term Disability: 1. I certify the above information is co	of Life Insurance of Life Insurance of Life Insurance of Life Indicate all Change in Multiount in Excess of Coyee/Member On Current Amour Current Amour orrect.	i that apply). tiple	\$ Cant	\$	\$	e Event/Sta	\$ _	Change % %
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employed Short Term Disability: Long Term Disability: Coverages (Employed L	of Life Insurance? erage (indicate al Change in Multi ount in Excess of oyee/Member On Current Amour Current Amour ourrect. e Signature te this Section - Pl	i that apply). tiple Late Appli Plan's Guaranteed Is ity): or Plan Sponso	\$ Cant	\$	\$	e Event/Sta	\$ _	Change % %
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employ Short Term Disability: Long Term Disability: Coverages (Employ Requesting an Am Disability Coverages (Employ Short Term Disability: Coverages (Employ Representative Completed (Employee/Member: Completed (Employee/Members)	of Life Insurance? erage (indicate al Change in Multi ount in Excess of oyee/Member On Current Amour Current Amour ourrect. e Signature te this Section - Pl	i that apply). tiple	\$ Cant	\$	\$	e Event/Sta	\$ _	Change % %
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employed Long Term Disability: Long Term Disability: Coverages (Employed Lo	of Life Insurance? erage (indicate al Change in Multi ount in Excess of oyee/Member On Current Amour Current Amour ourrect. e Signature te this Section - Pl	i that apply). tiple	\$ Cant	\$	\$	e Event/Sta	\$ _	Change%%
Reason for Requested Cove Salary Increase Requesting an Am Bisability Coverages (Employ Short Term Disability: Long Term Disability: Long Term Disability: Cal certify the above information is covered by the second of the secon	of Life Insurance? erage (indicate al Change in Multi ount in Excess of oyee/Member On Current Amour Current Amour ourrect. e Signature te this Section - Pl	i that apply). tiple Late Appli Plan's Guaranteed Is ity): or Plan Sponso Plan Sponso ease print. All question Relationship	\$ Cant	\$	\$	e Event/Sta	\$ _	Change%%
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employ Short Term Disability: Long Term Disability: Long Term Disability: Completed the American Sponsor - Authorized Representatives: Employee/Member: Completed the Names of Individualization of t	of Life Insurance? erage (indicate al Change in Multi ount in Excess of oyee/Member On Current Amour Current Amour ourrect. e Signature te this Section - Pl	i that apply). tiple Late Appli Plan's Guaranteed Is ity): or Plan Sponso Plan Sponso ease print. All question Relationship	\$ Cant	\$	\$	e Event/Sta	\$ _	Change%%
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employ Short Term Disability: Long Term Disability: Long Term Disability: Completed the American Sponsor - Authorized Representatives: Employee/Member: Completed the Names of Individualization of t	of Life Insurance? erage (indicate al Change in Multi ount in Excess of oyee/Member On Current Amour Current Amour ourrect. e Signature te this Section - Pl	i that apply). tiple Late Appli Plan's Guaranteed Is ity): or Plan Sponso Plan Sponso ease print. All question Relationship	\$ Cant	\$	\$	e Event/Sta	\$ _	Change % % _sed.
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employed Long Term Disability: Long Term Disability: Long Term Disability: Coverages (Employed Long Term Disability:	of Life Insurance of Life Insu	I that apply). Itiple Late Appli Plan's Guaranteed Is Ity): It \$ or Plan Sponso ease print. All question verage at this Time Sh Relationship Self	\$ Cant	\$	Life	e Event/Sta	\$ _	Change % % _sed.
Reason for Requested Covers	of Life Insurance of Life Insu	I that apply). Itiple Late Appli Plan's Guaranteed Is Ity): It \$ or Plan Sponso ease print. All question verage at this Time Sh Relationship Self	\$ Cant	\$	Life	e Event/Sta	\$ _	Change%%
Reason for Requested Cove Salary Increase Requesting an Am Disability Coverages (Employed Short Term Disability: Long Term Disability: Long Term Disability: Citertify the above information is considered Representatives. Employee/Member: Completed Spouse: Child(ren): Complete these questions in Yes No	of Life Insurance of Life Insu	i that apply). tiple	\$cant	\$	Life	e Event/Sta	\$ _	Change % % _sed.
Reason for Requested Covers Salary Increase Requesting an Am Disability Coverages (Employers) Short Term Disability: Long Term Disability:	of Life Insurance of Life Insurance of Life Insurance of Life Insurance of Life Indicate all Change in Multi- ount in Excess of Coyee/Member On Current Amour Current Amour Current Amour Current Amour Life Signature Life this Section - Plant Section - Plant Section - Plant Section - Plant Children Life Int Children Li	I that apply). Itiple Late Appli Plan's Guaranteed Is Ity): It \$ or Plan Sponso ease print. All question verage at this Time Sh Relationship Self	sue Limit Other sue Limit Other % Req % Req or - Authorized Representations must be answer ould be Listed Birthdate (MM/DD/YYYY) e Number 4 if addition o, please explain: _ pport? If no, please	\$	Life	or or Date Signand be pro	\$ _	Change % % _sed.

Evidence of Insurability Statement – Life and Disability Coverage

page 4 of 4

			questio	ns are che				etails in Number	ing questions to the b 4 below.	est of your	knowledge and b	eliet. It any of the
	100000	No		C W Pa	volution is to	AN P		4.1.5		DAVIDE A	I West was Turken	A. of
a. b.			Is any	individual	pregnant? If	yes, Who	ote in the l	Date Due:	AA cigarettes, cigar, pipe	ny complic	ations or problems	s:
ν.			Are an	y inpatient	or outpatien	t medical,	surgical o	or diagnostic pro	cedures recommende	ed or conte	mplated: If yes, W	/hen:
C.			Individ	ual:		W. C.E. 14	Name of	procedure:	Reas clinic, sanatorium, re	on for proc	edure:	1.5
d.		Ш	In the	oast 7 yea Who:	rs has any in	dividual be	en confir Why:	ned to a hospital	, clinic, sanatorium, re VVh	habilitation en:	or other treatmen	t facility?
e.			couns	elor for any		her than n	ninor illnes	sses (cold, flu, e		reatment fr	om any doctor, pra	actitioner or
f.									ete the following inform			
	Name		ndivid	-		edication		4 2 2 2	/Frequency		Diagnos	is
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	a alta		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Tour care	2250215	Tabillations	V Gald annual Gala			ek a aki a iz kaja a aiffu	Section 1
g.) nad any diseas scribe in <i>Numbe</i>	se, impairment of or tr r 4.	eatment (o	ther than minor illr	nesses) for any o
	I All	IDS*			- vertil ver	☐ Can	cer		Immune System [Nervous Syste	
	Arl As			ysema/Co	OPD		al Tunnel st Pain	Syndrome	 ☐ Intestine/Stomach ☐ Kidney/Bladder 	VUICER	☐ Paralysis/Pare	
	☐ Ba	ack/S	pine/N	eck		Chro	nic Fatigu		Liver/Spleen/Pand	creas	Skin Disorder	
				r/Bleeding e/Hyperte	/Blood Clot	☐ Diab	etes/Meta	abolic	Lungs/Breathing Lupus		☐ Stroke ☐ Substance Ab	use (Aleahal/Dr.
				Circulatio		☐ Epile	psy/Seizu	ure	☐ Mental/Emotional	Condition		
	☐ Bo	ones/	Joints			☐ Esop	hagus/Di	gestion/GERD	☐ Multiple Sclerosis		☐ Thyroid/Pituita	ary/Adrenal
	Br					☐ Hear	t		☐ Muscular Condition	n	☐ Tumor/Growth	1
	Virus). into th). The	e virus oodstre	is found am, it car	in some hun damage th	nan body e body's	fluids of i defenses	nfected people against diseas	is caused by a virus , most notably in ser e, resulting in life-thr	men and b reatening o	lood. If the AIDS diseases. There	virus finds its w
Ques	Virus). into th). The ne blo pace t	e virus oodstre	is found am, it car	in some hum n damage the conditions checosis	nan body e body's	fluids of i defenses	nfected people against diseas	most notably in ser	men and b reatening of 2a-c and 3a-	lood. If the AIDS diseases. There	virus finds its w is no known cur
Ques	Virus). into th). The ne blo pace t	e virus podstre below, d	is found am, it car escribe all o	in some hum n damage the conditions checosis	nan body e body's o ked in 3g a Date of	fluids of i defenses	nfected people against diseas rovide additional i Details/	most notably in ser e, resulting in life-the nformation for questions Treatments	men and b reatening of 2a-c and 3a-	lood. If the AIDS diseases. There f, if needed.	virus finds its w is no known cur
Que:	Virus). into th	pace to Name Indiv	e virus codstre below, d ne Of vidual	is found eam, it can escribe all o Diagn	in some hum n damage the conditions checosis	nan body e body's o ked in 3g ai Date of Onset	fluids of i defenses bove and p	nfected people against diseas rovide additional i Details/ Symptoms	most notably in ser e, resulting in life-the nformation for questions Treatments	men and b reatening of 2a-c and 3a-	lood. If the AIDS diseases. There f, if needed.	virus finds its w is no known cur
Cerchasthis	Virus). In the sp. Check hartification and the special control of t	pace to Nam India Nam Indi	e virus below, d be Of vidual f you are I certify inform shall be	escribe all of Diagnostic providing a these ansation providing a providing a come a	in some hum n damage the conditions checo osis additional inform swers and sta ded which tal art of my requ	ked in 3g al Date of Onset mation on a stements a ke place b	fluids of indefenses bove and possible separate a separate a separate a separate a separate completive en the cover separate sepa	nfected people against diseas rovide additional in Details/ Symptoms tttachment. ete and true to the time the form age and I acknowledge additional in the form age and I acknowledge against the form age against the form a	most notably in sere, resulting in life-thing in life in lin life in	men and be reatening of the care and 3a-care and 3a-care and be time cover tained a co	lood. If the AIDS diseases. There f, if needed. Full Rec Date lief. I will inform A age becomes effe py of this docume	etna of any mate
Cerchathis me	Check hartification documents of the condition of the con	Name bloomed b	e virus podstre below, d e Of vidual f you are I certify informs shall be ment: I g void a f my Pla	escribe all de providing a these ans a tom providing a tom pro	in some hum n damage the conditions checo osis additional inform swers and sta ded which tal art of my requ d that, to the ective date wi or's Plan inclu	ked in 3g al Date of Onset mation on a aterments a ke place b uest for gre extent per	separate a are complete two cover rmitted by efits payal	rovide additional in Details/ Symptoms ttachment. ete and true to the time the form rage and I acknow state law, false ble. I understang condition limits	most notably in sere, resulting in life-thing in life in lin life in	dge and be time cover tained a co lt in the der chare discks and empl	lood. If the AIDS diseases. There fi if needed. Full Rec Date dief. I will inform A age becomes effer by of this docume nial of claims or in osed on this form loyee actively at w	etna of any mate covery setna of any mate covery
Cechathis Medical Covall Character Covall Co	Check h Tification Knowle erage to condition Check h	Name bloomed b	e virus podstre below, d e Of vidual I certify informs shall be nent: I g void a f my Plin requir	escribe all de Diagno providing a these ansation proviciome a piunderstant s of its effean Sponso ements. It	in some hum n damage the conditions checosis additional inform swers and sta ded which tal art of my requ d that, to the ective date wi or's Plan inclu My signature	mation on a steements a ke place busest for growth no bending any indicates to	separate a are completiveen thoup cover rmitted by efits payal preexisting that I have	rovide additional in Details/ Symptoms tttachment. ete and true to the time the form rage and I acknow state law, false ble. I understar g condition limits e reviewed all in	most notably in sere, resulting in life-thing in life-thin	dge and be time cover tained a co lt in the der control and a co sand and a control an	liood. If the AIDS diseases. There fi if needed. Full Rec Date Still Rec Date Full Rec Date Full Rec Date	etna of any mate ctree. I agree tha nt as completed my insurance may be subject to ork and dependences and
Cechasthis me Acide Acid	Check hartification of the condition of	pace be not being on the being on the being ons of notition:	e virus below, d e Of vidual I certify inform shall be nent: I g void al f my Pla n requir : To all	escribe all de Diagno D	additional information of the conditions checosis additional information of the conditional	ked in 3g al Date of Onset mation on a stements a ke place b uest for gro extent per th no ben- ding any p indicates t ealth profical Informer	separate a are comple etween the oup cover rmitted by efits payal preexisting that I have essionals, nation Bur supplies	rovide additional in Details/ Symptoms tttachment. ete and true to the time the form age and I acknow state law, false ble. I understant g condition limits are reviewed all in the hospitals and cheau: You are a dincluding those	most notably in sere, resulting in life-thinformation for questions Treatments Received	dge and be time cover tained a co lt in the der ch are discles and emplents on this utions, insuletna Life Ir ess and/or a control or a color or the control or the cover and/or a color or the cover a color or the color or	lood. If the AIDS diseases. There file in the AIDS diseases. There follows a file in the AIDS diseases. There follows a file in the AIDS diseases. Full Record at the AIDS diseases. Full Record at the AIDS diseases. Full AIDS diseases are and the AIDS diseases. The AIDS diseases are and the AIDS diseases. The AIDS diseases are and the AIDS diseases. The AIDS diseases are and the AIDS diseases are and the AIDS diseases. The AIDS diseases are and the AIDS diseases are and the AIDS diseases. The AIDS diseases are and the AIDS diseases are and the AIDS diseases. There are and the AIDS diseases are and the AIDS diseases. The AIDS diseases are and the AIDS diseases are also ar	etna of any mate ctive. I agree that as completed my insurance may be subject to rk and dependeness and ospital service any (Aetna) rovided me or an or and rovided me or an o
Cerchathis me Acimpre and Air me Air mes	Check hartification de condition alth condition alt	here if Name bloom Nam	below, do le Of vidual f you are I certify information and the plant: I g void a f my Plant in require: To all plants, or cerning y family tests pundery underviews process.	escribe all de Diagno de Providing a these ans ation provi ecome a providing a these ans ation provincements. It is an Sponso ements. It is an Sponso ements and sponso en spo	additional information of the conditions checonsis and different programments and states of the conditional information of the conditional information of the conditional information of the coverage has on a criminal estigation. The	ked in 3g al Date of Onset mation on a atterments a ke place b uest for gre extent per ding any p indicates t ealth profin eatment or s been re- offender o is informa	separate a are complete by efits payal presenting that I have enstion Bur r supplies quested. or a crime tion will be	rovide additional in Details/ Symptoms attachment. ete and true to the time the forminge and lacknow state law, false ble. I understang condition limits are reviewed all in the control of the control	most notably in sere, resulting in life-thing in life-thin	dge and be time cover tained a co lt in the der ch are discles and emplents on this utions, insultens Life in to provide on obtained eligibility for eligibility eligibility for eligibility for eligibility eligi	liced. If the AIDS diseases. There for the Aids of the	etna of any mate ective. I agree that as completed my insurance may be subject took and dependences and cospital service and provided me or an erning results of the above may authorization will
Cerchathis me Acido me Air mes be on	Check hartification of the condition of	Name blooming the blooming of my being of my being on sof addition: attion: attion	e virus codstre below, d e Of vidual f you are I certify informs shall be nent: I g void a f my Pla n requir : To all plans, e cerning y family f tests p under under live (12 4" of til	providing a these ansation providing a these ansation providing a these ansation providing and these ansation providing and these ansation providing and the search of the	additional information of the conditions checosis additional informations and state of the conditional information of the conditional information of the conditional information and other hand of the coverage has c	ked in 3g al Date of Onset mation on a aternents a ke place b uest for gro extent pel th no ben- ding any p indicates t eath proficial Inform aternent or s been re- offender o is informa signed. I at I have a	separate a are complete two cover rmitted by efits payal pression Bur r supplies quested. or a crime quested. or a crime acknowle	nfected people against disease rovide additional in Details/ Symptoms attachment. ete and true to the time the form rage and I acknow state law, false ble. I understang condition limits a reviewed all in the province and including those (victim.) I acknow e used for the pedge that I have	most notably in sere, resulting in life-thinformation for questions Treatments Received Treatments may resu that conditions whice the	dge and be time cover tained a co lt in the der ch are discles and emplents on this utions, insultens and/or discounting and/or discounting and/or eligibility footice and I	lood. If the AIDS diseases. There fire needed. Full Rec Date The diseases. There follows a control of claims or in osed on this form loyee actively at we form for complete areas, medical or hasurance Compan AIDS/ARC/HIV) prinformation conced from any or all of or coverage. This Misrepresentatio	etna of any mate covery setna of any mate ctive. I agree than t as completed my insurance may be subject took and dependeness and cospital service and cospital service and reming results of the above may authorization will n section shown
Cechathis me Acl covaling for the covali	Check hartification of the condition of	here if here if ion: o the sedgm being ons of idition of my corn of my corn tweel 2 of is auti	below, do le Of vidual f you are I certify information in the properties of the pro	providing a these ansation providing a these ansation providing a these ansation providence a polymer of the second a the second	additional information of the conditions checosis additional informations and stated which tale and the total and the Medical and the Medical and the Medical and a criminal instigation. The coverage has a criminal instigation. The condition and the date and know that the medical and the medical and the date and know that the total and t	ked in 3g al Date of Onset mation on a atterments a ke place b uest for gro extent per th no beno ding any p indicates t ealth profre eatment or s been re- offender of is informa signed. I at I have a ginal.	separate a are complete two cover rmitted by efits payal pression Bur r supplies quested. or a crime quested. or a crime acknowle	nfected people against diseas rovide additional in Details/ Symptoms attachment. ete and true to the time the form rage and I acknow state law, false ble. I understang condition limits a reviewed all in hospitals and concern according those (Minnesota resinolucing). I acknow e used for the pedge that I have receive a copy	most notably in sere, resulting in life-thinformation for questions Treatments Received Treatments I have resulted that conditions which the conditions which the command the received to provide Area to mental illing dents are not required that information and statements are not required that information are of determining the read the Privacy Notations of the privacy Notations and the privacy Notations of the privacy Notations and the privacy Notations of the privacy Nota	dge and be time cover tained a coult in the der chare discless and emplents on this utions, insulating Life in optained a coult in the derivation of the could be considered and for a cou	liod. If the AIDS diseases. There fi needed. Full Rec Date lief. I will inform A age becomes effer age becomes effer and on this form loyee actively at we form for complete arers, medical or hasurance Compan AIDS/ARC/HIV) per information conced from any or all of or coverage. This Misrepresentation uest. I agree that	etna of any mate covery setna of any mate ctive. I agree than t as completed my insurance may be subject took and dependeness and cospital service and cospital service and reming results of the above may authorization will n section shown



Evidence of Insurability Statement Disability Coverage

Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Plan Sponsor

Complete Section A in its entirety. Be sure that:

Please Print

- All items are completed.
 The Control Number, Suffix and Account numbers are provided (A1).
- The Employee/Member's Social Security Number is provided (A2).
- Both the Employee/Member's and your name and address are shown in the spaces provided (A3 and A4).
- The telephone number of your authorized representative (A5), Employee/Member's date of hire (A6) and Employee/Member's home and work telephone numbers (A7) are provided.
- · Your Employee/Member's and your E-mail addresses are provided (A8 and A9).
- · Employee/Member's Annual Earnings is completed (A10)
- You check the appropriate Disability box(es) and provide current and requested amounts of coverage (A11).
- · Section A is signed by your Authorized Representative (A12).

Give the form to your Employee/Member for his/her confidential submission to Aetna.

Aetna will advise you of its coverage decision. Employee/Member will be notified directly if coverage is denied.

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Complete Section B. Be sure that:

- All items are completed.
- Birthdate, Sex, Height and Weight are completed (B1).
- . Height and Weight must be provided or this form will be returned unprocessed for your completion (B1).
- . Complete dates and details are given for all conditions checked in B2g, (B3).
- The form is signed by you. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company Medical Underwriting Department P.O Box 83641 Lincoln, NE 68501-3641

OR

Fax to: 1-800-792-9710

If you have any questions, call us toll-free at:

1-800-660-9913

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety and signed, it will be returned unprocessed for your completion.

EOI GR-67852 (12-07) A-POD

Make a copy for your records.

PH Sign Req'd Page 1 of 4

Evidence of Insurability Statement – Disability Coverage

page 2 of 4

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company, Medical Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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. Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna

Evidence of Insurability Statement – Disability Coverage

page 3 of 4

~
X Aetna
ARLIA
TIT BOULECT

Evidence of Insurability Statement Make a copy for your records. Mail the original to: Disability Coverage

Aetna Life Insurance Company Medical Underwriting Department

	Sponsor: Complete this Section Number Suffix	Account	2. Employee/Member Social Security	Number		
Plan Spo	onsor Name & Address		4, Employee/Member Name & Address	5 5		
TTN:						
500						
ame						
eet			Street			
у	La ID The Mark	State ZIP Code	City	State ZIP Code		
lan Spo	onsor - Authorized Rep Telephone Number) -	Employee/Member Date of Hire (MMDDAY)	7 Employee/Member Telephone Numb Work ()			
	onsor E-mail address		9. Employee/Member E-mail Address	34,01. 4		
	oloyee/Member's Annual Earning	20-				
	8,000	212		D. I. D		
Emplo Birth	nsor - Authorized Representative Signature oyee/Member: Complete this Sec thdate (MW/DD/YYYY) Interment of Health for Individual listed estions are checked "Yes", you must so No If female are you pregnant? Have you used tobacco pro Are any inpatient or outpatie	Sex M F F above. Please print. All question Sex M F F above. Please answer the following provide details in Number 3 below. If yes, Date Due: ducts in the last 12 months (cigarettent medical, surgical or diagnostic pr	Height (ft., in.) g questions to the best of your know Any complications or proces, cigar, pipe, chewing tobacco)? ocedures recommended or contemp	e forms cannot be processed. Weight (lbs.) Vledge and belief. If any of the following oblems: plated: If yes, When:		
Emplo Birth Stat que Yes	nsor - Authorized Representative Signature oyee/Member: Complete this Sec thdate (MW/DD/YYYY) Internent of Health for Individual listed estions are checked "Yes", you must In the past 7 years have you If yes, Why:	Sex M F F M M F All question Sex M F M M M M M M M M M M M M M M M M M	s must be answered. Incomplete Height (ft., in.) g questions to the best of your know Any complications or proces, cigar, pipe, chewing tobacco)? ocedures recommended or contemp Reason for procedure: sanatorium, rehabilitation or other tre When:	Weight (lbs.)		
Birth Stat que Yes	nsor - Authorized Representative Signature oyee/Member: Complete this Sec thdate (MWDD/YYYY) Internent of Health for Individual listed estions are checked "Yes", you must No If female are you pregnant? Have you used tobacco pro Are any inpatient or outpatie Name of procedure: In the past 7 years have you If yes, Why: In the past 7 years have you condition other than minor if	Sex M F F M F M M M M M M M M M M M M M M	s must be answered. Incomplete Height (ft., in.) g questions to the best of your know Any complications or proces, cigar, pipe, chewing tobacco)? ocedures recommended or contemp Reason for procedure: sanatorium, rehabilitation or other tre When: ived medical treatment from any doc	weight (lbs.) Weight (lbs.) Vledge and belief. If any of the following oblems:		
Birth Stat que	nsor - Authorized Representative Signature oyee/Member: Complete this Sec thdate (MWDD/YYYY) In the past 7 years have you for yes, Why: In the past 7 years have you for yes, Why: In the past 7 years have you condition other than minor if	Sex M F F M F M M M M M M M M M M M M M M	s must be answered. Incomplete Height (ft., in.) g questions to the best of your know Any complications or proces, cigar, pipe, chewing tobacco)? ocedures recommended or contemp Reason for procedure: sanatorium, rehabilitation or other tre When: ived medical treatment from any doc	weight (lbs.) Weight (lbs.) Wedge and belief. If any of the following oblems: plated: If yes, When: eatment facility?		
Birth State que	nsor - Authorized Representative Signature oyee/Member: Complete this Sec thdate (MWDD/YYYY) In the past 7 years have you for yes, Why: In the past 7 years have you for yes, Why: In the past 7 years have you condition other than minor if	Sex M F above. Please print. All question Sex M F above. Please answer the following provide details in Number 3 below. If yes, Date Due: ducts in the last 12 months (cigarettent medical, surgical or diagnostic print been confined to a hospital, clinic, a been examined, monitored or receinesses (cold, flu, etc.)?	s must be answered. Incomplete Height (ft., in.) g questions to the best of your know Any complications or proces, cigar, pipe, chewing tobacco)? ocedures recommended or contemp Reason for procedure: sanatorium, rehabilitation or other tre When: ived medical treatment from any doc	Weight (lbs.)		
Birth State	nsor - Authorized Representative Signature oyee/Member: Complete this Sec thdate (MWDD/YYYY) In the past 7 years have you condition other than minor if If yes, Why. Are you currently taking mee	Sex M F above. Please print. All question Sex M F above. Please answer the following provide details in Number 3 below. If yes, Date Due: ducts in the last 12 months (cigarettent medical, surgical or diagnostic print been confined to a hospital, clinic, a been examined, monitored or receinesses (cold, flu, etc.)?	s must be answered. Incomplete Height (ft., in.) g questions to the best of your know Any complications or proces, cigar, pipe, chewing tobacco)? ocedures recommended or contemp Reason for procedure: sanatorium, rehabilitation or other tre When: ived medical treatment from any doc When: Iowing information:	e forms cannot be processed. Weight (lbs.) Vledge and belief. If any of the following oblems: plated: If yes, When: eatment facility? ctor, practitioner or counselor for any		
en Sponse	nsor - Authorized Representative Signature oyee/Member: Complete this Sec thdate (MWDD/YYYY) Interior of Health for Individual listed estions are checked "Yes", you must Interior of Health for Individual listed estions are checked "Yes", you must In the past of procedure: In the past of years have you lifyes, Why: In the past of years have you condition other than minor if lifyes, Why: Are you currently taking men Medication	Sex M F F above. Please print. All question Sex M F above. Please answer the following provide details in Number 3 below. If yes, Date Due: ducts in the last 12 months (cigarett ent medical, surgical or diagnostic print been confined to a hospital, clinic, a been examined, monitored or receilnesses (cold, flu, etc.)? dication(s)? If yes, complete the followage/	s must be answered. Incomplete Height (ft., in.) g questions to the best of your know Any complications or proces, cigar, pipe, chewing tobacco)? ocedures recommended or contemp Reason for procedure: Reason for procedure: sanatorium, rehabilitation or other tre When:ived medical treatment from any doc When: Iowing information: Frequency	e forms cannot be processed. Weight (lbs.) Vledge and belief. If any of the following oblems: plated: If yes, When: eatment facility? ctor, practitioner or counselor for any		

Evidence of Insurability Statement – Disability Coverage

page 4 of 4

In the lues.	Diagnosis	Date of Onset	Details/ Symptoms	Treatments Received	Full Recovery Date
] Checi	k here if you are providing add.	itional information on a sepa	arate attachment.		
certification detries of the control	f any material changes ge becomes effective. I etained a copy of this do wledgment: I understance ce coverage being void	nswers and statements to the information pro- agree that this docum ocument as completed and that, to the extent p as of its effective date	s are complete and true vided which take place ent shall become a paid by me. permitted by state law, with no benefits payal	between the time the form t of my request for group false statements may resuble. I understand that con-	ult in the denial of claims or in m ditions which are disclosed on
Certific Aetna o coverage have na Acknown nsurand his formand em nforman Authorinospital	ation: I certify these and fany material changes are becomes effective. I etained a copy of this dowledgment: I understance coverage being void in may be subject to all oployee actively at work attion and statements on tization: To all physician service and prepaid he	swers and statements to the information pro- agree that this docume ocument as completed and that, to the extent p as of its effective date conditions of my Plans and dependent health this form for complete and other health pr alth plans, employers	s are complete and truivided which take place tent shall become a paid by me. bermitted by state law, with no benefits payal Sponsor's Plan includir condition requirement ness and accuracy ofessionals, hospitals a and the Medical Inform	between the time the form t of my request for group false statements may resu- ble. I understand that con- ing any preexisting conditions. My signature indicates and other health care institu- nation Bureau: You are au	n is completed and the time coverage and I acknowledge the lit in the denial of claims or in miditions which are disclosed on in limitations, fraud provisions that I have reviewed all autions, insurers, medical or authorized to provide Aetna Life
Certific Aetna o coverag have n Acknown surand his forman and em nospital nsurand not requ acknow will be u signed.	ation: I certify these and fany material changes are becomes effective. I etained a copy of this dowledgment: I understance coverage being void in may be subject to all of ployee actively at work attion and statements on sization: To all physician service and prepaid he ce Company (Aetna) infalloS/ARC/HIV) provided information of the purpose of collections of the purpose of collections.	swers and statements to the information pro- agree that this docume comment as completed and that, to the extent p as of its effective date conditions of my Plans and dependent health this form for complete as and other health pr alth plans, employers formation concerning d me or any members cion concerning results btained from any or a determining eligibility f have read the Privac o receive a copy of t	s are complete and true vided which take place lent shall become a paid by me. bermitted by state law, a with no benefits payal Sponsor's Plan includir condition requirement ness and accuracy rofessionals, hospitals a and the Medical Inform healthcare, advice, treas of my family for whom is of AIDS/ARC/HIV testor coverage. This authy Notice and Misrepro	between the time the form t of my request for group false statements may resulate. I understand that conditions. My signature indicates and other health care institution Bureau: You are authorition Bureau: You are authorition supplies (including coverage has been requite performed on a criminal full in further underwriting increasion will be valid for the sentation section show	n is completed and the time coverage and I acknowledge the alt in the denial of claims or in multions which are disclosed on an limitations, fraud provisions that I have reviewed all autions, insurers, medical or



Evidence of Insurability Statement Group Universal Life Coverage

Aetna Life Insurance Company

Read This Instruction Page Carefully.

Aetna may contact you directly to request additional information upon receipt of this completed Statement.

Instructions

Employee/Member

Read the Privacy Notice and Misrepresentation section on "Page 2 of 4" of the Insurability Statement before completing.

Please Print

Complete Section A in its entirety. Be sure that:

- All items are completed.
- The Control Number, Suffix and Account numbers are provided (A1).
- Your Social Security Number is provided (A2).*
- Both the employer's and your name and address are shown in the spaces provided (A3 and A4).*
- The telephone number of your authorized representative (if available A5), your date of hire (A6) and your home and work telephone numbers (A7) are provided.
- You check the appropriate box(es) for individual(s) requesting coverage. Provide the current
 amount of coverage, requested additional amount of coverage and resulting total amount of
 coverage for each individual for whom coverage is being requested (A8).
- You provide the reason for requested coverage and your Annual Earnings (A9).

Complete Section B. Be sure that:

- · All items are completed.
- . Only the names of individuals requesting coverage at this time are listed (B1).
- Height and Weight must be provided or this form will be returned unprocessed for your completion (B1).
- The appropriate boxes regarding dependent child coverage are checked, if applicable (B2a, B2b, and B2c).
- Complete dates and details are given for all conditions checked in B3g (B4).
- The form is signed by you. If you are requesting spouse coverage, the spouse's signature is also required. Read the Certification, Acknowledgment and Authorization prior to signing the form (bottom of Section B).

Make a copy for your records. Mail the original to:

Aetna Life Insurance Company Medical Underwriting Department P.O. Box 83641 Lincoln, NE 68501-3641

OR

Fax to: 1-800-792-9710

If you have any questions, call us at:

1-800-660-9913

*Verify that your name, address and **Social Security Number** as shown in Section A are complete and accurate. We may need to direct additional inquiries to your attention.

Aetna will advise your employer of its coverage decision. You will be notified directly if coverage is denied.

If a final underwriting decision cannot be made within six months, Aetna reserves the right to request a new Evidence of Insurability Statement.

Please Note: If this form is not completed in its entirety and signed, it will be returned unprocessed for your completion.

EOI GR-67829-2 (2-08) A-POD

Make a copy for your records.

Group Universal Life Page 1 of 4

Evidence of Insurability Statement – Group Universal Life Coverage

page 2 of 4

Privacy Notice

In evaluating your insurability, we (Aetna) will rely primarily on the health information you furnish to us in this Evidence of Insurability Statement. In addition, however, we may ask you to take a physical examination, or request additional medical information about you from any of the sources specified in the authorization on Page 4 of 4 of this form.

Disclosure of Information to Others

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetha Life Insurance Company may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right, or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company Medical Underwriting Department 151 Farmington Avenue

Hartford, CT 06156-2975

Under New Mexico law, a resident of New Mexico has the right to register as a "protected person" in connection with disclosure of confidential domestic abuse information. If you wish to exercise this right, write to the address shown above.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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. Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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, lines, and denial of insurance benefits.

Submission and Approval

The requested coverage will not be in effect unless and until evidence of insurability is submitted as required and is approved by Aetna.

Page 2 of 4

Evidence of Insurability Statement – Group Universal Life Coverage

page 3 of 4



Evidence of Insurability Statement Make a copy for your records. Mail the original to: Group Universal Life Coverage Aetna Life Insurance Company

Aetna Life Insurance Company Medical Underwriting Department P.O. Box 83641

Control Number Suffix Account	2. Employee/N	lember Social Security Nun	nber	
	4	-		
lan Sponsor/Employer Name & Address	4. Employee/M	ember Name & Address		
TN:				
me				
ee!	Street			
y State ZIP Code	City		State	ZIP Code
lan Sponsor - Authorized Rep Telephone Number 6 Employee/Member Date of Hire (s		ember Telephone Numbers	Home ()	
	☐ Child(ren)	, -	Tiome ()	
Current or Guarantee Issue Amount of Life Insurance Coverage? \$_ Additional Amount of Life Insurance Coverage requested? \$_ Resulting Total Life Insurance Amount if Approved (a + b)? \$_		\$ \$ \$ _	\$ \$ \$	
Reason for Requested Coverage (indicate all that apply). Salary Increase	nit Other (Please explain)	Life Event/Status Cl	
☐ Salary Increase ☐ Change in Multiple ☐ Late Appl ☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Lin	nit	Please explain)		
☐ Salary Increase ☐ Change in Multiple ☐ Late Appl ☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Lin Employee/Member's Annual Earnings: \$ Employee/Member: Complete this Section - Please print. All ques Only the Names of Individual(s) Requesting Coverage at this Time Sh	tions must be answ	Please explain) ered. Incomplete form	ms <u>cannot</u> be proce	essed.
Salary Increase Change in Multiple Late Apple Requesting an Amount in Excess of Plan's Guaranteed Issue Lin Employee/Member's Annual Earnings: \$	tions must be answ	Please explain) ered. Incomplete form	ms <u>cannot</u> be proce	essed.
☐ Salary Increase ☐ Change in Multiple ☐ Late Appl ☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Lin Employee/Member's Annual Earnings: \$ Employee/Member: Complete this Section - Please print. All questing Only the Names of Individual(s) Requesting Coverage at this Time Share ployee/Member:	tions must be answ	Please explain) ered. Incomplete form	ms <u>cannot</u> be proce	essed.
Salary Increase Change in Multiple Late Apple Requesting an Amount in Excess of Plan's Guaranteed Issue Lin Employee/Member's Annual Earnings: \$	tions must be answ	Please explain) ered. Incomplete form	ms <u>cannot</u> be proce	essed.
Salary Increase Change in Multiple Late Apple Requesting an Amount in Excess of Plan's Guaranteed Issue Line Employee/Member's Annual Earnings: \$	tions must be answould be Listed Relationship Self	Please explain)ered. Incomplete for	ms <u>cannot</u> be proce	essed.
Salary Increase Change in Multiple Late Apple Requesting an Amount in Excess of Plan's Guaranteed Issue Lin Employee/Member's Annual Earnings: \$	tions must be answould be Listed Relationship Self	Please explain)ered. Incomplete for	ms <u>cannot</u> be proce	essed.
Salary Increase ☐ Change in Multiple ☐ Late Apple ☐ Requesting an Amount in Excess of Plan's Guaranteed Issue Line Employee/Member's Annual Earnings: \$	tions must be answard be Listed Relationship Self Relationship Self	Please explain) ered. Incomplete for a Birthdate (MM/DD/YYYY)	ms <u>cannot</u> be proce	essed.
Salary Increase	tions must be answard be answard be Listed Relationship Self Relationship Self Relationship Self Relationship Self	Please explain) ered. Incomplete for a Birthdate (MM/DD/YYYY) nal space is needed.	ms <u>cannot</u> be proce	essed.
Salary Increase	tions must be answard be Listed Relationship Self Power 4 if additional addi	Please explain) ered. Incomplete for a Birthdate (MM/DD/YYYY) nal space is needed. o, please explain:	ms <u>cannot</u> be proce	Weight (lbs.)
Salary Increase	tions must be answard be Listed Relationship Self Power 4 if additional addi	Please explain) ered. Incomplete for a Birthdate (MM/DD/YYYY) nal space is needed. o, please explain:	ms <u>cannot</u> be proce	Weight (lbs.)
Salary Increase	tions must be answard be Listed Relationship Self Power 4 if additional addi	Please explain) ered. Incomplete form Birthdate (MM/DD/YYYY) nal space is needed. o, please explain: s to the best of your kn	Sex Height (ft., in.)	Weight (lbs.) If any of the
Salary Increase	tions must be answood be Listed Relationship Self Polymore 4 if additional a	Please explain) ered. Incomplete form Birthdate (MM/DD/YYYY) anal space is needed. o, please explain: s to the best of your known and space is needed.	Sex Height (ft., in.) sowledge and belief.	Weight (lbs.)
Salary Increase Change in Multiple Late Appl Requesting an Amount in Excess of Plan's Guaranteed Issue Lin Employee/Member's Annual Earnings: \$	tions must be answood be Listed Relationship Self Power 4 if additional attending school? If note of the property of the prop	Please explain) ered. Incomplete form Birthdate (MM/DD/YYYY) anal space is needed. o, please explain: s to the best of your kind on the property of the prop	Sex Height (ft., in.) nowledge and belief. s or problems:	Weight (lbs.)
Salary Increase	tions must be answard be Listed Relationship Self Due Date: Deadures recommended of	Please explain) ered. Incomplete form Birthdate (MM/DD/YYYY) mal space is needed. o, please explain: s to the best of your kind to be a contemplated? If yes, whit is contemplated? If yes, white years are the properties of the pr	Sex Height (ft., in.) owledge and belief. s or problems: hen.	Weight (lbs.)

Evidence of Insurability Statement – Group Universal Life Coverage

page 4 of 4

3,	23331010	3 100 00 00 00 00	1 - Continued. Us	e Number 4 i	f additional space is r	eeded.			
ij	Yes	156							
d,				ndividual been	confined to a hospital, cl	nic, sanatorium,	, rehabilitation or other treat	ment facility?	
		If yes, W			Why:		Wh	and the second second	
ð.					examined by, consulted	with, or received	d medical treatment from ar	ny physician or pra	ctitioner for any condition
Ш			n minor illnesses (co	old, flu, etc.)?	4.1		40		
		If yes, W		Tax 1 2 - 20 23	Why:	a Cara Cara	- Who	en:	
	ЦΙ			taking medicati	on(s)? If yes, complete	the following info			45.77.4
		Name of	f Individual		Medication		Dosage/Frequency		Diagnosis
П	_								
Ш	-							_	
	_								
	Within t	the pact 10 ve	are have you or you	r engues or chil	d/ran) had any disaasa	impairment of o	r treatment (other than min	or illnesses) for an	of the following?
						impairment of o	i deadheir (odler thai mili	of liftlesses) for any	y of the following?
Ш	☐ AID		ropriate box(es) and	☐ Cancer	Miber 4.	- Immuno	System Dinarder	☐ Nervous S	verton.
	☐ Arth				Funnel Syndrome		System Disorder /Stomach/Ulcer	☐ Paralysis/F	
			sema/COPD	☐ Chest P		☐ Kidney/B	to be write the profits	☐ Reproduct	
		ck/Spine/Nec			Fatigue/Fibromyalgia		leen/Pancreas	Skin Disor	
			n Bleeding/Blood Clo			☐ Lungs/Br		☐ Stroke	901
			Hypertension	☐ Ears/Ey		Lupus			Abuse (Alcohol/Drug)
	2-00	od Vessels/0		☐ Epilepsy		The second second second second	motional Condition		nsils/Swallowing
		nes/Joints			gus/Digestion/GERD	☐ Multiple :	The state of the s	The state of the s	tuitary/Adrenal
	☐ Bra			☐ Heart		☐ Muscular		☐ Turnor/Gro	The state of the s
Ш	Oth	her		3.					
l. ues	defense In the s Name	es against di pace below, d	sease, resulting in l	life-threatenin	of Details/	o known cure. ovide additional i	information for questions 2: Treatment(s) Received		in the Total Ac-
ies	defense In the s Name	es against di pace below, d e of	sease, resulting in lescribe all conditions	life-threatening s checked in qu Date	g diseases. There is n uestion 3g above and pro of Details/	o known cure. ovide additional i	information for questions 2		ded.
ies	defense In the s Name	es against di pace below, d e of	sease, resulting in lescribe all conditions	life-threatening s checked in qu Date	g diseases. There is n uestion 3g above and pro of Details/	o known cure. ovide additional i	information for questions 2		ded. Full Recovery
ies	defense In the s Name	es against di pace below, d e of	sease, resulting in lescribe all conditions	life-threatening s checked in qu Date	g diseases. There is n uestion 3g above and pro of Details/	o known cure. ovide additional i	information for questions 2		ded. Full Recovery
ies	defense In the s Name	es against di pace below, d e of	sease, resulting in lescribe all conditions	life-threatening s checked in qu Date	g diseases. There is n uestion 3g above and pro of Details/	o known cure. ovide additional i	information for questions 2		ded. Full Recovery
ies	defense In the sp Name Indiv	es against di pace below, d e of vidual	sease, resulting in lescribe all conditions Diagnosis	llfe-threatenin s checked in qu Date Ons	g diseases. There is n lestion 3g above and pro of Details/ et Sympto	o known cure. ovide additional i	information for questions 2		ded. Full Recovery
les	defense In the spanning In the spanning Indiv	es against di pace below, d e of vidual	sease, resulting in lescribe all conditions Diagnosis Diagnosis	llfe-threatenin s checked in qu Date Ons	g diseases. There is n uestion 3g above and pro of Details/ et Sympto	o known cure. ovide additional i ms achment.	information for questions 2: Treatment(s) Received	a-c and 3a-f, if nee	ded. Full Recovery Date
eı	defenss In the sp Name Indiv	es against di pace below, d e of vidual neck here if yo on: I certify	sease, resulting in lescribe all conditions Diagnosis Diagnosis Du are providing addy these answers	life-threatenings checked in quantity Date Ons ditional informational and statemen	g diseases. There is n uestion 3g above and pro of Details/ et Sympto nation on a separate attents are complete a	o known cure. ovide additional i ms achment. nd true to the	information for questions 2: Treatment(s) Received	a-c and 3a-f, if nee	ded. Full Recovery Date will inform Aetna of an
es	In the sy Name Indiv	es against di pace below, d e of vidual neck here if yo on: I certify nanges to th	sease, resulting in lescribe all conditions Diagnosis Diagnosis Du are providing addy these answers ne information pri	life-threatenings checked in quantities of the Date Ons of the Ons	g diseases. There is n uestion 3g above and pro of Details/ et Sympto nation on a separate attents are complete at h take place between	o known cure. ovide additional i ms achment. nd true to the n the time the	information for questions 2: Treatment(s) Received best of my knowledge form is completed a	a-c and 3a-f, if nee e and belief. I v nd the time cov	ded. Full Recovery Date will inform Aetna of an
er er er	In the sylvanter in the	es against di pace below, d e of vidual eeck here if yo on: I certify nanges to th I agree that	sease, resulting in lescribe all conditions Diagnosis Diagnosis Diagnosis Diagnosis Diagnosis Diagnosis	life-threatenings checked in quantities of the Date Ons of the Ons	g diseases. There is n uestion 3g above and pro of Details/ et Sympto nation on a separate attents are complete at h take place between	o known cure. ovide additional i ms achment. nd true to the n the time the	information for questions 2: Treatment(s) Received	a-c and 3a-f, if nee e and belief. I v nd the time cov	ded. Full Recovery Date will inform Aetna of an
en	Chetification	es against dispace below, de of ridual eck here if your on: I certify hanges to the lagree that hent as com	sease, resulting in lescribe all conditions Diagnosis Diagnosis Diagnosis Diagnosis Diagnosis Diagnosis Diagnosis	life-threatenings checked in quantities on the constitution of the	g diseases. There is n lestion 3g above and pro of Details/ et Sympto lation on a separate attents are complete a th take place between a part of my reques	o known cure. vide additional i ms achment. nd true to the n the time the st for group c	information for questions 2: Treatment(s) Received best of my knowledge form is completed a	e and belief. I vind the time covided ge that I ha	ded. Full Recovery Date will inform Aetna of an erage becomes ve retained a copy of
en al ffe	Chtification	neck here if you on: I certify nanges to the lagree that ent as com-	pu are providing addy these answers ne information proteins document suppleted by me, understand that eing void as of its	ditional informand statements ovided which hall becomes	g diseases. There is n lestion 3g above and pro lestion 3g above and pro lestion 3g above and pro lesting parties and support and separate attents are complete attents are complete attents are place between a part of my requesting permitted by state attents no benefits	o known cure. ovide additional is ms achment. nd true to the n the time the st for group co	information for questions 2: Treatment(s) Received best of my knowledge form is completed a coverage and I acknowlatements may result inderstand that conditions	e and belief. I vand the time cow Medge that I have the denial of cons which are constants which	ded. Full Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form
ies ien inat ffe is icl	In the sylvantification of the communication of the	neck here if you on: I certify name that name that name that name that name that name that nent as come digment: I coverage b bject to all of	pu are providing addy these answers ne information proteins document suppleted by me, understand that eing void as of its conditions of my	ditional informand statement ovided which hall becomes	g diseases. There is n lestion 3g above and pro lestion 3g above and pro lestion 3g above and pro lesting persists attion on a separate att ents are complete at h take place between lesting a part of my reques at permitted by state ate with no benefits Plan including any p	achment. In the time the st for group color law, false st payable. I unreexisting co	information for questions 2: Treatment(s) Received best of my knowledge form is completed a coverage and I acknowlatements may result inderstand that condition limitations, frait	e and belief. I vand the time cow Medge that I have the denial of cons which are could provisions as	ded. Full Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form and employee actively
cernal ffe nis ici	Chrification	neck here if you on: I certify name that neck age to the larger that nent as com- coverage b bject to all of	pu are providing addy these answers ne information proteins document suppleted by me, understand that eing void as of its conditions of my nealth condition in	ditional informand statement ovided which hall becomes	g diseases. There is n lestion 3g above and pro lestion 3g above and pro lestion 3g above and pro lesting persists attion on a separate att ents are complete at h take place between lesting a part of my reques at permitted by state ate with no benefits Plan including any p	achment. In the time the st for group color law, false st payable. I unreexisting co	information for questions 2: Treatment(s) Received best of my knowledge form is completed a coverage and I acknowlatements may result inderstand that conditions	e and belief. I vand the time cow Medge that I have the denial of cons which are could provisions as	ded. Full Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form and employee actively
Certain fife in istance in a contract on the c	Chetification	neck here if your con: I certify agree that nent as comedigment: I coverage bibject to all of dependent itess and acceptance and acceptance are all of dependent itess and acceptance and	pease, resulting in lescribe all conditions Diagnosis	ditional informand statements ovided which hall becomes to the external employer's requirements	g diseases. There is no pestion 3g above and properties of Details/et Sympton as eparate at the period of the peri	achment. In the time the st for group content in the st f	e best of my knowledge form is completed a coverage and I acknowlatements may result inderstand that condition limitations, frainave reviewed all informations.	e and belief. I v nd the time cov Medge that I ha in the denial of o ons which are o ad provisions a mation and stat	ded. Full Recovery Date will inform Aetna of an erage becomes everetained a copy of claims or in my disclosed on this form the ements on this form
Certain fife is in a contract of the contract	Chetification of the surface of the	neck here if your coverage below, and the seck here if your con: I certify any control and the seck here if your coverage belonged to all of the seck and acution:	pease, resulting in lescribe all conditions Diagnosis Di	ditional informand statements to the exter seffective demployer's requirements other health	g diseases. There is no pestion 3g above and prosect of Details/et Sympto set	achment. In the time the st for group contents and true to the number of the st for group contents and other than the state of th	e best of my knowledge form is completed a coverage and I acknowlatements may result inderstand that condition limitations, frait have reviewed all informer health care institutions.	e and belief. I vand the time covaledge that I have the denial of cons which are coud provisions at mation and statements, insurers, in	Full Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form the employee actively tements on this form the employee actively
Certain fife in survivor on tutter	Chetification of the control of the	pace below, de of ridual meck here if your on: I certify anges to the lagree that a comment as comment to all of dependent less and action: To all deprepaid here pendent below to all dependent less and action: To all deprepaid here against the less and action: To all deprepaid here against the less and action: To all deprepaid here against the less and action: To all deprepaid here against the less and action: To all deprepaid here.	pease, resulting in lescribe all conditions Diagnosis	ditional informand statements to the exter seffective demployer's requirements other health oloyers and the colores and the colores are the colores and the colores are the colores and the colores are colores.	g diseases. There is no pession 3g above and prosect of Details of Details of Sympton attornion on a separate attents are complete as the take place between the permitted by state attents are with no benefits plan including any plan includin	achment. Inditional interest for group contents and true to the payable. I unreexisting contents that I holitals and othion Bureau:	e best of my knowledge form is completed a coverage and I acknowlatements may result inderstand that condition limitations, frainave reviewed all informations.	e and 3a-f, if nee e and belief. I v nd the time cov dedge that I ha n the denial of c ons which are a ud provisions a mation and stat ons, insurers, n provide Aetna	ded. Full Recovery Date will inform Aetna of ar erage becomes we retained a copy of claims or in my disclosed on this form and employee actively tements on this form in
Certain fife is in a contract of the contract	Chrification of the control of the c	pace below, de of ridual meck here if your on: I certify anges to the lagree that a coverage beloeved to all of dependent less and action: To all dependent (Aetna) info/C/HIV) provi-	sease, resulting in lescribe all conditions Diagnosis	ditional informand stateme ovided which hall become to the requirement other health oloyers and the ing healthcanembers of incomplex of	g diseases. There is no pession 3g above and properties of Details is a superior on a separate attents are complete as the take place between a part of my request the permitted by state atte with no benefits Plan including any part of the permitted by state attents in th	achment. achment. ach true to the nother than the time the strongroup contacts that I hours and other than the strong contacts that I hours and other than the surpelies coverage has soverage has sov	reatment(s) Received best of my knowledge form is completed a coverage and I acknowledge and I acknowledge and I acknowledge form is completed a coverage and I acknowledge and I acknowledge form is completed and I information limitations, framewer eviewed all information are nealth care institution. You are authorized to see including those relates been requested. (M	e and 3a-f, if nee e and belief. I v nd the time cov dedge that I ha n the denial of c oud provisions a mation and stat ons, insurers, n provide Aetna ed to mental illr innesota reside	ded. Full Recovery Date will inform Aetna of an erage becomes evertained a copy of claims or in my disclosed on this form the employee actively tements on this form the edical or hospital Life Insurance these and/or ents are not required to
Certain State Control	Characterial chara	pace below, de of ridual pace below, de of ridual pace here if your on: I certify anges to the lagree that as come dependent I despendent I despen	pease, resulting in lescribe all conditions Diagnosis	ditional informand statement ovided which hall become to the health oloyers and the lolyers an	g diseases. There is no pession 3g above and properties of Details is a superior on a separate attents are complete a complete and take place between a part of my request the permitted by state attents are with no benefits plan including any part of my request including any part of my signature individual professionals, hospital professiona	achment. achment. ach true to the nother than the time the payable. I payable. I payable. I payable. I ocates that I hotals and other tor supplies to overage has ned on a crimer.	information for questions 2: Treatment(s) Received best of my knowledge form is completed a coverage and I acknowlatements may result in inderstand that condition limitations, frait ave reviewed all information are authorized to see including those relates been requested. (Mininal offender or a criminal offender or a	e and 3a-f, if need and 3a-f, if need and 3a-f, if need and the time covered and the time covered and provisions and and statements on and statements and the times of a residence victim.) I acknowledge the victim.) I acknowledge and to mental illustrations and the victim.) I acknowledge and the victim.	rull Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form in employee actively tements on this form in the form the energy and or the form the energy and or ents are not required to cnowledge that
en la	Characterial checitive. I document when the characterial checitive in the characterial checitive is an arrow of the characterial checitive. I document when the characterial checitive in	pace below, de of ridual pace below, de of ridual pace here if your on: I certify anges to the lagree that as come dependent I despendent less and action: To all (Aetna) information con obtained for	pease, resulting in lescribe all conditions Diagnosis	ditional informand statement ovided which hall become to the health ologers and the ling healthcare of AIDS/AF, the above respective of the ling healthcare of AIDS/AF, the above respective of the ling healthcare of AIDS/AF, the above respective of the ling healthcare of AIDS/AF, the above respective of the ling healthcare of the ling healthca	g diseases. There is no pestion 3g above and properties of Details at Sympton and properties of Details at Sympton and properties are complete as a part of my request at the with no benefits are with no benefits. My signature indicate with no benefits are with no benefits at with no benefits. My signature indicate with no benefits are with no benefits are with no benefits. My signature indicate with no benefits are with no benefits are with no benefits. My signature indicate with no benefits are with no bene	achment. achment. ach true to the nother than the time the payable. I unreexisting concates that I horitals and other in the supplies coverage has ned on a crimunderwriting	information for questions 2: Treatment(s) Received best of my knowledge form is completed a coverage and I acknow tatements may result in inderstand that condition limitations, frait ave reviewed all information are authorized to see (including those relates been requested. (Mainal offender or a criminvestigation. This infiniter in the second control of the cont	e and 3a-f, if need and 3a-f, if need and 3a-f, if need and the time covered and provisions and state and provisions and state and provide Aetna and to mental illustration and state and to mental illustration and state and to mental illustration will be a victim.) I acknown and the provide Aetna and the pro	ded. Full Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form in demployee actively tements on this form in the dical or hospital Life Insurance less and/or ents are not required to crowledge that ensed for the purpose
certain final fina	Characterial checitive. I document when the characterial checitive in the characterial checitive is an arrow of the characterial checitive. I document when the characterial checitive in	pace below, de of ridual pace below, de of ridual pace here if your on: I certify anges to the lagree that as come dependent I despendent less and action: To all (Aetna) information con obtained in obtained in ning eligibility.	bease, resulting in lescribe all conditions Diagnosis	ditional informand statement ovided which hall become to the requirement other health ologers and the property of AIDS/AF, the above of This authorical property of the authorical formatter of the property of the authorical formatter of the property of the above of This authorical formatter of the property of the of the prop	g diseases. There is no pestion 3g above and properties of Details at Sympton and properties of Details at Sympton and properties are complete as a part of my request at the with no benefits are with no benefits. My signature indicate with no benefits are with no benefits. My signature indicate with no benefits are with no benefits are with no benefits. My signature indicate with no benefits are with no benefits are with no benefits. My signature indicate with no benefits are with no ben	achment. achment. achment. ach true to the nother threat for group concerns that I hours and other threat for Bureau: ach true to the nother threat for group concerns that I hours and other threat for supplies the tor supplies the tor supplies the tor threat for a crimunderwriting or thirty (12) if the tor threat for the thre	information for questions 2: Treatment(s) Received best of my knowledge form is completed a coverage and I acknow tatements may result in inderstand that condition limitations, frait ave reviewed all information are authorized to see (including those relates been requested. (Mainal offender or a criminvestigation. This information in the date	e and 3a-f, if need and 3a-f, if need and 3a-f, if need and the time covered and provisions and state and provisions and state and provide Aetna and to mental illustration and state and to mental illustration and state and to mental illustration will be signed. I acknown and acknown and acknown and acknown ac	rull Recovery Date Will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form in the employee actively tements on this form in the first are not required to enses and/or ents are not required to ensed for the purpose owledge that I have
ies ienatiffe instruction instruction info	Chtification of the plant of the P	neck here if you neck h	pu are providing addenses of the second and conditions of the second and the seco	ditional informand statements ovided which hall become seffective demployer's requirements other health bloyers and thing healthcanembers of responsible to a the above members of the above members of the above members authorizes and the sembers of responsible to the above members of responsible to the above members of the above members of responsible to the above members of the above	g diseases. There is no pestion 3g above and properties of Details/et Sympto set Sympto	achment. Indicate the time the strong concates that I he bitals and other into the strong concates that I he bitals and other into the strong concates that I he bitals and other into resupplies coverage has seed on a crimunderwriting or thirty (12) in Page 2 of invide additional into the strong concates that I he bitals and other into the strong coverage has seed on a crimunderwriting or thirty (12) in Page 2 of invide additional into the strong contact the strong	reatment(s) Received best of my knowledge form is completed a coverage and I acknow tatements may result inderstand that conditional limitations, france reviewed all informer health care institutions (including those relates been requested. (Mainal offender or a criminvestigation. This informents from the date 4" of this form and left.	e and belief. I vend the time covered to mental illininesota reside to victim.) I acknow that I have consumed to mental illininesota reside to mental illininesota reside to victim.) I acknow that I have consumed to the victim.	will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form in employee actively tements on this form in edical or hospital Life Insurance ness and/or ents are not required to knowledge that the used for the purpose owledge that I have the a right to receive a right to receive the same of the contract of the purpose owledge that I have the a right to receive the same of the contract of the purpose owledge that I have the aright to receive the same of the contract of the purpose owledge that I have the contract of the purpose owledge that I have the contract of the purpose owledge that I have the contract of the purpose owledge that I have the purpose owledge the purpose owledge the I have the I have the purpose owledge the I have the I
ies ien instructio	Christication of the real of the Poy of the	neck here if your on: I certify on the control of t	pease, resulting in lescribe all conditions Diagnosis	ditional informand statement ovided which hall become to the requirement other health alloyers and training healthcatembers of resentation uest. I agreement larger authors authors authors larger authors uest. I agreement larger authors under the larger aut	g diseases. There is no pestion 3g above and properties of Details/et Sympto set Sympto	achment. achment. achment. ach true to the time the time the time the total for group contains and other in the time that I have a the	reatment(s) Received best of my knowledge form is completed a coverage and I acknow tatements may result inderstand that condition limitations, frait and reviewed all information are neglected. (Mainal offender or a criminvestigation. This infimonths from the date 4" of this form and its authorization is as v	e and belief. I vent the time covered that I have the time covered that I have the time covered that I have the time to make the time to mental illustration and state that I have the time. I acknow that I have alid as the original covered to the covered that I have alid as the original covered to the time.	Full Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form in employee actively tements on this form in edical or hospital Life Insurance tess and/or ents are not required to knowledge that a used for the purpose owledge that I have the a right to receive anal.
certain final formation for the contract of th	Christication of the real of the Poy of the	neck here if your on: I certify on the control of t	pu are providing added to the conditions of the	ditional informand statement ovided which hall become to the requirement other health alloyers and training healthcatembers of resentation uest. I agreement larger authors authors authors larger authors uest. I agreement larger authors under the larger aut	g diseases. There is no pestion 3g above and properties of Details/et Sympto set Sympto	achment. achment. achment. ach true to the time the time the time the total for group contains and other in the time that I have a the	reatment(s) Received best of my knowledge form is completed a coverage and I acknow tatements may result inderstand that conditional limitations, france reviewed all informer health care institutions (including those relates been requested. (Mainal offender or a criminvestigation. This informents from the date 4" of this form and left.	e and belief. I vent the time covered that I have the time covered that I have the time covered that I have the time to make the time to mental illustration and state that I have the time. I acknow that I have alid as the original covered to the covered that I have alid as the original covered to the time.	Full Recovery Date Mill inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form for employee actively tements on this form for edical or hospital Life Insurance less and/or ents are not required to cowledge that a layer owledge that I have owledge that I have a right to receive a nal.
ies ien instructio	Christication of the real of the Poy of the	neck here if your on: I certify on the control of t	pease, resulting in lescribe all conditions Diagnosis	ditional informand statement ovided which hall become to the requirement other health alloyers and training healthcatembers of resentation uest. I agreement larger authors authors authors larger authors uest. I agreement larger authors under the larger aut	g diseases. There is no pestion 3g above and properties of Details/et Sympto set Sympto	achment. achment. achment. ach true to the time the time the time the total for group contains and other in the time that I have a the	reatment(s) Received best of my knowledge form is completed a coverage and I acknow tatements may result inderstand that condition limitations, frait and reviewed all information are neglected. (Mainal offender or a criminvestigation. This infimonths from the date 4" of this form and its authorization is as v	e and belief. I vent the time covered that I have the time covered that I have the time covered that I have the time to make the time to mental illustration and state that I have the time. I acknow that I have alid as the original covered to the covered that I have alid as the original covered to the time.	Full Recovery Date will inform Aetna of an erage becomes we retained a copy of claims or in my disclosed on this form the employee actively tements on this form the employee actively tements are not required to ensure a required the cowledge that I have to a right to receive anal.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Premium Waiver

Premium Waiver – disability claims

Premium Waiver for permanently and totally disabled employees

If your Life Insurance benefit includes a Premium Waiver (PW) provision, an employee who is not able to work due to a permanent and total disability will be eligible to have his/her Life Insurance extended, without premium payments, provided his/her claim for Premium Waiver extension is approved by Aetna.

An employee must meet the following conditions to be eligible:

- Life Insurance must be in force for the employee when the employee becomes totally disabled; and
- The employee leaves work due to disease or injury that causes the total disability before reaching a specific age as stated in the policy (usually 60); and
- The permanent and total disability must last for at least the number of months indicated in the policy; and
- The employee must give Aetna any proof to support the claim when requested during the first two years after the PW was approved. After that, the employee must give Aetna proof once a year.

Some policies do vary, so be careful to check your Group Policy for the specific terms that apply to your Group Policy. If an employee is eligible for PW benefits, a notice of the claim must be submitted to Aetna no later than the filing limit indicated in the Policy. Notice received outside of this timeframe will be treated as late and the claim will be denied without further consideration.

If the employee is not eligible for PW benefits (for example, the employee was over the age limit, not disabled or filed late), please refer to "Disabilities – General Information," which appears later in this chapter.

Non-Premium Waiver – disability claims

If your Group Policy does not include a PW provision and Aetna has agreed to investigate claims for total disability on your company's behalf (for example, Death Benefit Only/Aetna Investigates Disability, referred to as DBO/AID), an employee who is not able to work due to a permanent and total disability will be eligible to have his/her Life Insurance extended, subject to continued premium payments, provided the disability claim is approved by Aetna.

Similar to the Premium Waiver provision discussed before, Life Insurance must be in force for the employee when the employee becomes totally disabled; the permanent and total disability must last for at least the number of months indicated in the Policy; the disease or injury that causes the total

disability must begin prior to the specific age limit (usually 60); and, the employee must furnish Aetna any proof to support the claim when requested during the first two years after the claim was approved. Thereafter, the employee must furnish Aetna with such proof once a year.

Again, some policies do vary, so be careful to check your Group Policy for the specific terms that apply to your Group Policy.

If an employee becomes disabled, a Life Insurance Continuation form must be submitted to Aetna no later than the timely filing limit indicated in the Policy. A Life Insurance Continuation form received outside of this timeframe will be treated as late and will be denied without further consideration.

If the employee is not eligible (for example, the employee was over the age limit, not disabled or did not file in a timely manner), please refer to "Disabilities – General Information."

If the Aetna Policy terminates, then coverage ceases for anyone on disability extension.

Note: If your Group Policy allows coverage to continue for totally disabled employees and your company makes the total disability determination, it is not necessary to submit a Group Disability claim application to Aetna.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Premium Waiver (continued)

Disabilities – general information

If an employee is away from work due to disease or injury and the employee is not able to meet the test of disability or was late in applying for the disability extension, Life Insurance may be continued by payment of premiums for up to a maximum of 12 months from the date the employee last worked. You have the option of discontinuing this continuation period at any time. At the end of this continuation period, the employee must apply (that is, convert) for a policy of individual insurance in order to remain covered for Life Insurance.

Please refer to your Policy for conversion availability and timing restrictions for submitting written conversion applications and premium payments.

Disability claims – employer's role and responsibilities

If the employee has been continuously away from work for nine months due to a disability, then you should submit a notice of disability claim to Aetna's Life Insurance Service Center. This notice (that is, the Group Disability claim form) must be submitted to Aetna no later than 12 months from the date that the employee last worked. When submitting the notice, please also include with it any additional information you may have that might help Aetna substantiate that the employee is permanently and totally disabled.

Upon approval of a claim for PW benefits, you should immediately discontinue

payment of any Life Insurance charges for the disabled employee's coverage. For policies without a Premium Waiver extension, premium payments must continue in order for Life Insurance to remain in effect.

Disability claims – employee responsibilities

In addition to submitting the Life Insurance Continuation form (as described later in this chapter), when applying for PW or DBO/AID benefits, the insured employee must also have his/her physician complete the attending physician's statement form. See "Attending Physician Statement form" later in this chapter. Disabled employees who are approved for Premium Waiver or DBO/AID benefits will be periodically required to furnish proof of continuous disability. When such proof is required, we will work directly with the employee to secure the necessary documentation. If the required proof is not submitted within 31 days or if we determine the disability has ceased, Aetna reserves the right to automatically terminate coverage, with written notice to the disabled employee and a copy to you.

Disability claims – submitting notice of claim for disability benefits

Once both the Life Insurance Continuation and Attending Physician Statement forms have been completed and returned to you by the employee or the employee's representative, fax or mail them to the Life Insurance Service Center. If faxing, please fax the claim application to 1-800-238-6239.

Completing a Life Insurance Continuation form

The employee is responsible for completing Sections 1-3. As the employer, you are responsible for completing section 4.

Before submitting the Life Insurance Continuation form, please check to make sure all sections have been thoroughly completed. Missing or incomplete information will only delay approval of the disability claim.

Section 1 - Employee information

- 1. The employer's name.
- 2. If the employer has more than one location, the employee must list the location where he or she was working when disability caused active work to cease. If there is only one location, the employee should write N/A.
- The employee's full name, first, middle, last. (Do not use nicknames or abbreviations.)
- 4. The employee's date of birth (day, month and year).
- 5. The employee's sex.
- 6. The employee's address (street, city, state, zip code).
- 7. A daytime phone number where the employee can be reached.
- 8. The occupation at the time of the disability.
- 9. The cause of the disability. If more space is needed, attach a separate sheet.

Section 2 - Attending physician

- 1. The name(s) of physicians treating the employee for the disability.
- 2. The physician's address (street, city, state, zip code).
- 3. The conditions the employee is being treated for.

Section 3 - Release

- 1. The insured's signature.
- 2. The date the insured signs the release.

Section 4 – Employer information

- Your Group Policy's control number. (Refer to your Billing Statement.)
- 2. Your Group Policy's control suffix number. (Refer to your Billing Statement.)
- 3. You Group Policy's control claim account. (Refer to your billing statement.)
- 4. The employee's Social Security number.
- 5. How the employee was paid prior to his/her disability.
- 6. The amount of Life Insurance in force (basic and Supplemental) at the time the disability began.
- 7. The employee's rate of basic earnings when the disability began.
- 8. The reason the employee did not return to work after the last day worked.
- 9. The date the employee last worked.

- 10. If insurance was not in force on the date the disability began, list the date the insurance discontinued.
- 11. Please check the type of disability provision included in your Group Policy.
- 12. The date the employee first began work for you.
- 13. The date the employee's insurance took effect.
- 14. Indicate whether the employee had previously been required to furnish Evidence of Insurability. If yes, give the date the evidence was submitted.
- 15. Complete this section only if the employee is covered for Paid-Up Life Insurance.
- 16. If the employee contributes toward the cost of Life Insurance coverage, the date the employee's last contribution covered him/her for (period ending).
- 17. The employer's address (street, city, state, zip code).
- 18. A daytime number where the person completing this form can be reached.
- 19. Signature of an authorized company representative.
- 20. Date signed.

Please note: Applications for PW must include beneficiary forms. Applications for PW or DBO/AID that include a supplemental benefit must include enrollment forms.

Attending Physician's Statement form

The employee should complete the Patient Information and the Employer Information sections before giving the form to his/her physician. The remaining sections, 1-10, and the Remarks section are to be completed by the physician who is primarily responsible for the care and treatment of the employee.

When the application has been reviewed, you and the employee will be notified of the decision.

Once the Life Insurance Continuation form and Attending Physician's Statement form have been completed and returned to you by the employee or the employee's representative, fax or mail them to the Life Insurance Service. Please send the forms to us using the pink envelope (GC-1327). If mailing, please be sure you send the forms to the address listed for disability claims (see Customer Service Information chapter.) If faxing, please fax the claim application to 1-800-238-6239.

Life Insurance Continuation – Permanent & Total Disability Claim

page 1 of 2

1. Employee	Employer Name					Bran	ch	
Information	Employee Name		Birthdate (MA	M/DD/YYY	Y) Sex	Male [] Female	
	Address (street, city, state, zip o					ime Telephor		
	Occupation		Cause of Disability			()		
	Остараны			Journal of Dies				
2. Attending Physician	Physician's Name		Physician's Add	ress		Co	ndition Tr	eated
Information	-							
List the physician(s) now								
attending you. Use back if more space is needed))					-		
		normadon concernin	g health care adv	rice, treatmen	it of Suj	oplies prov	rided the p	atient
4. Employer Information	(including that relating to benefits. Aetna may profor the purpose of review term of the policy or conthis authorization upon relation authorization upon relation Number Control Number	o mental illness and/ wide the employer na wing the experience stract under which a request and agree th	or AIDS/ARC/HIV amed above with and operation of t claim has been so at a photographic	/). This inform any benefit of the policy or ubmitted. I kr	nation v calculati contract now that authori	vill be used on used in t. This auth t I have a r	d to evalua payment norization ight to rec s valid as Date	ate claims for of this claim is valid for the eive a copy of
	(including that relating to benefits. Aetna may pro for the purpose of review term of the policy or con this authorization upon r Patient's or Authorized	o mental illness and/ wide the employer na wing the experience of stract under which a request and agree the Person's Signature Coverage Code TRM1 Amount of insurance in Force of Date Last Worked \$	or AIDS/ARC/HIV amed above with and operation of t claim has been so at a photographic Control Suffix	/). This inform any benefit of the policy or ubmitted. I know copy of this	nation vealculaticontraction that contraction that authorition aut	vill be used on used in the sauth that is authorized and the sauthorized and s	d to evalua payment norization ight to recess valid as	ate claims for of this claim is valid for the eive a copy of the original.
	(including that relating to benefits. Aetna may profor the purpose of review term of the policy or conthis authorization upon this authorization upon the Patient's or Authorized Control Number Employee is Hourly Salary Reason Employee Did Not Return to W Type of Coverage DBO-AID PTD (check one):	o mental illness and/wide the employer nawing the experience stract under which a crequest and agree the Person's Signature Coverage Code TRM1 Amount of insurence in Force of Date Last Worked Stork After Last Day Worked Premium Waive in Installment, pro	or AIDS/ARC/HIV amed above with and operation of t claim has been st at a photographic Control Suffix an Rate of Basic Earni \$ er vide terms	/). This inform any benefit of the policy or ubmitted. I know copy of this Claim Account	nation vealculaticontraction that authorion verted urly	vill be used on used in the control of the control	d to evalua payment payment payment payment payment to receive a valid as pate	ate claims for of this claim is valid for the eive a copy of the original,
	(including that relating to benefits. Aetna may profor the purpose of review term of the policy or conthis authorization upon this authorization upon this authorization upon this authorization upon this authorization upon the Patient's or Authorized Control Number	o mental illness and/wide the employer nawing the experience stract under which a crequest and agree the Person's Signature Coverage Code TRM1 Amount of insurence in Force of Date Last Worked Stork After Last Day Worked Premium Waive in Installment, pro	or AIDS/ARC/HIV amed above with and operation of t claim has been so at a photographic Control Suffix Rate of Basic Earni \$	/). This inform any benefit of the policy or ubmitted. I know copy of this Claim Account I have been been been been been been been be	nation vealculaticontraction that contraction that authorized urly	vill be used on used in the control of the control	d to evalua payment payment norization ight to recess valid as Date	ate claims for of this claim is valid for the eive a copy of the original,
	(including that relating to benefits. Aetna may profor the purpose of review term of the policy or conthis authorization upon this authorization upon the Patient's or Authorized Control Number Employee is Hourly Salary Reason Employee Did Not Return to W Type of Coverage DBO-AID PTD (check one):	o mental illness and/ wide the employer na wing the experience stract under which a request and agree th Person's Signature Coverage Code TRM1 Amount of insurence in Force of Date Last Worked Premium Waive Installment, pro Lump Sum ence of insurability?	or AIDS/ARC/HIV amed above with and operation of t claim has been st at a photographic Control Suffix In Rate of Basic Earnings Rate of Basic Earnings	/). This inform any benefit of the policy or ubmitted. I know copy of this Claim Account	nation vealculaticontraction that contraction that authorized the contraction of the cont	vill be used on used in the control of the control	d to evalua payment payment norization ight to rec s valid as Date	ate claims for of this claim is valid for the eive a copy of the original,
	(including that relating to benefits. Aetna may profor the purpose of review term of the policy or conthis authorization upon this authorization upon this authorization upon this authorization upon this authorization upon the patient's or Authorized Control Number	o mental illness and/wide the employer na wing the experience stract under which a request and agree the Person's Signature Coverage Code TRM1	or AIDS/ARC/HIV amed above with and operation of t claim has been st at a photographic Control Suffix The state of Basic Earnings Rate of Basic Earnings Rate of Basic Earnings	/). This inform any benefit of the policy or ubmitted. I know the copy of this copy of this copy of this copy of this copy of the copy of this copy of the copy of this copy o	nation vealculatic contraction with a contraction with a contraction with a contraction of the contraction o	vill be used on used in the tribing and the tribing and the tribing and tribin	to evalua payment payment to recommend to re	ate claims for of this claim is valid for the reive a copy of the original. Annual of Not in Force a Insurance Took Effect d-up Coverage) st renewal date f policy is
	(including that relating to benefits. Aetna may profor the purpose of review term of the policy or conthis authorization upon this authorization upon this authorization upon this authorization upon this authorization upon the patient's or Authorized Control Number	o mental illness and/wide the employer na wing the experience stract under which a request and agree the Person's Signature Coverage Code TRM1	or AIDS/ARC/HIV amed above with and operation of to claim has been st at a photographic Control Suffix Rate of Basic Earnings Rate of Basic Earnings Contributions s Paid-up Insura	/). This inform any benefit of the policy or ubmitted. I know the copy of this copy of this copy of this copy of this copy of the copy of this copy of the copy of this copy o	pation vealculation vealculation vealculation vealculation without authorition for the control of the control o	vill be used on used in the tribing and the tribing and the tribing and tribin	to evalua payment payment to recommend to re	ate claims for of this claim is valid for the reive a copy of the original. Annual of Not in Force a Insurance Took Effect d-up Coverage) st renewal date f policy is
	(including that relating to benefits. Aetna may profor the purpose of review term of the policy or conthis authorization upon this authorization upon this authorization upon this authorization upon this authorization upon the patient's or Authorized. Control Number	o mental illness and/wide the employer na wing the experience stract under which a request and agree the Person's Signature Coverage Code TRM1	or AIDS/ARC/HIV amed above with and operation of to claim has been st at a photographic Control Suffix Rate of Basic Earnings Rate of Basic Earnings Contributions s Paid-up Insura	/). This inform any benefit of the policy or ubmitted. I know the copy of this copy of this copy of this copy of this copy of the copy of this copy of the copy of this copy o	pation vealculation vealculation vealculation vealculation without authorition for the control of the control o	vill be used on used in the tribing and the tribing and the tribing and tribin	to evalua payment payment to recommend to re	ate claims for of this claim is valid for the series a copy of the original. Annual onlined if Not in Force is Insurance Took Effective acree of the original original original original original original original original

Life Insurance Continuation – Permanent & Total Disability Claim

page 2 of 2

5. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties. Attention Washington Residents: 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.

40-005 GC-9007 (1-07)

Page 2 of 2

XAetna

Attending Physician's Statement

- You may use the Remarks section on the reverse side if you need more room to respond.
- . The patient is responsible for completion of this form without expense to the company.

If you have any qu	estions, please contact the Customer Service Unit at 1-800-523-5	5065.		
Patient Information	Name	Social Security Num	nber Birthda	ate (MM/DD/YYYY)
	Address (include No. Streef, Town, State, Zip Code) Address is new			
Release	To all providers of health care: You are authorized to provide Aetna Life Insurance Company independent claim administrator and consulting health profess has contracted, information concerning health care advice, tre relating to mental illness and/or AIDS/ARC/HIV). This information may provide the employer named below with any benefit calcureviewing the experience and operation of the policy or contract contract under which a claim has been submitted. I know that request and agree that a photographic copy of this authorization Note: If the person signing this is the guardian or attorney-in-papers to Aetna and send a copy to the Attending Physe Employee or Authorized Person's Signature	ionals and utilization atment or supplies protion will be used to evilation used in payment. This authorization I have a right to recept as well as the confect for the claimant	review organizated ovided the patier valuate claims for this claim for its valid for the televice a copy of this priginal.	ions with whom Aetr nt (including that r benefits. Aetna or the purpose of erm of the policy or authorization upon
Employer	Name and Address		Contro	Number
Information				
	(b) Date symptoms first appeared of accident happened	IVIO	Day	
	(b) Date symptoms first appeared or accident happened (c) Date patient ceased work because of disability	☐Yes, state whe ent's employment?	n and describe. □ No □ Yes	S Unknown
2. Diagnosis	 (d) Has patient ever had same or similar condition? ☐ No (e) Is condition due to injury or sickness arising out of patie (f) Names and addresses of other treating physicians NameAddress 	☐Yes, state wheent's employment? Day Yr Dooratory data and an	n and describe. No Yes	unknown

Attending Physician's Statement page 2 of 3

Patient Information	Name Social Security Number						
4. Nature of Treatment	(a) Type and dates of treatment: (b) Prescribed medications:						
	(c) Surgical procedures and dates;						
5. Progress	(a) Patient has						
	Confined from through						
6. Cardiac (if applicable)	(a) Functional capacity limitation (American Heart Ass'n): (b) Blood Pressure (last visit): Systolic Class 1 (none) Class 3 (marked) Class 2 (slight) Class 4 (complete)						
7. Limitations	(a) What are patient's present capabilities?						
	(b) What are present limitations (physical and/or mental)?						
	(c) What restrictions are placed on patient?						
8. Physical Impairment *As defined in	☐ Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%) ☐ Class 2 - Medium manual activity.* (15-30%) ☐ Class 3 - Slight limitation of functional capacity; capable of light work.* (35-55%)						
Federal Dictionary of Occupational Titles.	□ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%) □ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) □ Remarks:						
Dictionary of Occupational	☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%)						
Dictionary of Occupational Titles. 9. Mental/ Nervous Impairment	Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) Remarks:						
Dictionary of Occupational Titles. 9. Mental/ Nervous Impairment	Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) Remarks: Please define "stress" as it applies to this claimant.						
Dictionary of Occupational Titles. 9. Mental/ Nervous Impairment (if applicable)	Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) Remarks: Please define "stress" as it applies to this claimant. Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? □ No □ (a) What is the patient's prognosis? □ Guarded □ Good □ Fair □ Poor □ Other (b) When do you feel patient's maximum medical improvement will be reached? □ 1 Mo. □ 1-3 Mos. □ 3-6 Mos. □ 6-9 Mos. □ 1 yr. or longer (c) What is the estimated date of the patient's return to work? □ own job/occ □ other occ □ no return expected (d) Do you consider the patient to be a viable candidate for Vocational Rehabilitation (job retraining)?						
Dictionary of Occupational Titles. 9. Mental/ Nervous Impairment (if applicable) 10. Prognosis	Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) Remarks: Please define "stress" as it applies to this claimant. Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? □ No □ (a) What is the patient's prognosis? □ Guarded □ Good □ Fair □ Poor □ Other (b) When do you feel patient's maximum medical improvement will be reached? □ 1 Mo. □ 1-3 Mos. □ 3-6 Mos. □ 6-9 Mos. □ 1 yr. or longer (c) What is the estimated date of the patient's return to work? □ own job/occ □ other occ □ no return expected (d) Do you consider the patient to be a viable candidate for Vocational Rehabilitation (job retraining)?						
Dictionary of Occupational Titles. 9. Mental/ Nervous Impairment (if applicable) 10. Prognosis	Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) Remarks: Please define "stress" as it applies to this claimant. Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? □ No □ (a) What is the patient's prognosis? □ Guarded □ Good □ Fair □ Poor □ Other (b) When do you feel patient's maximum medical improvement will be reached? □ 1 Mo. □ 1-3 Mos. □ 3-6 Mos. □ 6-9 Mos. □ 1 yr. or longer (c) What is the estimated date of the patient's return to work? □ own job/occ □ other occ □ no return expected (d) Do you consider the patient to be a viable candidate for Vocational Rehabilitation (job retraining)?						
Dictionary of Occupational Titles. 9. Mental/ Nervous Impairment (if applicable) 10. Prognosis	Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) Remarks:						
Dictionary of Occupational Titles. 9. Mental/ Nervous Impairment (if applicable) 10. Prognosis	Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary*) activity. (75-100%) Remarks: Please define "stress" as it applies to this claimant. Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? □ No □ (a) What is the patient's prognosis? □ Guarded □ Good □ Fair □ Poor □ Other (b) When do you feel patient's maximum medical improvement will be reached? □ 1 Mo. □ 1-3 Mos. □ 3-6 Mos. □ 6-9 Mos. □ 1 yr. or longer (c) What is the estimated date of the patient's return to work? □ own job/occ □ other occ □ no return expected (d) Do you consider the patient to be a viable candidate for Vocational Rehabilitation (job retraining)? □ Yes □ No, please explain Attending Physician's Name (print) □ Degree						

Attending Physician's Statement

page 3 of 3

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

GC-1430 (6-06) A-POD Page 3 of 3

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Accelerated Death Benefit

What is ADB?

If your Group Policy includes the Accelerated Death Benefit ('ADB') feature, employees and spouses of the employees may be eligible to receive an early payment of their Life Insurance benefit in the event they are diagnosed with a terminal illness.

What is the definition of terminal illness under ADB?

An employee or spouse is considered terminally ill if he or she suffers from an incurable, progressive and medically recognized condition and, to a reasonable medical probability and based on generally accepted prognostic protocol, will not survive normally more than six, 12 or 24 months, dependent on the policy language.

How much is payable?

The minimum ADB that can be requested is \$5,000,* the maximum ADB that may be requested is up to 75 percent of the total Life Insurance amount, not to exceed \$500,000 dependant on the Policy language. Upon payment of the ADB, the person's Life Insurance amount will be reduced by the amount of the benefit received as shown in the following example. Premiums will also be reduced accordingly.

Policies vary so check your Group Policy for the specific terms that apply to this benefit.

Example:

- (a) Amount of Life Insurance prior to a request for an ADB = \$100,000
- (b) ADB requested and approved at 50 percent = \$50,000
- (c) Amount of Life Insurance remaining after payment of the ADB = \$50,000

The above terms apply in most instances; however, they may vary from state to state. In addition, the ADB may be reduced by an interest charge. Please refer to the Accelerated Death Benefit section of your Group Policy for the specific terms that apply to your Policy.

More information

If your Group Policy includes the ADB feature, a letter that explains the ADB feature for employees is shown next. Aetna recommends that you copy this letter on your company letterhead and give it to your employees when they first become covered for Life Insurance. Again, this letter should only be given to employees if your Policy includes the ADB feature.

In the unfortunate event of terminal illness, you or the employee must request an Accelerated Death Benefit Claim Kit. The claim kit contains all the necessary forms, including instructions a person will need to follow in order to request an ADB. A sample ADB form is shown later in this chapter.

^{*}CT - No minimum; NY - The lesser of \$50,000 and 25 percent of the amount of your Life Insurance then in force; PA -25 percent of the death benefit amount.

Plan sponsor letter to employees

Dear Employee:

Terminal illness is not a subject many of us want to talk about, much less experience. However, in planning for the future, each of us needs to consider this situation and its impact on our family's emotional and financial well-being.

We need to consider the fact that the impact of a terminal illness does not end when the person dies. The cost of services and treatment not covered under your health insurance plan can have a serious impact on your family's financial health during and following the illness.

To help you preserve your life savings, we are introducing an Accelerated Death Benefit under the Group Term Life Insurance policy issued by Aetna Life Insurance Company.

The following questions and answers will help you understand how this feature works.

What is an Accelerated Death Benefit (ADB)?

ADB, often referred to as a living benefit, provides an early payment of up to 75 percent of the Life Insurance benefit available under your or your spouses term life policy, in the event you or your spouse is diagnosed with a terminal illness.

An employee or spouse is considered terminally ill if he or she suffers from an incurable, progressive and medically recognized condition, and, to a reasonable medical probability and based on generally accepted prognostic protocol, will not survive more than 6,12 or 24 months. Aetna will make the final determination based on medical documentation submitted by your physician.

Who is eligible for ADB?

The ADB feature is available to covered employees and covered spouses. It does not apply to covered children.

How does an individual activate this benefit?

You may apply through your company's benefits department, which will provide you with a claim form. The benefit is payable in a lump sum. You should consult your tax professional to determine the consequences of this benefits payment.

Upon payment of the ADB, the policy participant's Life Insurance coverage will be reduced by the amount of the benefit received. Premiums will also be reduced accordingly.

What is the cost of ADB?

There is no additional cost included in the Life Insurance rates. The ADB payment, however, may be reduced by an interest charge. The interest charge will be calculated on the amount of the benefit you elect to receive. Typically, the interest rate used is the current yield on 90-day Treasury Bills, as of the date of application for the ADB.

	f you nee	need more information abo	out ADB, contact tl	he Benefits	department
--	-----------	---------------------------	---------------------	-------------	------------

Sincerely,
(NI)
(Name) (Title)
(Company)

*CT - No minimum; NY - The lesser of \$50,000 and 25 percent of the amount of your Life Insurance then in force; PA -25 percent of the death benefit amount.



****INSTRUCTION PAGE****

Enclosed please find:

- · An Application for Accelerated Death Benefit
- A Request for Medical Documentation letter
- · Two Authorizations to Release Information
- An Authorization to Obtain Information
- Attending Physician's Statement
- · A sample letter to the employee
- · An Accelerated Death Benefit Disclosure Statement
- An Accelerated Death Benefit Assignee Consent Form
- · A Questions and Answer Sheet
- · Accelerated Death Benefit Forms on File Server Guide

Steps to follow:

- Complete the Employer section of the "Application for Accelerated Death Benefit" and forward it with the remainder of the forms to the employee.
- 2. For employees and spouses of an employee who are eligible for an Accelerated Death Benefit, Aetna provides the member with valuable and direct access to a licensed social worker who can assist them with the delivery of their life, health care and emotional needs. Our care advocate is sensitive to the physical, emotional, spiritual and culturally diverse needs of individuals and families who are facing tough decisions associated with a life-limiting illness. Our dedicated care advocate is available to the member during normal business hours and is available to assist the member with any questions they may have with completing the enclosed forms and may be reached by calling: 1-800-276-5120.
- If coverage is contributory, forward the current and prior 2 years enrollment forms through the Portal by attachment or by fax to 1-800-238-6239 or by mailing the forms to Aetna, P.O. Box 14549, Lexington, KY 40512-4549. To overnight the information send it to: ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- Forward the Accelerated Death Benefit claim kit to the employee.
- 5. The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" form and return it with the signed copies of the "Authorization to Release Information" and the "Authorization to Obtain Information" forms to the Aetna. If assistance is needed during the claim process, contact our Customer Service Unit at 1-800-523-5065.
- 6. If the employee has completed an Absolute Assignment, the Assignee must authorize the Aetna to review the Accelerated Death Benefit claim and to issue benefits to the insured. The employee must send the "Assignee Consent" form to the Assignee. The Assignee must complete the form and return it to Aetna. The completed forms may be mailed or faxed to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
 Fax Number 1-800-238-6239. To overnight the information send it to ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization to Release Information" form and send them to their physician(s) along with the Attending Physician's Statement.
- The medical documentation should then be mailed or faxed to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington KY 40512-4549

 Fax Number: 1-800-238-6239 along with a copy of the "Request for Medical Documentation letter". To overnight the medical documentation send it to: ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.

GC-1582 (3-07) MA PAGE 1 of 17

	If yes, please provide the following	ng information:	son or entity?	es LI No		
	Assignee Name					
	Telephone Number			X . A . B .	AS AG AS	CIAGA
	The completed form must be ma Lexington, KY 40512-4549 Fax I	iled or faxed to Number 1-800-2	Aetna Life Insurance	Service Ce	nter, P.O. Box	14549, ACS Inc. Attn: Life
Plan Sponsor:	Claims, 101 Yorkshire Boulevard	d, Lexington, KY forward the pac claimant's prior t Center, P.O. Bo To overnight the	40509. kage to the employe wo years enrollment x 14549, Lexington, e information send it	e. When the forms to: KY 40512- to:	employee retu 4549	
Section A:		of forksille bo				
Employer Name	and Address		Control-Suffix-Accou Control-Suffix-Accou			
			Amount of Basic Inst			(TRM1 or 2)
			Amount of Optional I			(TRM3 or 4)
If insurance \$	is based on earnings, basic rate of e		ast worked.	'ear		
2. a Effective I	Date of Employee's Insurance		3. Are premiu	ıms still bein	g paid on this er	mployee?
b. Effective I Sex	Date of Spouse's Insurance	6. Date Last Wo	Yes Yes		mber or Social Se	acurity Number
☐ Male ☐	Female			Jei uilcate NU	THINGS OF SOCIAL SE	ounty Number
 Was the em Note: If yes 	ployee required to submit evidence of , date evidence submitted:	of insurability?	☐ Yes ☐ No			
What is the	Disability Provision?	remium Waiver		DBO-AID	☐ DBO	
Our Premiur	m Waiver department will contact you ee submitted a claim for permanent	u regarding your	eligibility.	No		
Note: If yes	s, date claim submitted:	com alconomity :	Ц (66			
 Maximum al Basic 	llowable ADB \$	ai	nd/or %			
Optional	\$		nd/or%			
ection B: Employee's Name	me & Address a & Address (if applicable)	K I IFE INE	Date of Birth	Social Se	curity Number	Telephone Number
opouse s marrie	a vidaress (ii applicable)		Date of Birth	Occidi oc	curry rvarrisci	receptione (variable)
Caregiver Name	e & Address		Telephone Number		Relationship	to Claimant
			lo, please provide the	e name, add	ress and teleph	none number of the
s the claimant	currently residing at home? Ye	es L No Ifr	And the state of the state of the			
ls the claimant o						
ls the claimant current residence.	ce. edical coverage through Aetna?	Yes No	Group	Number		
Is the claimant current resident Do you have me If yes, please pro Member Service	ce. edical coverage through Aetna? ovide your ID Number Stelephone Number	Yes No	Group (This in	Number formation is	found on your A	etna ID card).
Is the claimant of current residence. Do you have me if yes, please promote the moder Service of the promote the moder service of no, please promote the moder service of the modern	ce. edical coverage through Aetna? ovide your ID Number Telephone Number vide the following:	Yes No	Group (This in	Number formation is	found on your A	setna ID card).
s the claimant of current residence. Do you have me f yes, please promotes the promotes of th	edical coverage through Aetna? ovide your ID Number es Telephone Number vide the following: ess of your Medical insurer	Yes No	7	formation is Insurer's 1	elephone Numl	
Is the claimant of current residence. Do you have meet yes, please promote yet yes, please prowers and Addroup/Plan Numers.	edical coverage through Aetna? ovide your ID Number es Telephone Number vide the following: ess of your Medical insurer	Yes No ID Number Basic	\$	formation is Insurer's 1	elephone Numl	ber
Is the claimant of current residence. Do you have me lif yes, please proper Service of no, please propers and Address propers and Address proup/Plan Nun Amount of access	edical coverage through Aetna? edical coverage through Aetna? ovide your ID Number es Telephone Number vide the following: ess of your Medical insurer mber Member elerated death benefit requested:	Yes No ID Number Basic Optional	\$	formation is Insurer's 1	elephone Numl	ber
Is the claimant of current residence. Do you have me if yes, please prowers be provided from the please proward and Address of the please prowers. The amount of acce. Note: The amount of policy's issue.	edical coverage through Aetna? edical coverage through Aetna? ovide your ID Number es Telephone Number ovide the following: ess of your Medical insurer nber	Yes No ID Number Basic Optional mount shown in lag in New York: If	\$sssssssccelerated	Insurer's 7	elephone Numl d/or d/or	per
Is the claimant ocurrent residence Do you have me If yes, please pro Member Service If no, please pro Name and Addro Group/Plan Nun Amount of acce Note: The amou For policy's issu assistance prog	edical coverage through Aetna? edical coverage through Aetna? es Telephone Number ess of Jour Medical insurer mber Member elerated death benefit requested: unt you request cannot exceed the a led in New York or Claimant's residing rams such as medical assistance (Member elerated in New York or Claimant's residing rams such as medical assistance (Member elerated in New York or Claimant's residing rams such as medical assistance (Member elerated in New York or Claimant's residing elerated e	Yes No ID Number Basic Optional mount shown in Ing in New York: Fedicaid), Aid to Fedicaid)	\$sss	Insurer's 7 and and death benefint Children a	elephone Numl d/or d/or d/or street eli its may affect eli nd Supplementa	ber
Is the claimant current residence Do you have me If yes, please pro Member Service If no, please pro Name and Addro Group/Plan Nun Amount of acce Note: The amount For policy's issu assistance programmed Receipt of accelerated deat	edical coverage through Aetna? edical coverage through Aetna? ovide your ID Number es Telephone Number wide the following: ess of your Medical insurer Member elerated death benefit requested: unt you request cannot exceed the a sed in New York or Claimant's residing rams such as medical assistance (Merated death benefits in periodic pay th benefits, policyowners or certifical	Yes No ID Number Basic Optional mount shown in Ing In New York: A edicaid), Aid to Fiments may be tre the holders should	\$ssssssss_	Insurer's Tangent death benefit Children a luoppitate societ in a luoppitate societ so	elephone Numi d/or d/or its may affect eli nd Supplementa mp sum. Prior al services agen	gibility for public al Security Income. to applying for cy concerning how
Is the claimant ourrent residence Do you have me If yes, please pro Member Service If no, please pro Name and Addro Group/Plan Nun Amount of acce Note: The amount For policy's issue assistance programs Receipt of accelerated deat receipt will affect be taxable. Receipt such benefits	edical coverage through Aetna? edical coverage through Aetna? ovide your ID Number es Telephone Number vide the following: ess of your Medical insurer Member elerated death benefit requested: unt you request cannot exceed the a led in New York or Claimant's residir rams such as medical assistance (Merated death benefits in periodic pay the benefits, policyowners or certificat the eligibility of the recipient and/or eipt of accelerated death benefits in ps, policyowners or certificate holders	Yes No ID Number Basic Optional mount shown in I g in New York: I edicaid), Aid to Fi ments may be tre te holders should the recipient's si periodic payment should seek ass	\$	Insurer's Tananaman death benefit Children aleceipt in a lu opriate socia Further, recrently than red tax adviso	elephone Number of Albert elling Supplementa mp sum. Prior tal services agencient of accelerate ceipt in a lump or, in addition, no	gibility for public all Security Income. to applying for cy concerning how ed death benefits may sum. Prior to applying health care facility as
Is the claimant current residence of a control of the control of t	edical coverage through Aetna? edical coverage through Aetna? es Telephone Number ess of your Medical insurer mber Member elerated death benefit requested: unt you request cannot exceed the a led in New York or Claimant's residir rams such as medical assistance (Merated death benefits in periodic pay th benefits, policyowners or certifical t the eligibility of the recipient and/or elipt of accelerated death benefits in elipt of accelerated death elipt of accelerated death elipt of accelerated death elipt of accelerated death elipt of accelerated elipt elipt of accelerated elipt elipt of accelerated elipt elip	Yes No ID Number Basic Optional mount shown in I g in New York: I edicaid), Aid to Fi ments may be tre te holders should the recipient's si periodic payment should seek ass	\$	Insurer's Tananaman death benefit Children aleceipt in a lu opriate socia Further, recrently than red tax adviso	elephone Number of Albert elling Supplementa mp sum. Prior tal services agencient of accelerate ceipt in a lump or, in addition, no	gibility for public all Security Income. to applying for cy concerning how ed death benefits may sum. Prior to applying health care facility as
Is the claimant current resident current resident current resident page 5 of 10 yes, please promotes fro, please promotes and Addragroup/Plan Num Amount of accel Note: The amoi For policy's issu assistance progreceipt will affect be taxable. Receipt of accelerated deat receipt will affect be taxable. The taxable will be taxable will	edical coverage through Aetna? edical coverage through Aetna? ovide your ID Number es Telephone Number wide the following: ess of your Medical insurer Member Member elerated death benefit requested: unt you request cannot exceed the a sed in New York or Claimant's residing rams such as medical assistance (Merated death benefits in periodic pay the benefits, policyowners or certificat the eligibility of the recipient and/or eipt of accelerated death benefits in s, policyowners or certificate holders 20 of the Public Health Law can require 20 of the Public Health Law can require	Yes No ID Number Basic Optional mount shown in lag in New York: Redicaid), Aid to Fiments may be trette holders should the recipient's speriodic payment is should seek asse any person to account and without coern and without coern and without coern (a) (d). New York information specifications and without seek asset and without coern (a) (d). New York information specifications (b)	\$	Insurer's and an and death benefit Children and eceipt in a lu opriate social Further, recrently than red tax adviso eath benefit a hird party, etter to the point prohibits Aence Law §32:	Telephone Number of Control of Co	gibility for public al Security income. to applying for cy concerning how ed death benefits may sum. Prior to applying health care facility as drnission to such health tifficate holder containing accelerated death ed in writing to the polic
Is the claimant of current residence of you have melf yes, please properties of no. please prope	edical coverage through Aetna? dedical coverage through Aetna? ovide your ID Number es Telephone Number vide the following: ess of your Medical insurer nber	Yes No ID Number Basic Optional mount shown in lag in New York: Redicaid), Aid to Fiments may be trette holders should the recipient's speriodic payment is should seek asse any person to account and without coern and without coern and without coern (a) (d). New York information specifications and without seek asset and without coern (a) (d). New York information specifications (b)	\$	Insurer's and an and death benefit Children and eceipt in a lu opriate social Further, recrently than red tax adviso eath benefit a hird party, etter to the point prohibits Aence Law §32:	Telephone Number of Control of Co	gibility for public il Security Income. to applying for cy concerning how ed death benefits may sum. Prior to applying health care facility as dmission to such health tificate holder containing accelerated death ed in writing to the policy

page 3 of 17

Claimant's Name Social Security Number

Section C:

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

Date Signature of Employee Telephone

GC-1582 (3-07) MA PAGE 3 of 17

XAetna

Request for Medical Documentation

Date	
Group Policy No:	Employer:
Employee Name:	Employee's SSN:
Spouse Name (if applicable):	Spouse's SSN:
Dear Physician:	
have elected to claim part of my group life ins is less than months (specified under the	surance benefits to which I may be entitled if my life expectancy e Plan).
must provide the following medical documental eligibility:	ation to the Insurance Company for evaluation of benefit
treatment, Clinical records for the terminal disease. An assessment of mental competency. Names, addresses, and phone numbers of a Your assessment on the medical probability provide the medical rationale in support of your it is medically probable that my life expectation projected life expectancy. If you are unable contact me if this situation changes. Attached is a signed Release authorizing you to	that my life expectancy will be () months or less. Please our opinion. ancy will exceed () please provide an opinion on my to establish a projected life expectancy at this time, please to submit the requested information to the Insurance Company, with a copy of this letter to assure proper identification, ddress is: Box 14549, Lexington, KY 40512-4549. the information send it to:
Thank you for your prompt assistance in this m	natter.
Signature of employee	Date
Signature of spouse (if applicable)	Date
	Medical Documentation. Send this request and the Physician's
	ease Medical Information form to your physician.



Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Nam	ne
Employee's SSN	r
Spouse's Name	(if applicable)
pouse's SSN	
Employer	
o all Physicians	SC.
ne person for wi	ted to provide Aetna Life Insurance Company information concerning the health condition of thom information is being requested. HIV tests results may be released pursuant to this formation will be used for the purpose of evaluating and administering a request for an other Benefit.
	de the employer named above with any benefit calculation used in payment of this claim for eviewing the experience and operation of the policy or contract.
	on is valid for the term of coverage of the contract under which a request for an Accelerated as been submitted.
Aetna Life Insu ax Number: 1-	e required medical information immediately to: rance Service Center, P.O. Box 14549, Lexington, KY 40512-4549 800-238-6239. To overnight the information send it to: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
opy of this auth	e a right to receive a copy of this authorization upon request, and agree that a photographic orization is as valid as the original. I understand that I am responsible for any charges made for providing medical information.
ate	Signature of employee, or his/her Authorized Representative*
ate	Signature of spouse, or his/her Authorized Representative* (if applicable)
	Representative is signing this Release, please attach legal documentation as proof of such both the Physician's Copy and the Insurance Company Copy.
M	ign and date both copies of this Release. Send the Physician's copy with the Request for ledical Records to your physician. Return the Insurance Company Copy to the Employer with the Application for Accelerated Death Benefits.
	Physician's Copy

GC-1582 (3-07) MA PAGE 5 of 17

page 6 of 17



Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

	INFORMATION
Employee's Nam	e
Employee's SSN	
Spouse's Name (if applicable)
Spouse's SSN	
Employer	
Primary Care Ph Name:	nysician
Address:	
Telephone #:	
To all Physicians	
the person for wh	ed to provide Aetna Life Insurance Company information concerning the health condition of nom information is being requested. HIV tests results may be released pursuant to this permation will be used for the purpose of evaluating and administering a request for an the Benefit.
	le the employer named above with any benefit calculation used in payment of this claim for viewing the experience and operation of the policy or contract.
	n is valid for the term of coverage of the contract under which a request for an Accelerated s been submitted.
	required medical information immediately to:
	ance Service Center, P.O. Box 14549, Lexington, KY 40512-4549 300-238-6239. To overnight the information send it to:
	Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
copy of this author	e a right to receive a copy of this authorization upon request, and agree that a photographic orization is as valid as the original. I understand that I am responsible for any charges made for providing medical information.
Date	Signature of employee, or his/her Authorized Representative*
Date	Signature of spouse, or his/her Authorized Representative* (if applicable)
	Representative is signing this Release, please attach legal documentation as proof of such oth the Physician's Copy and the Insurance Company Copy.
Me	gn and date both copies of this Release. Send the Physician's copy with the Request for edical Records to your physician. Return the Insurance Company Copy to the Employer with Application for Accelerated Death Benefits.
	Insurance Company Copy
GC-1582 (3-07) MA	PAGE 6 of 17

60

page 7 of 17



Authorization To Obtain Information Aetna Life Insurance Service Center P.O. Box 14549

Macula	For Insurance Benefits	Lexington, KY 40512-4549 Telephone Number: 1-800-523-5065 Fax Number: 1-800-238-6239
Land Comment	(print name)	
Relationship to insured Self Spouse		
Parent	£ = 6.0 × £ · · · · · · 6 × · · · · · · · · · · · ·	
	ative (attach copy of appointment by court) ealthcare Power of Attorney/Guardian (attach copy c	of appointment by court)
	ealificate Power of Altomey/Guardian (altach copy to	
records on(prin	SSN	Ī-
from any physician, med company, claim adminis higher learning or emplo	it riame) dical practitioner or health care professional, hospita strator, bank or financial institution, credit reporting a byer to release the following information to Aetna Life inistrators and consulting health professionals with w	gency, university, college or institution of e Insurance Company (Aetna) and any
including test results	information (including that related to mental illness, s) concerning health care, advice, treatment or suppli cords, histories, physical or diagnostic examinations	es furnished to the insured, including but not
 Employment informa 	tion and history, including job duties and earnings, ir	nformation pertaining to my credit history;
 Information regarding 	g school attendance, credits earned or school related	d activities
 Police records and re 	eports, Autopsy and Toxicology Reports (if applicable	e)
Workers' Compensat	ner individual and group life and accidental death and tion claims, and other claims filed, including amounts formation related to such other claims.	
Aetna Life Insurance S Fax Number: 1-800-23	red information immediately to: Service Center, P.O. Box 14549, Lexington, KY 40 8-6239. To overnight the information send it to: laims, 101 Yorkshire Boulevard, Lexington, KY 4	
administering the Accele	ation obtained by use of this authorization will be use erated Death Benefit claim on the claimant, and, for y be eligible for if the Application for the Accelerated	the administration of any other benefit or
I may revoke this Author on actions that Aetna ha disclosed may be protect longer protected by feder	id for the term of the policy or contract under which a rization at any time by notifying Aetna in writing, but as taken prior to receiving my written revocation. I ac cted by law and that information disclosed under this eral privacy regulations. I know that I have a right to a photographic copy of this authorization is as valid a	that such notification will not have any effect cknowledge that the information to be authorization may be redisclosed and no receive a copy of this Authorization upon
Signature	And Street Control of the Control of	Date;
Address		
Telephone Number		
	eing signed by the Claimant's legal representative, yo orney, health care power of attorney, court appointed entative.	
Obtain Information fro Ir	nt/Legal Representative: Sign and date this Authonsurance Benefits, Insurance Company Copy, along cation for Benefits. Send the Physician's copy along	with any relevant documents to your

Physician's Copy

GC-1582 (3-07) MA PAGE 7 of 17

page 8 of 17



Authorization To Obtain Information Aetna Life Insurance Service Center P.O. Box 14549

Acuia	For Insurance Benefits	Lexington, KY 40512-4549 Telephone Number: 1-800-523-5065 Fax Number: 1-800-238-6239
1	(print name)	
Power of Attorney/He		
records on	t name)	
from any physician, med company, claim adminis higher learning or emplo	t name) dical practitioner or health care professional, hospital strator, bank or financial institution, credit reporting ac over to release the following information to Aetna Life inistrators and consulting health professionals with w	I, clinic or other medical facility, insurance gency, university, college or institution of e Insurance Company (Aetna) and any
including test results)	nformation (including that related to mental illness, s) concerning health care, advice, treatment or supplic cords, histories, physical or diagnostic examinations	es furnished to the insured, including but not
 Employment information 	tion and history, including job duties and earnings, in	nformation pertaining to my credit history;
 Information regarding 	g school attendance, credits earned or school related	d activities
Police records and re	eports, Autopsy and Toxicology Reports (if applicable	e)
Workers' Compensat	ner individual and group life and accidental death and tion claims, and other claims filed, including amounts formation related to such other claims.	d dismemberment and disability coverage, s and dates of benefits awarded, medical
Aetna Life Insurance S Fax Number: 1-800-238	red information immediately to: Service Center, P.O. Box 14549, Lexington, KY 40 8-6239. To overnight the information send it to: aims, 101 Yorkshire Boulevard, Lexington, KY 4	
administering the Accele	ation obtained by use of this authorization will be use erated Death Benefit claim for insurance benefits on vice the claimant may be eligible for if the Application	the claimant, and, for the administration of
I may revoke this Author on actions that Aetna ha disclosed may be protect longer protected by feder	id for the term of the policy or contract under which a rization at any time by notifying Aetna in writing, but the as taken prior to receiving my written revocation. I ac cited by law and that information disclosed under this eral privacy regulations. I know that I have a right to re a photographic copy of this authorization is as valid a	that such notification will not have any effect cknowledge that the information to be authorization may be redisclosed and no receive a copy of this Authorization upon
Signature		Date;
Telephone Number		
	eing signed by the Claimant's legal representative, yourney, health care power of attorney, court appointed entative.	
Obtain Information fro In	nt/Legal Representative: Sign and date this Authonsurance Benefits, Insurance Company Copy, along cation for Benefits. Send the Physician's copy along	with any relevant documents to your

Insurance Company Copy

PAGE 8 of 17

62

GC-1582 (3-07) MA

page 9 of 17

Actno Attending Physician's

Send this form to: Aetna Life Insurance Company

Acula	2	Statement Acce Benefit Reques		d Dea	Atri Lex Tele	D. Box 14549 Lington, KY 40512-4549 ephone: 1-800-523-5065 LI: 1-800-238-6239
The patient is response to the com		ompletion of this form without				on the reverse side if you aplete this form in full.
	amed belov	y release of a portion of his/l v. In order to determine eligi				
Patient Information	Name		Relations Employee		Social Securi Number	Birthdate (MM/DD/YYYY)
	Address (i	nclude No. Street, Town, State	, Zip Code) [Addres	ss is new	-1
Employer Information	Name of E	mployee	Name of	Employer		Control Number
Diagnosis and History	Diagnosis	(including any complications)				
	IDC diagno	ostic code (mandatory)	Date of la	st examir	nation (MM/DD/Y)	YYY)
	Subjective	symptoms	-1			
	Clinical fi	findings (including current X-ra ndings: c Studies and Results:	ys, EKG's, lal	poratory o	data and any clin i	ical findings):
		any other illnesses, opportunist resent condition?			onditions, complice ease describe:	cations or significant findings
	Height	Weight Are there any	weight loss pa	atterns?	Yes N	o If "Yes," please describe:
	Date symp (MM/DD/Y	otoms first appeared or acciden YYY)	t happened	What is	the current stage	e of the insured's illness?
		nt ever had same or similar con ☐ No If "Yes," state when a			of any recurrence D/YYYY)	es Date patient ceased work because of disability MM/DD/YYYY)
2. Nature of Treatment	Type and	dates of treatment:				
	Prescribed	Medications:				
	Surgical pr	rocedures and dates:				
						40.4

page 10 of 17

Treatment (cont.)	How has patient responded to treatment?	
	Has Patient been hospital confined? Yes Confined from	☐ No If "Yes," give name and address of hospital. Through
3. Progress and	2, 446, 423	What is the patient's Activities of Daily Living status.
3. Progress and Limitations	Patient is: Ambulatory House confined Bed confined Hospital confined	What is the patient's Activities of Daily Living status.
	Performance Status Scale:	What restrictions are placed on the patient?
	Karonfsky% Or ECOG (Zubrod)	
Cardiac (if applicable)	Functional capacity limitation (American Heart Ass	n): Class 1 (none) Class 3 (marked) Class 2 (slight) Class 4 (complete
5. Mental Status	Do you believe the patient is competent to endorse	
e hamania	☐ Yes ☐ No What is the patient's Prognosis?	On what date did you dispuse the nations as to project the same of
6. Prognosis	What is the patient's Prognosis? ☐ Guarded ☐ Good ☐ Fair ☐ Poor ☐ Other	On what date did you diagnose the patient as terminally ill' (MM/DD/YYYY)
	Life Expectancy: Is the insured expected to die w If "Yes," how many months until the expected date	
7. Treating	Names and addresses of other treating physicians	
8. Remarks		
	Attending Physician's Name (print)	Specialty Degree
	Attending Physician's Name (print) Address (No., Street, City, State, Zip Code)	
	Address (No., Street, City, State, Zip Code)	Specialty Degree Telephone Number
		Specialty Degree

page 11 of 17

9. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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

Attention California, Ohio and Pennsylvania Residents: Any person who knowingly and with

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law,

Attention Kentucky Residents: 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 may subject such any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each

to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filling 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or claim c

information concerning any fact material thereto commits a fraudulent insurance act, which may be crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

GC-1582 (3-07) MA

PAGE 11 of 17

page 12 of 17



Sample Letter to Employee

<Date>

<Name>
<Address>
<City, State, Zip Code>

RE: Employee: <Employee's Name>
Plan Sponsor: <Plan Sponsor>
Control Number: <Control Number>

Dear < Name>:

We understand that you have requested to apply for an Accelerated Death Benefit. In order for Aetna Life Insurance Company, hereafter referred to as Aetna, to determine if you qualify for this benefit, please follow these instructions:

First, make sure you have received the items listed below:

- One Application for Accelerated Death Benefit
- One Request for Medical Records letter
- · Two copies of the Authorization to Release Information forms
- One Authorization to Obtain Information
- One Attending Physician's Statement
- One Accelerated Death Benefit Assignee Consent form to be completed when an Absolute Assignment has been
 executed
- One Accelerated Death Benefit Disclosure Statement

After you have read this letter:

- · Read the Disclosure Statement and keep it for your records.
- Complete and sign the employee section of the Application for Accelerated Death Benefit form.
 Sign and date both copies of the Authorization to Release Information forms and the Authorization to Obtain Information form. Send one copy of each completed form to the Aetna.
- Sign the Request for Medical Records letter and forward it along with the Authorization to Release Information form and the Attending Physician's Statement form to your physician. The Attending Physician's Statement and medical records must be returned to Aetna.
- If you completed an Absolute Assignment, send the Assignee Consent form to your Assignee for completion. The
 completed form must be returned to Aetna.

The information to be provided to Aetna may be mailed or faxed to: Aetna Life Insurance Service Center

P.O. Box 14549

Lexington, KY 40512-4549 Fax: 1-800-238-6239

To overnight the information to Aetna send it to: ACS, Inc.

Attn: Life Claims 101 Yorkshire Boulevard Lexington, KY 40509

Please be certain that either you or your physician provide Aetna with the necessary medical records for our use in determining your eligibility for this benefit.

In order to avoid delays when responding to this letter, please include the name and Social Security Number for the Insured or deceased in any correspondence.

If you need assistance or have any questions, regarding your claim, please contact Aetna's Customer Service Unit at 1-800-523-5065.

Sincerely,

<Name and Title>

Aetna Life Insurance Company

cc: <Plan Sponsor's Name>

GC-1582 (3-07) MA

page 13 of 17



Aetna Life Insurance Company Disclosure Statement at the Time of Application for Accelerated Death Benefit (ADB)

Any ADB paid by Aetna Life Insurance Company, in accordance with your request for payment under the terms of your Booklet-Certificate and the Group Policy, will be subject to the following.

While you may use the money you receive from this benefit for any purpose, including payment of long term care or nursing home expenses, the ADB in this life insurance policy is NOT part of long-term care or other nursing home coverage. Unlike conventional life insurance proceeds, an ADB payable under your life insurance coverage COULD BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use ADB benefits.

Consequences of this Benefit:

Receipt of an ADB MAY ADVERSELY AFFECT ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that your life insurance booklet-certificate includes an ADB may affect your eligibility for these government programs. In addition, exercising the option to receive an ADB and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

- A. Effect on your amount of Coverage under your Booklet-Certificate: Your death benefit amount will be REDUCED if you receive an ADB. Here is an illustration of the effect an ADB payment has on your Booklet-Certificate.
 - (1) Face Amount of Insurance: [\$40,000]
 - (2) Amount to be Accelerated (25% of Face Amount): [\$10,000]
 - (3) Amount of ADB Paid ([\$10,000]
 - (4) Amount of Insurance Remaining: [\$30,000]

	Konold It Williams
Signature of Applicant	Aetna Life Insurance Company

PLEASE KEEP THIS DISCLOSURE STATEMENT FOR YOUR RECORDS

1 11 10/11

GC-1582 (3-07) MA PAGE 13 of 17

XAetna

Accelerated Death Benefit Assignee Consent Form

payable on the life of	gai age and the assig	gnee(s) of the group life insura	arice policy benefits
1500 1700	NIEZY -		who is insured unde
Insured's		Social Security Number	
roup policy number		issued by Aetna Life Insur	ance Company (Aetna) to
		I/We hereby consent	and request Aetna to
Plan Sponso	r Name		
eview and pay the Acce	elerated Death Benef	it to	
Print Assignee Nam	ne -	Signature	Date
ssignee Address			Telephone Number
	idence of		
State/Prov			
State/Prov			
State/Prov County of On this	day of		, personally
County of On this Appeared before	day of me at	, 20_	, personally
State/Prov County of On this Appeared before State/Providence	day of me at of (Insert here the names	, 20, of all persons making this statemen	, personally , the above named
State/Prov County of On this Appeared before State/Providence	day of me at of (Insert here the names		, personally , the above named
State/Prov County of On this Appeared before State/Providence and made oath the	me at day of of (Insert here the names nat the statements an	, 20, of all persons making this statemen	, personally , the above named

XAetna

Questions and Answer Sheet

This sheet is intended to provide information on commonly asked question as by Employers and employees.

What is involved in the Claim Process?

A claim kit will be provided to you by your sales or service representative that will include:

- An Application for Accelerated Death benefit. Complete the Employer section of the application and forward it with the remainder of the forms to the employee.
- The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" and return it with the "Authorization to Release Information" to their employer.
- The employer will send the "Application", "Authorization to Release Information" along with the prior two years enrollment forms to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
 Fax Number 1-800-238-6239. To Overnight the information send it to:
 ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- A Disclosure Statement
 - (a) Standard Option. This form applies when the employee does not incur an interest charge that is deducted from his/her benefit. This document provides the claimant with basic information on how the ADB benefit will impact the life benefit.
 - (b) Discount Option. This form applies when there is an interest charge deducted from the ADB payment. The interest charge deducted is equal to the current rate of a three-month United States Treasury bill in effect on the date of payment and is calculated for the period of the life expectancy period as stated in the contract.
- The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization To Release Information" and send them to their physician(s) along with the "Attending Physician's Statement".
- The medical documentation should be sent to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
 Fax Number 1-800-238-6239. To Overnight the information send it to:
 ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509 along with a copy of the "Request for Medical Documentation letter".

ADB Forms (GC-1459 & GC 1459-1) are available on the Forms Repository: http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

For State of Connecticut residents only – the interest charge is the Aetna standard rate not to exceed 8%.

GC-1582 (3-07) MA PAGE 15 of 17

page 16 of 17

What happens when Aetna receives the completed claim form and medical records?

- The entire claim file will be reviewed. Aetna may require an independent medical examination at Aetna's expense. (not applicable for State of Connecticut residents)
- When a claim is approved, the payment will be forwarded within a week either directly to the Claimant or to the Employer for distribution to the Claimant.
- When a claim is denied, we will inform the Claimant that benefits are not payable at the
 present time and that for a re-evaluation of his/her claim, he/she should let us know
 immediately when there is a change in his/her medical status.

What is the responsibility of the Claimant?

He/she must provide his/her Physician(s) with the model letter, Attending Physician's Statement and a medical release form. The Clamant is then responsible to follow up with his/her Physician and make sure the Physician provides the medical information required by Aetna in order to evaluate his/her claim.

If the claim is not approved, can the Claimant appeal the decision?

Yes, the Claimant can always appeal the claim decision. However, his/her Physician must provide up to date medical documentation that the life expectancy is within the timeframe of the policy. The Physician may also want to discuss this issue with our medical professionals.

What is the tax status of an ADB payment?

The ADB benefit received may be subject to income tax. At the end of the year Aetna reports all ADB payments to the IRS and generates a 1099 that is mailed to each Clamant. We must provide the IRS with the amount that was paid and confirm that the insured's Physician certified that the claimant is terminally ill and will die within 24 months. The employee should consult with his/her tax advisor or the IRS for additional information on the tax implications of these benefits on his/her own personal income.

What happens when the claimant dies?

The Employer should submit a proof of Death form with the death certificate and all pertinent beneficiary cards.

Where should other questions regarding this benefit be directed?

Contact your Analyst at: 1-(800) 523-5065.

GC-1582 (3-07) MA PAGE 16 of 17



ACCELERATED DEATH BENEFIT FORMS ON FILE SERVER

Claim Kits

ADB Claim Kits (GC-1459 & GC-1459-1) are located on the Forms Repository: http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

The claim kit includes the following letters and forms which are located on the Life Claim Service Center website under forms and letters.

Forms:

Instruction Page

- 1. Employee/Spouse Claim Application Form
- 2. Request for Medical Documentation
- 3. Authorization Physician's Copy
- 4. Authorization Insurance Company Copy
 - 5. Disclosure Statement Non Discount (Standard)
 - 6. Disclosure Statement Discount Option
 - 7. Attending Physician's Statement
 - 8. Accelerated Death Benefit Assignee Consent Form

Letters

- Letter to Employee
- 2. Letter to Employer

Additional Documents

Located in the Life Claim website under ADB Letters:

- 1. EE D App.doc Approval letter to employee non-discounted (standard option)
- 2. EE App.doc Approval letter to employee discount option
- 3. EE Approval letter to employee discount option for State of CT resident doc

GC-1582 (3-07) MA PAGE 17 of 17



Accelerated Death Benefit (Discount Option)

****INSTRUCTION PAGE****

Enclosed please find:

- An Application for Accelerated Death Benefit
- A Request for Medical Documentation letter
- Two Authorizations to Release Information
- An Authorization to Obtain Information
- · Attending Physician's Statement
- · A sample letter to the employee
- An Accelerated Death Benefit Disclosure Statement
- · An Accelerated Death Benefit Assignee Consent Form
- · A Questions and Answer Sheet
- Accelerated Death Benefit Forms on File Server Guide

Steps to follow:

- Complete the Employer section of the "Application for Accelerated Death Benefit" and forward it with the remainder of the forms to the employee.
- 2. For employees and spouses of an employee who are eligible for an Accelerated Death Benefit, Aetna provides the member with valuable and direct access to a licensed social worker who can assist them with the delivery of their life, health care and emotional needs. Our care advocate is sensitive to the physical, emotional, spiritual and culturally diverse needs of individuals and families who are facing tough decisions associated with a life-limiting illness. Our dedicated care advocate is available to the member during normal business hours and is available to assist the member with any questions they may have with completing the enclosed forms and may be reached by calling: 1-800-276-5120.
- If coverage is contributory, forward the current and prior 2 years enrollment forms through the Portal by attachment or by fax to 1-800-238-6239 or by mailing the forms to Aetna, P.O. Box 14549, Lexington, KY 40512-4549. To overnight the information send it to: ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- 4. Forward the Accelerated Death Benefit claim kit to the employee.
- 5. The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" form and return it with the signed copies of the "Authorization to Release Information" and the "Authorization to Obtain Information" forms to the Aetna. If assistance is needed during the claim process, contact our Customer Service Unit at 1-800-523-5065.
- 6. If the employee has completed an Absolute Assignment, the Assignee must authorize the Aetna to review the Accelerated Death Benefit claim and to issue benefits to the insured. The employee must send the "Assignee Consent" form to the Assignee. The Assignee must complete the form and return it to Aetna. The completed forms may be mailed or faxed to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
 - Fax Number 1-800-238-6239. To overnight the information send it to ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization to Release Information" form and send them to their physician(s) along with the Attending Physician's Statement.
- The medical documentation should then be mailed or faxed to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington KY 40512-4549
 Fax Number: 1-800-238-6239 along with a copy of the "Request for Medical Documentation letter"
 To overnight the medical documentation send it to: ACS, Inc., Attn: Life Claims, 101
 Yorkshire Boulevard, Lexington, KY 40509.

GC-1582-1 (3-07) MA PAGE 1 of 17

page 2 of 17

Employee:	☐ Employee ☐ Spouse Have you assigned your benefits to another	er person or	entity?	Yes No		
	If yes, please provide the following information Assignee Name					
	Telephone Number The completed form must be mailed or fax	14 4 4	na lesses		50.5	11616
	Lexington, KY 40512-4549 Fax Number 1-	ed to Aetha -800-238-62	39. To overr	right the information	n send it to	ACS, Inc., Attn: Life
Plan Sponsor:	Claims, 101 Yorkshire Boulevard, Lexington Please complete Section A and forward the section A a	on, KY 4050	09.			
ian oponsor.	information please forward it along with the	e claimant's	prior years e	enrollment forms to	0	This the
	Aetna Life Insurance Service Center, P. Fax Number: 1-800-238-6239. To overnice	O. Box 145 aht the infor	49, Lexingt omation send	on, KY 40512-454 it to:	9	
Section A:	ACS, Inc., Attn: Life Claims, 101 Yorksh					
Employer Name	and Address	Cor	ntrol-Suffix-A	ccount-Plan	-	
		Cor	ntrol-Suffix-A	ccount-Plan	-	
		7. 2500		c Insurance \$_ onal Insurance \$_		(TRM1 or 2) (TRM3 or 4)
If insurance	is based on earnings, basic rate of earnings			onal modrance &		(11/1/10/01/4)
\$			Month	Year		
	Date of Employee's Insurance Date of Spouse's Insurance			miums still being	oald on this	employee?
4. Sex	5. Date Employed 6. Date Las	st Worked		ee Certificate Num	ber or Socia	Security Number
Male 8. Was the em	Female ployee required to submit evidence of insura	ability?		Yes I	No	
Note: If yes	s, dáte evidence submitted: Disability Provision? ☐ Premium W		I PTD	IT DBO-AID	1-1	DBO
Our Premiu	m Waiver department will contact you regard	ding your eli				DBO
10. Has employ	ee submitted a claim for permanent total dis s, date claim submitted:	ability?		∐Yes ∐	No	
 Maximum a 	Iowable ADB	7.00		10 = T		
Basic Optional	\$	and/or				
	\$	and/or		%		
Optional	\$ \$	and/or		% %		
Date	Signature of Employer's Bene	fit Represe	ntative			ephone
Date	Signature of Employer's Bene ase complete Section B Return this applica	efit Represe	ntative	surer's Copy of the	"Authorizatio	on to Release
Date Employee: Ple	Signature of Employer's Bene hase complete Section B . Return this application from to your employer. Your medic	efit Represer ation togethe al records ca	ntative r with the Ins an be sent di	surer's Copy of the rectly to the Aetna	"Authorization at the addre	on to Release ess above
Date Employee: Pla	Signature of Employer's Bene hase complete Section B . Return this application from to your employer. Your medic	efit Represer ation togethe al records on THE INFOR	ntative r with the Ins an be sent di	surer's Copy of the rectly to the Aetna	"Authorization at the addre	on to Release ess above
Date Employee: Ple Info Section B: Employee's Nar	Signature of Employer's Bene lase complete Section B . Return this applica ormation" form to your employer. Your medic ****** PLEASE PRINT OR TYPE me & Address	ofit Represention together all records or THE INFOR	ntative r with the Ins an be sent di MATION BE of Birth	surer's Copy of the rectly to the Aetna ELOW ***** Social Securi	"Authorization at the addre ty Number	on to Release ess above. Telephone Numbe
Date Employee: Ple Info Section B: Employee's Nar	Signature of Employer's Bene hase complete Section B . Return this application from to your employer. Your medic	ofit Represention together all records or THE INFOR	ntative r with the Ins an be sent di MATION BE	surer's Copy of the rectly to the Aetna	"Authorization at the addre ty Number	on to Release ess above Telephone Numbe
Date Employee: Ple Info Section B: Employee's Nare Spouse's Name	Signature of Employer's Benerase complete Section B. Return this application from to your employer. Your medic ***** PLEASE PRINT OR TYPE ne & Address & Address (if applicable)	efit Represei ation togethe al records or THE INFOR Date	ntative r with the Ins an be sent di MATION BE of Birth	surer's Copy of the rectly to the Aetna ELOW ***** Social Securi	"Authorization at the address ty Number ty Number	on to Release ess above. Telephone Numbe Telephone Numbe
Date Employee: Ple Info Section B: Employee's Nare Spouse's Name	Signature of Employer's Benerase complete Section B. Return this application from to your employer. Your medic ***** PLEASE PRINT OR TYPE ne & Address & Address (if applicable)	efit Represei ation togethe al records or THE INFOR Date	ntative r with the Ins an be sent di MATION BE of Birth	surer's Copy of the rectly to the Aetna ELOW ***** Social Securi	"Authorization at the address ty Number ty Number	on to Release ess above. Telephone Numbe
Date Employee: Ple Info Section B: Employee's Narre Spouse's Name Caregiver Name	Signature of Employer's Benerate complete Section B. Return this applicate primation" form to your employer. Your medic ***** PLEASE PRINT OR TYPE one & Address & Address (if applicable)	efit Represention together al records carrier INFOR Date	ntative r with the Insen be sent di MATION BE of Birth of Birth	surer's Copy of the rectly to the Aetna LOW ***** Social Securi Social Securi	"Authorization at the address ty Number ty Number Relations	on to Release ess above Telephone Numbe Telephone Numbe ship to Claimant
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name	Signature of Employer's Bene asse complete Section B. Return this applicate primation from to your employer. Your medic ***** PLEASE PRINT OR TYPE ne & Address & Address (if applicable) & Address currently residing at home? Yes No	efit Represention together al records carrier INFOR Date	ntative r with the Insen be sent di MATION BE of Birth of Birth	surer's Copy of the rectly to the Aetna LOW ***** Social Securi Social Securi	"Authorization at the address ty Number ty Number Relations	on to Release ess above Telephone Numbe Telephone Numbe ship to Claimant
Date Employee: Ple Info Section B: Employee's Nare Spouse's Name Caregiver Name	Signature of Employer's Benerates complete Section B. Return this applicate primation from to your employer. Your medic ************************************	efit Represeition togethe al records or THE INFOR Date Date	ntative r with the Ins an be sent di MATION BE of Birth Telephone N	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Sumber Social Securi S	"Authorization at the address ty Number ty Number Relations and teleph	on to Release ess above Telephone Numbe Telephone Numbe ship to Claimant none number of the
Date Employee: Ple Info Section B: Employee's Nare Spouse's Name Caregiver Name	Signature of Employer's Benerates complete Section B. Return this applicate primation from to your employer. Your medic ************************************	offit Representation together all records on THE INFOR Date Date Date Date Street Date Str	ntative r with the Insen be sent di MATION BE of Birth Telephone N	surer's Copy of the rectly to the Aetna LOW ***** Social Securi Social Securi	"Authorization at the address ty Number ty Number Relations and teleph	Telephone Number Telephone Number Ship to Claimant Thone number of the
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo	Signature of Employer's Benerates complete Section B. Return this applicate primation" form to your employer. Your medic ************************************	offit Representation together all records or THE INFOR Date Date Date Date Sent Sent Sent Sent Sent Sent Sent Se	ntative r with the Insen be sent di MATION BE of Birth Telephone N ase provide	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Number the name, addres and/or	"Authorization at the address ty Number ty Number Relations and teleph	on to Release ess above Telephone Numbe Telephone Numbe ship to Claimant mone number of the _% _%
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo	Signature of Employer's Benerates complete Section B. Return this applicate principle of the section B. Return this application of the section of the section B. Return this application of the section B. Return this application of the section of t	particular department of the control	ntative r with the Insen be sent di MATION BE of Birth Telephone N ase provide	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Number the name, addres and/or and/or	"Authorization at the address the address ty Number ty Number Relations and telephenefits ma	on to Release less above Telephone Number Telephone Number The Claimant throne number of the 19% 19% 19% 19% 19% 19% 19% 19% 19% 19%
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issuefor public assis	Signature of Employer's Benerates complete Section B. Return this applicate primation from to your employer. Your medic ***** PLEASE PRINT OR TYPE in the address are a security in the security residing at home? Yes Note to the security of accelerated assistance programs such as medical assistance programs. Receipt of accelerated	partition together all records control of the Information Date of the Information of the	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ase provide x 11. ecceipt of acceptation, Aid to	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Sumber the name, addres and/or and/or celerated death b Families with De	"Authorization at the address the address ty Number ty Number Relations and telephanements managements are pendent City be treated."	on to Release ess above Telephone Numbe Telephone Numbe ship to Claimant none number of the % y affect eligibility hildren and differently than
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issist for public assis Supplemental receipt in a lun	Signature of Employer's Benerates complete Section B. Return this applicate primation from to your employer. Your medic ************************************	perit Representation together all records or THE INFOR Date Date Date Date Date Date Date Date	ntative r with the Insen be sent di MATION BE of Birth Telephone N ase provide x 11. eccipt of acciaid), Aid to rifts in perio	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Sumber the name, addres and/or and/or celerated death b Families with De dic payments mayowners or certif	"Authorization at the address ty Number ty Number Relations and telephonements many better to the content of th	on to Release ess above Telephone Number Telephone Number of the essential
Date Employee: Pleinfo Section B: Employee's Name Spouse's Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issifor public assis Supplemental: receipt in a lun with the appro recipient's spo	Signature of Employer's Benerates complete Section B. Return this applicate prize and the section B. Return this application of form to your employer. Your medic ************************************	particular process of the Information of the Inform	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ase provide x 11. eccipt of accaid), Aid to fits in perio of will affect death benef	surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Sumber the name, addres and/or and/or celerated death b Families with De dic payments mayowners or certif t the eligibility of fits may be taxabi	"Authorization at the address the address ty Number ty Number Relations and telephonenefits management Cipy be treated icate holdes the recipiede. Receipt	on to Release ess above. Telephone Numbe Telephone Numbe ship to Claimant none number of the % % y affect eligibility hildren and d differently than reshould consult int and/or the c of accelerated
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issue for public assis Supplemental receipt in a lun with the approvecipient's spodeath benefits	Signature of Employer's Benerates complete Section B. Return this applicate principle of the section B. Return this application of the section B. Return this application of the section o	partit Representation together all records care all recor	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ase provide x 11. eccipt of accadi, Aid to fits in perionefits, policy death benefit receipt in	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Sumber the name, addres and/or and/or celerated death b Families with De dic payments mayowners or certif t the eligibility of fits may be taxab a lump sum, Prio	"Authorization at the address the address ty Number ty Number ty Number Relations and telephone and telephone to appendent City be treate to the recipie the Receipter to applying the address the recipies to applying the address the address the recipies to applying the address the a	Telephone Number of the should consult that and/or the coffacelerated and for such
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issifor public assis Supplemental irreceipt in a lun with the appro recipient's spo death benefits benefits, policy facility as define	Signature of Employer's Benerate complete Section B. Return this applicate principle of the PLEASE PRINT OR TYPE of the Address & Address (if applicable) & Address (if applicable) & Address & Address & Address & Address & Address Basic Optionate of the Address of the Address of the Address Prior to applying for accelerated of the Address	prit Representation together all records or THE INFOR Date Date Date Date Date Date Date Date	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ase provide x 11. eccipt of accaid), Aid to fits in perionefits, policy of will affect death benefit receipt in receipt in refrom a que y person to a	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Secur	"Authorization at the address ty Number ty Number Relations and telephone and telephone to the recipie te. Receipt to to applying."	Telephone Number Telephone Number Telephone Number Ship to Claimant Telephone number of the """ """ """ """ """ """ """ ""
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issue for public assis Supplemental is receipt in a lun with the approperity in a lun with the apprope	Signature of Employer's Benerates complete Section B. Return this applicate prize and the section Section B. Return this application and the section Section B. Return this application and the section Section B. Return the section B. Return this application B. Return the section B. Return the sectio	partit Representation together all records care all require any care all requires and without all requires and without all requires and requires any care all requires and requ	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ase provide x 11. eceipt of accept of accept will affect death benefin receipt in ce from a quere in such a coercion on in	surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Social Securi In Social Secur	"Authorization at the address the address ty Number ty Number ty Number Relations and telephonenefits management Ciny be treate cate holdes the recipie the Receipt to applying to a death did party.	Telephone Number Telephone Number Telephone Number Ship to Claimant Telephone number of the Telephone Number of accelerated Number of accelerated Number of the Telephone Numb
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amost for public assis Supplemental receipt in a lunwith the approrecipient's spodeath benefits benefits, policy facility as define condition of adn This application Within 5 days of	Signature of Employer's Benerates complete Section B. Return this application of From to your employer. Your medic ************************************	particular properties of the Information of the Inf	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ease provide x 11. eceipt of accept will affect the fits in perion receipt in ce from a que r person to a are in such the coercion on revide an ack	Surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Secur	"Authorization at the address ty Number ty Number Relations and telephone and telephone to applying to applying to a party, er to the po	Telephone Number Telephone Number Telephone Number Ship to Claimant Telephone number of the """ """ """ """ """ """ """ ""
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issistor public assis Supplemental receipt in a lun with the appro- recipient's spodeath benefits, policy facility as define condition of adn This application Within 5 days of certificate holde prohibits Aetna	Signature of Employer's Benerates complete Section B. Return this applicate principle. Your medic ************************************	particular properties of the Information together all records on THE INFOR Date Date Date Date Date Date Date Date	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ase provide x 11. eccipt of accaid), Aid to fits in perio offits, policipt will affect death benefit receipt in cefrom a que y person to a are in such fa coercion on i ovide an ack ance Law §3 4 days from	surer's Copy of the rectly to the Aetna Social Securion and/or and/or and/or and/or and/or and/or and/or and/or securion social social securion social securion	"Authorization at the address the address ty Number ty Number ty Number Relations and telephone and telephone to applying to applying to applying to the poor. In addition to the poor the information at the information at the information at the address the information at the address the information at the information at the address the addre	Telephone Number Telephone Number Telephone Number Ship to Claimant Telephone number of the Ship to Claimant Should consult and/or the Should consult the of accelerated not not not health care benefit as a Ship to Ship
Date Employee: Ple Info Section B: Employee's Name Spouse's Name Caregiver Name Caregiver Name Is the claimant of current residence Amount of acce Note: The amo For policy's issue for public assis Supplemental is receipt in a lun with the approprient's spodeath benefits benefits, policy facility as define condition of adn This application Within 5 days of certificate holde prohibits Aetna York Insurance	Signature of Employer's Benerates complete Section B. Return this applicate principle. Your medic ************************************	partit Representation together all records on THE INFOR Date Date Date Date Date Date Date Date	ntative r with the Insen be sent di MATION BE of Birth of Birth Telephone N ase provide x 11. eceipt of accept of accept of will affect death benefing receipt in a green to a green such a green such a green such a green a coercion on the coercion of the coercion on the coercion of	surer's Copy of the rectly to the Aetna ELOW ***** Social Securi Social Securi Social Securi Social Securi Ithe name, addres	"Authorization at the address the address ty Number ty Number ty Number Relations and telephone and telephone to applying the recipie the recipie the Receipt to applying to a death do arty, er to the pok Insurance the Information ampleted appropriet of a death do arty.	Telephone Number of the Ship to Claimant one number of the Ship to Claimant on the Ship to Ship

GC-1582-1 (3-07) MA

Accelerated Death Benefit (Discount Option)

page 3 of 17

Claimant's Name Social Security Number

Section C:

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

Date Signature of Employee Telephone

GC-1582-1 (3-07) MA

XAetna

Request for Medical Documentation

	ign and date this Request to opy of the Authorization to			
Signature of spo	ouse (if applicable)		Date	
Signature of em			Date	
	our prompt assistance in th			
Aetna Life Insu Fax Number: 1	rance Service Center, P.C -800-238-6239. To overnig : Life Claims, 101 Yorkshi). Box 14549, Lexington the high control of the highest the information services.	nd it to:	
or their review.	Please forward the recornsurance Company. The	ds, with a copy of this		
An Attending A narrative su treatment, Clinical record An assessme Names, addre Your assessme provide the mili tis medica projected life contact me if	Physician's Statement. ummary describing the diag ds for the terminal disease. ent of mental competency. esses, and phone numbers ment on the medical probab nedical rationale in support lly probable that my life exp expectancy. If you are una this situation changes. gned Release authorizing y	of other treating physic ility that my life expecta of your opinion. sectancy will exceed (_ ible to establish a projec	ians, if applicable. ncy will be () mo) please provide a cted life expectancy at	onths or less. Please n opinion on my this time, please
	ne following medical docum		e Company for evalua	tion of benefit
	claim part of my group life months (specified under		hich I may be entitled	if my life expectancy
ear Physician:				
pouse Name (i	if applicable):	Spous	e's SSN:	
mployee Name	e!	Emplo	yee's SSN:	
Group Policy No): 	Emplo	yer:	

75

page 5 of 17



Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

Employee's Name	
Employee's SSN	
Spouse's Name (if applica	able)
Spouse's SSN	
Employer	
To all Physicians:	
he person for whom info	ovide Aetna Life Insurance Company information concerning the health condition of ormation is being requested. HIV tests results may be released pursuant to this in will be used for the purpose of evaluating and administering a request for an affit.
	mployer named above with any benefit calculation used in payment of this claim for the experience and operation of the policy or contract.
This authorization is valid Death Benefit has been	d for the term of coverage of the contract under which a request for an Accelerated submitted.
Aetna Life Insurance S Fax Number: 1-800-238	ed medical information immediately to: ervice Center, P.O. Box 14549, Lexington, KY 40512-4549 8-6239. To overnight the information send it to: aims, 101 Yorkshire Boulevard, Lexington, KY 40509.
copy of this authorization	t to receive a copy of this authorization upon request, and agree that a photographic is as valid as the original. I understand that I am responsible for any charges made riding medical information.
Date	Signature of employee, or his/her Authorized Representative*
Date	Signature of spouse, or his/her Authorized Representative* (if applicable)
	sentative is signing this Release, please attach legal documentation as proof of such Physician's Copy and the Insurance Company Copy.
Medical R	date both copies of this Release. Send the Physician's copy with the Request for Records to your physician. Return the Insurance Company Copy to the Employer with cation for Accelerated Death Benefits.
	Physician's Copy
GC-1582-1 (3-07) MA	PAGE 5 of 17

76

page 6 of 17



Authorization To Release Information Including Release of HIV, AIDS and ARC INFORMATION

	Release of HIV, AIDS and ARC INFORMATION
Employee's Name	
Employee's SSN	
Spouse's Name (if a	oplicable)
Spouse's SSN	
Employer	
Primary Care Physic lame:	sian
Address:	(-
elephone #:	
o all Physicians:	
he person for whom	provide Aetna Life Insurance Company information concerning the health condition of information is being requested. HIV tests results may be released pursuant to this ation will be used for the purpose of evaluating and administering a request for an enefit.
	e employer named above with any benefit calculation used in payment of this claim for ring the experience and operation of the policy or contract.
his authorization is veath Benefit has be	valid for the term of coverage of the contract under which a request for an Accelerated en submitted.
Aetna Life Insurance Fax Number: 1-800-2	uired medical information immediately to: e Service Center, P.O. Box 14549, Lexington, KY 40512-4549 238-6239. To overnight the information send it to: Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
copy of this authoriza	ght to receive a copy of this authorization upon request, and agree that a photographic tion is as valid as the original. I understand that I am responsible for any charges made roviding medical information.
Date	Signature of employee, or his/her Authorized Representative*
Date	Signature of spouse, or his/her Authorized Representative* (if applicable)
	resentative is signing this Release, please attach legal documentation as proof of such the Physician's Copy and the Insurance Company Copy.
Medica	nd date both copies of this Release. Send the Physician's copy with the Request for all Records to your physician. Return the Insurance Company Copy to the Employer with plication for Accelerated Death Benefits.

Insurance Company Copy

GC-1582-1 (3-07) MA PAGE 6 of 17

page 7 of 17



Authorization To Obtain Information Aetna Life Insurance Service Center

MACUIA	For Insurance Benefits	Lexington, KY 40512-4549 Telephone Number: 1-800-523-5065 Fax Number: 1-800-238-6239
	(print name)	
Relationship to insured (Self Spouse Parent Personal Representa		
Power of Attorney/He	ealthcare Power of Attorney/Guardian (attach copy	
records on	(name)	N:
from any physician, med company, claim administ higher learning or emplo	iname) lical practitioner or health care professional, hospitatrator, bank or financial institution, credit reporting a yer to release the following information to Aetna Linistrators and consulting health professionals with	al, clinic or other medical facility, insurance agency, university, college or institution of fe Insurance Company (Aetna) and any
including test results)	nformation (including that related to mental illness, concerning health care, advice, treatment or supports, histories, physical or diagnostic examination	lies furnished to the insured, including but not
 Employment informat 	ion and history, including job duties and earnings,	information pertaining to my credit history;
 Information regarding 	school attendance, credits earned or school relate	ed activities
 Police records and re 	ports, Autopsy and Toxicology Reports (if applicab	ole)
Workers' Compensati	er individual and group life and accidental death ar ion claims, and other claims filed, including amoun ormation related to such other claims.	
Aetna Life Insurance S Fax Number: 1-800-238	ed information immediately to: ervice Center, P.O. Box 14549, Lexington, KY 4 3-6239. To overnight the information send it to aims, 101 Yorkshire Boulevard, Lexington, KY	
administering the Accele	tion obtained by use of this authorization will be us rated Death Benefit claim on the claimant, and, for be eligible for if the Application for the Accelerate	the administration of any other benefit or
I may revoke this Author on actions that Aetna had disclosed may be protect longer protected by fede	d for the term of the policy or contract under which ization at any time by notifying Aetna in writing, but is taken prior to receiving my written revocation. It at the department of the things and that information disclosed under the privacy regulations. I know that I have a right to a photographic copy of this authorization is as valid	t that such notification will not have any effect acknowledge that the information to be is authorization may be redisclosed and no receive a copy of this Authorization upon
Signature	And St. Commission of the Association of the Associ	Date;
Telephone Number		
If this authorization is be document (power of atto individual as the represe	ing signed by the Claimant's legal representative, yrney, health care power of attorney, court appointentative.	you must furnish a copy of the relevant ad guardianship papers, etc.) designating that

Physician's Copy

GC-1582-1 (3-07) MA

physician.

page 8 of 17



Authorization To Obtain Information Aetna Life Insurance Service Center

	For Insurance Benefits	Lexington, KY 40512-4549 Telephone Number: 1-800-523-5065 Fax Number: 1-800-238-6239
	(print name)	
Relationship to insured (p Self Spouse Parent		
Personal Representat Power of Attorney/Hea	ive (attach copy of appointment by court) althcare Power of Attorney/Guardian (attach copy	
records on	name) SSI	N:
from any physician, medi- company, claim administr higher learning or employ	name) cal practitioner or health care professional, hospit rator, bank or financial institution, credit reporting yer to release the following information to Aetna L istrators and consulting health professionals with	tal, clinic or other medical facility, insurance agency, university, college or institution of ife Insurance Company (Aetna) and any
including test results)	formation (including that related to mental illness, concerning health care, advice, treatment or suppords, histories, physical or diagnostic examination	olies furnished to the insured, including but not
 Employment information 	on and history, including job duties and earnings,	information pertaining to my credit history;
 Information regarding 	school attendance, credits earned or school relati	ed activities
Police records and rep	oorts, Autopsy and Toxicology Reports (if applicat	ole)
Workers' Compensation	er individual and group life and accidental death aron claims, and other claims filed, including amoun rmation related to such other claims.	
Aetna Life Insurance Se Fax Number: 1-800-238-	ed information immediately to: ervice Center, P.O. Box 14549, Lexington, KY -6239. To overnight the information send it to ims, 101 Yorkshire Boulevard, Lexington, KY);
administering the Acceler	ion obtained by use of this authorization will be us rated Death Benefit claim on the claimant, and, fo be eligible for if the Application for the Accelerate	r the administration of any other benefit or
I may revoke this Authoriz on actions that Aetna has disclosed may be protect longer protected by feder	I for the term of the policy or contract under which zation at any time by notifying Aetna in writing, bu staken prior to receiving my written revocation. I ed by law and that information disclosed under the al privacy regulations. I know that I have a right to photographic copy of this authorization is as valid	It that such notification will not have any effect acknowledge that the information to be is authorization may be redisclosed and no preceive a copy of this Authorization upon
Signature	The State of the s	Date;
	ng signed by the Claimant's legal representative, ney, health care power of attorney, court appoint ntative.	

Insurance Company Copy

GC-1582-1 (3-07) MA

page 9 of 17

Attending Physician's

Send this form to:

		mpletion of th	is form without					
	med below		portion of his/h	need mo er life insura	re room to nce unde	o respond. Comple er the accelerated	the reverse side if you te this form in full. death benefit provision of quest, the following	
Patient nformation	Name			Relationsh Employee		Social Security Number	Birthdate (MM/DD/YYYY)	
	Address (in	clude No. Str	eet, Town, State,	Zip Code)	Address	is new		
Employer nformation	Name of E	mployee		Name of E	Employer		Control Number	
. Diagnosis and History	Diagnosis (including any	complications)					
	IDC diagno	stic code (ma	indatory)	Date of las	st examina	ation (MM/DD/YYY	()	
	Subjective symptoms							
	Objective findings (including current X-rays, EKG's, laboratory data and any clinical findings): Clinical findings:							
	Diagnostic Studies and Results:							
	Are there any other illnesses, opportunistic infections, medical conditions, complications or significant findings affecting present condition? Yes No If "Yes," please describe:							
	Height	Weight	Are there any v	ere any weight loss patterns?				
	Date symptoms first appeared or accident happened (MM/DD/YYYY)					hat is the current stage of the insured's illness?		
	Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe. Date(s) of any recurrences (MM/DD/YYYY) Date patient ceased we because of disability (MM/DD/YYYYY)							
2. Nature of Treatment	Type and dates of treatment:							
	Prescribed Medications:							
	Surgical pr	ocedures and	dates					

Accelerated Death Benefit (Discount Option)

page 10 of 17

2. Nature of Treatment (cont.)	How has patient responded to treatment?		
	Has Patient been hospital confined? Yes Confined from	☐ No If "Yes," give namThrough	
3. Progress and Limitations	Patient is: Ambulatory House confined Bed confined Hospital confined Performance Status Scale: Karonfsky	What is the patient's Activit What restrictions are place	
	Or ECOG (Zubrod)		
Cardiac (if applicable)	Functional capacity limitation (American Heart Ass	n): Class 1 (none) [Class 2 (slight) [Class 3 (marked) Class 4 (complete
5. Mental Status	Do you believe the patient is competent to endorse Yes No	checks and direct the use o	proceeds thereof?
6. Prognosis	What is the patient's Prognosis? ☐ Guarded ☐ Good ☐ Fair ☐ Poor ☐ Other	(MM/DD/YYYY)	ose the patient as terminally ill?
	Life Expectancy: Is the insured expected to die w If "Yes," how many months until the expected date		
7. Treating Physicians	Names and addresses of other treating physicians.		
8. Remarks			
	Attending Physician's Name (print)	Specialty	Degree
		opediaty	
	Address (No., Street, City, State, Zip Code)		Telephone Number
	Signature		Date
			-4 1 -

Accelerated Death Benefit (Discount Option)

page 11 of 17

9. Misrepresentation | Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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 quilty of a crime and may be subject to fines and confinement in prison.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties. Attention Washington Residents: 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.

PAGE 11 of 17 GC-1582-1 (3-07) MA



Sample Letter to Employee

<Date>

<Name>

<Address>

<City, State, Zip Code>

RE: Employee: <Employee's Name>
Plan Sponsor: <Plan Sponsor>
Control Number: <Control Number>

Dear < Name>:

We understand that you have requested to apply for an Accelerated Death Benefit. In order for Aetna Life Insurance Company, hereafter referred to as Aetna, to determine if you qualify for this benefit, please follow these instructions:

First, make sure you have received the items listed below:

- · One Application for Accelerated Death Benefit
- · One Request for Medical Records letter
- · Two copies of the Authorization to Release Information forms
- One Authorization to Obtain Information
- · One Attending Physician's Statement
- One Accelerated Death Benefit Assignee Consent form to be completed when an Absolute Assignment has been
 executed
- One Accelerated Death Benefit Disclosure Statement

After you have read this letter:

- Read the Disclosure Statement and keep it for your records.
- Complete and sign the employee section of the Application for Accelerated Death Benefit form.

Sign and date both copies of the Authorization to Release Information forms and the Authorization to Obtain Information form. Send one copy of each completed form to the Aetna.

- Sign the Request for Medical Records letter and forward it along with the Authorization to Release Information form and the Attending Physician's Statement form to your physician. The Attending Physician's Statement and medical records must be returned to Aetna.
- If you completed an Absolute Assignment, send the Assignee Consent form to your Assignee for completion. The completed form must be returned to Aetna.

The information to be provided to Aetna may be mailed or faxed to: Aetna Life Insurance Service Center

P.O. Box 14549

Lexington, KY 40512-4549 Fax: 1-800-238-6239

To overnight the information to Aetna send it to: ACS, Inc.

Attn: Life Claims 101 Yorkshire Boulevard Lexington KY 40509

Please be certain that either you or your physician provide Aetna with the necessary medical records for our use in determining your eligibility for this benefit.

In order to avoid delays when responding to this letter, please include the name and Social Security Number for the Insured or deceased in any correspondence.

If you need assistance or have any questions, regarding your claim, please contact Aetna's Customer Service Unit at 1-800-523-5065.

Sincerely,

<Name and Title>

Aetna Life Insurance Company

cc: <Plan Sponsor's Name>

GC-1582-1 (3-07) MA

page 13 of 17



Aetna Life Insurance Company Disclosure Statement at the Time of Application for Accelerated Death Benefit (ADB)

Any ADB paid by Aetna Life Insurance Company, in accordance with your request for payment under the terms of your Booklet-Certificate and the Group Policy, will be subject to the following.

While you may use the money you receive from this benefit for any purpose, including payment of long term care or nursing home expenses, the ADB in this life insurance policy is NOT part of long-term care or other nursing home coverage. Unlike conventional life insurance proceeds, an ADB payable under your life insurance coverage COULD BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use ADB benefits.

Consequences of this Benefit:

Receipt of an ADB MAY ADVERSELY AFFECT ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that your life insurance booklet-certificate includes an ADB may affect your eligibility for these government programs. In addition, exercising the option to receive an ADB and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

- A. Effect on your amount of Coverage under your Booklet-Certificate: Your death benefit amount will be REDUCED if you receive an ADB. Here is an illustration of the effect an ADB payment has on your Booklet-Certificate.
 - (1) Face Amount of Insurance: [\$40,000]
 - (2) Amount to be accelerated (25% of Face Amount): [\$10,000]
 - (3) Amount of ADB paid ([\$10,000, less \$176 interest charge: [\$9824.00]
 - (4) Amount of Life Insurance Remaining: [\$30,000]

	Konold At Williams
Signature of Applicant	Aetna Life Insurance Company

PLEASE KEEP THIS DISCLOSURE STATEMENT FOR YOUR RECORDS

1 11 10/11

GC-1582-1 (3-07) MA PAGE 13 of 17

XAetna

Accelerated Death Benefit Assignee Consent Form

			who is insured unde
Insured's Name	S	cial Security Number	
Group policy number	issued t	y Aetna Life Insura	nce Company (Aetna) to
70.0	I/M	e hereby consent a	nd request Aetna to
Plan Sponsor Name			
eview and pay the Accelerated	Death Benefit to	Insured's Name	
Print Assignee Name	Signature		Date
ssignee Address	of		
Assignee Address State/Providence	of		
Assignee Address State/Providence County of			
State/Providence County of On this	day of		, personally
State/Providence County of On this Appeared before me at	1000	, 20	, personally
State/Providence County of On this Appeared before me at State/Providence of (Insert	day of here the names of all persons	, 20 making this statement)	, personally , the above named
State/Providence County of On this Appeared before me at State/Providence of (Insert	day of	, 20 making this statement)	, personally , the above named
State/Providence County of On this Appeared before me at State/Providence of (Insert and made oath that the	day of here the names of all persons	_, 20 making this statement) above made and su	, personally , the above named

XAetna

Questions and Answer Sheet

This sheet is intended to provide information on commonly asked question as by Employers and employees.

What is involved in the Claim Process?

A claim kit will be provided to you by your sales or service representative that will include:

- An Application for Accelerated Death benefit. Complete the Employer section of the application and forward it with the remainder of the forms to the employee.
- The employee is to complete the Employee section of the "Application for Accelerated Death Benefit" and return it with the "Authorization to Release Information" to their employer.
- The employer will send the "Application", "Authorization to Release Information" along with the prior two years enrollment forms to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
 Fax Number 1-800-238-6239. To Overnight the information send it to:
 ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509.
- A Disclosure Statement
 - (a) Standard Option. This form applies when the employee does not incur an interest charge that is deducted from his/her benefit. This document provides the claimant with basic information on how the ADB benefit will impact the life benefit.
 - (b) Discount Option. This form applies when there is an interest charge deducted from the ADB payment. The interest charge deducted is equal to the current rate of a three-month United States Treasury bill in effect on the date of payment and is calculated for the period of the life expectancy period as stated in the contract.
- The employee is to complete the "Request for Medical Documentation letter" and the remaining "Authorization To Release Information" and send them to their physician(s) along with the "Attending Physician's Statement".
- The medical documentation should be sent to:
 Aetna Life Insurance Service Center, P.O. Box 14549, Lexington, KY 40512-4549
 Fax Number 1-800-238-6239. To Overnight the information send it to:
 ACS, Inc., Attn: Life Claims, 101 Yorkshire Boulevard, Lexington, KY 40509 along with a copy of the "Request for Medical Documentation letter".

ADB Forms (GC-1459 & GC 1459-1) are available on the Forms Repository: http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

For State of Connecticut residents only – the interest charge is the Aetna standard rate not to exceed 8%.

GC-1582-1 (3-07) MA PAGE 15 of 17

Accelerated Death Benefit (Discount Option)

page 16 of 17

What happens when Aetna receives the completed claim form and medical records?

- The entire claim file will be reviewed. Aetna may require an independent medical examination at Aetna's expense. (not applicable for State of Connecticut residents)
- When a claim is approved, the payment will be forwarded within a week either directly to the Claimant or to the Employer for distribution to the Claimant.
- When a claim is denied, we will inform the Claimant that benefits are not payable at the
 present time and that for a re-evaluation of his/her claim, he/she should let us know
 immediately when there is a change in his/her medical status.

What is the responsibility of the Claimant?

He/she must provide his/her Physician(s) with the model letter, Attending Physician's Statement and a medical release form. The Clamant is then responsible to follow up with his/her Physician and make sure the Physician provides the medical information required by Aetna in order to evaluate his/her claim.

If the claim is not approved, can the Claimant appeal the decision?

Yes, the Claimant can always appeal the claim decision. However, his/her Physician must provide up to date medical documentation that the life expectancy is within the timeframe of the policy. The Physician may also want to discuss this issue with our medical professionals.

What is the tax status of an ADB payment?

The ADB benefit received may be subject to income tax. At the end of the year Aetna reports all ADB payments to the IRS and generates a 1099 that is mailed to each Clamant. We must provide the IRS with the amount that was paid and confirm that the insured's Physician certified that the claimant is terminally ill and will die within 24 months. The employee should consult with his/her tax advisor or the IRS for additional information on the tax implications of these benefits on his/her own personal income.

What happens when the claimant dies?

The Employer should submit a proof of Death form with the death certificate and all pertinent beneficiary cards.

Where should other questions regarding this benefit be directed?

Contact your Analyst at: 1-(800) 523-5065.

GC-1582-1 (3-07) MA PAGE 16 of 17

XAetna

ACCELERATED DEATH BENEFIT FORMS ON FILE SERVER

Claim Kits

ADB Claim Kits (GC-1459 & GC-1459-1) are located on the Forms Repository: http://aetnet.aetna.com/bts/pages/plan_sponsor/contracting_consulting/forms/all-forms.html

The claim kit includes the following letters and forms which are located on the Life Claim Service Center website under forms and letters.

Forms:

Instruction Page

- 1. Employee/Spouse Claim Application Form
- 2. Request for Medical Documentation
- 3. Authorization Physician's Copy
- 4. Authorization Insurance Company Copy
 - 5. Disclosure Statement Non Discount (Standard)
 - 6. Disclosure Statement Discount Option
 - 7. Attending Physician's Statement
 - 8. Accelerated Death Benefit Assignee Consent Form

Letters

- Letter to Employee
- 2. Letter to Employer

Additional Documents

Located in the Life Claim website under ADB Letters:

- 1. EE D App.doc Approval letter to employee non-discounted (standard option)
- 2. EE App.doc Approval letter to employee discount option
- 3. EE Approval letter to employee discount option for State of CT resident doc

GC-1582-1 (3-07) MA

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Accidental Death & Personal Loss

This chapter covers the Accidental Death and Personal Loss (AD&PL) coverage.

AD&PL death benefits

A benefit may be payable if an employee suffers a bodily injury caused by an accident, and if, as a direct result of the injury loses his/her life. To be eligible for this benefit, loss of life must occur within 365 days of the accident. The 365-day time limit applies in most instances, but may vary from state to state.

When a totally disabled employee dies, the Proof of Death form must be submitted to Aetna within the filing limit indicated in your policy. If the Proof of Death form is not provided within this timeframe, benefits may be denied.

In addition to the above, your Group Policy may also provide a Seatbelt and Airbag benefit, an Education benefit, a Child Care benefit, a Coma benefit and a benefit for Repatriation of Remains. Details are provided in your Group Policy.

AD&PL death claims

Employees who are covered for Accidental Death & Personal Loss at the time of their death will generally be covered for Life Insurance as well. If the employee is covered for Life Insurance at the time of death, it will not be necessary to complete a separate Proof of Death form. To indicate that an employee may be eligible to receive an Accidental Death benefit when filing their Life Insurance claim, please check the box for AD&PL coverage shown in Section C. The beneficiary or the beneficiary's representative should supply the information required by Section F on the form.

Aetna may also request information in addition to that requested in Section F. If we request any additional information, the beneficiary or the beneficiary's representative will be expected to cooperate by furnishing us with the requested information.

If the employee is not covered for Life Insurance at the time of death, but is covered for Accidental Death and Personal Loss Coverage, it will be necessary to complete a Proof of Death form.

AD&PL and other losses

A benefit may be payable if an employee suffers a bodily injury caused by an accident, and if, as a direct result of the injury, loses:

- His or her life.
- A hand, by actual severance at or above the wrist joint.
- A foot, by actual severance at or above the ankle joint.
- An eye, involving irrecoverable and complete loss of sight in the eye.

Your Group Policy may also pay a benefit if an employee, as a direct result of an injury caused by an accident, loses:

- His/her speech or hearing. The loss must be total and deemed permanent. (A total loss of speech or hearing will be deemed permanent if the loss has been present for 12 consecutive months, unless an attending physician states otherwise.)
- The thumb and index finger of the same hand, by actual severance of entire digit.
 (Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.)

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Accidental Death & Personal Loss

(continued)

Your Group Policy may also pay a benefit if an employee loses his/her life due to exposure to natural or chemical elements, disappears as a direct result of an accident, or suffers a bodily injury in an accident; and if, within 30 days after the accident and as a direct result of the injury, he/she suffers a coma or is stricken with one of the following forms of paralysis:

- Quadriplegia the entire and irrecoverable paralysis of both upper and lower limbs.
- Paraplegia the entire and irrecoverable paralysis of both lower limbs.
- Hemiplegia the entire and irrecoverable paralysis of the upper and lower limbs on one side of the body.
- Uniplegia the entire and irrecoverable paralysis of one limb.

Please refer to the Accidental Death and Personal Loss Coverage section of your Group Policy for the coverage amounts and specific terms that apply to your Group Policy.

AD&PL limitations

Benefits are payable for losses caused by accidents only. There may be situations when a benefit is not payable as the loss was not caused by an accident. Benefits may not be payable if the loss was caused or contributed to by:

- Bodily or mental infirmity.
- Disease, ptomaine or bacterial infection*.

- Suicide or attempted suicide (sane or insane).
- Medical or surgical treatment*.
- Intentionally self-inflicted injury.
- War or any act of war (declared or undeclared).
- Voluntary inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.
- Use of alcohol, intoxicants or drugs, except as prescribed by a physician. An accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred shall be deemed to be caused by the use of alcohol.
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used to carry passengers (with or without cargo).

This is not an exhaustive list of the limitations but an example of the usual standard limitations. Please check your Group Policy for the entire list of limitations.

AD&PL claims

If an employee or a dependent that is covered for Accidental Death and Dismemberment suffers a covered loss, the Accidental Dismemberment Claim form that follows must be completed.

Note: Aetna recommends that you fax the Accidental Dismemberment Claim form to Aetna at 1-800-238-6239. It is not necessary to mail the originals. If you elect to mail the Accidental Dismemberment Claim form to Aetna, please send the originals to the address indicated on the Accidental Dismemberment Claim form. A sample form is shown later in this chapter.

How do I complete an Accidental Dismemberment Claim form?

- The employee is responsible for completing Section 1 and signing Section 2. You are responsible for completing Section 3.
- The covered person's physician is responsible for completing and signing the Physician Statement section on the reverse side of the form.
- When the covered person or the covered person's representative returns the completed form to you, check to make sure that Sections 1 and 2 and the Physician's Statement have been thoroughly completed. If any of the required information is missing, it will only delay benefits payments.
- If all the required information has been provided, complete and sign Section 3 before submitting the claim to the Aetna Life Insurance Service Center.

^{*}This does not apply if the loss is caused by an infection that results directly from the injury or if surgery needed because of the injury.

Section 1: The employee completes all boxes of this section. It includes:

- 1. Employee's name (last, first, middle initial).
- 2. Employee's date of birth.
- 3. Employee's Social Security number.
- 4. Employee's current address, including street, city, state and zip code.
- 5. A daytime number where the employee can be reached.
- 6. Employee's present occupation.
- 7. The date the accident occurred.
- 8. Details of the accident: submit police/ accident report with any available newspaper clippings concerning the accident. If the loss was suffered by a covered dependent, provide the dependent's full name (last, first, middle initial), date of birth and Social Security number.
- 9. List the name(s), address(es) and phone numbers of any physician(s) who treated the employee or dependent for the injury.
- 10. The employee should indicate whether he or she is eligible for workers' compensation and why.
- 11. The employee should indicate whether he or she is covered for any other accident insurance. Give company(ies) name(s) and policy numbers if known.

Section 2: The employee signs and dates this section granting Aetna the right to perform its contractual obligations.

Section 3: The employer completes all boxes of this section. It includes:

- 12. Employer's name.
- 13. Employer's current address, including street, city, state and zip code.
- 14. A daytime number where a representative of the employer can be reached.
- 15. Control number (see your billing statement).
- 16. Control suffix (see your billing statement).
- 17. Claim account (see your billing statement).
- 18. Plan code, if any (see your billing statement).
- 19. Date the employee or dependent became covered for AD&PL.
- 20. Amount of AD&PL coverage in force on the date of the accident.
- 21. If coverage for an employee or dependent has ceased, the effective date of discontinuance.
- 22. If the employee contributes toward the cost of AD&PL coverage, the date the employee's last contribution covered them for (period ending).
- 23. Was the employee actually working at the time of the accident?
- 24. If the employee was not actively at work at the time of the accident, what was the date last worked.
- 25. The amount and method of paying the employee at the time of the accident.

- 26. Was the accident work related? If yes, explain.
- 27. Signature of an authorized company representative.
- 28. Date signed.

Physician's Statement

The physician who was primarily responsible for treating the covered person's injury completes all sections, signs and dates the form.

Investigating a claim

All AD&PL claims require investigation to establish that benefits are payable in accordance with your Group Policy. During the investigation, the beneficiary will be kept informed. The investigation will usually include, but is not limited to, securing police, autopsy, toxicology reports and medical records. We may also use an outside vendor to assist us.

If it is determined that the beneficiary is not entitled to the benefit, he or she will be notified in writing, explaining the reason for the adverse claim determination and the process for requesting a review should they disagree.

The beneficiary will be provided an opportunity to appeal our decision and will be asked to document the reason he or she believes the claim should be paid.

page 1 of 3



Accidental Dismemberment/Personal **Loss Claim Form**

Submit to Aetna Life Insurance Company Life Insurance Service Ctr. P.O. Box 14549 Lexington, KY 40512-4549 Telephone: 1-800-523-5065 Fax: 1-800-238-6239

- Employer completes Section 1Employee completes Section 2.
- Injured Person completes sections 3 and 4.
- Physician completes the Physician Statement on the reverse side.
- . Ultra Benefit Claim Statement Sections completed as needed.
- Submit to Aetna: Claim form, Enrollment form, Attending Physician's

					Statement, the app Benefits Statement		ced Perso	nal Prot	ection form(s) Ultra	
				Please	print all information	n.				
. Employer	Name							Fax Num	ber	
Information	Address (street, city,	state, zip c	ode)					Davtime) Telephone Number	
	1,144(259 (61125)(511))	entre Lank	0407					()	
	Control Number	Suffix	Account	Plan Code	Policy Effective Date (MM/DD/YYYY)	Employee's Ef (MM/DD/YYY)		Date Inst (MM/DD/	rance discontinued if not in fo	
	Were premiums paid	up to date	of accident?	-	Rate of Basic Earnings	on Date of Accide	ent			
	□ No □ Yes				\$	☐ Hourly	☐ Weekl	y DM	lonthly	
	Date employee first b work (MM/DD/YYYY)			last worked, if M/DD/YYYY)	Total amount of coverage Basic AD&PL (ADI	V 3.14	Basic A		e for this injury DD1 or 2)	
		t)			Optional AD&PL (A	ADD3 or 4)	S Optiona S	I AD&PL	Optional AD&PL (ADD3 or	
	Was the accident a re	esull of emp	oloyment?	□ No □	Yes If "Yes", explai					
	What is the employee's current occupation? Describe the day to day activities of the occupation of								opy of the job description.	
	Authorized Represen	ntative Signa	ature		Authorized Representat	ive's Printed Nam	e		Date (MM/DD/YYYY)	
2. Employee Information	Name				Sex	2.00	(MM/DD/YY	(Y)	Social Security Number	
	Address (street, city,	state, zip c	ode)				ephone Num	ber	Home Telephone Number	
						(()		()	
Injured Person's	Name	7			Relations	hip to Emplo	yee	Social Security Number		
Information	Address (street, city,	state, zip c	ode)			Birthdate (MM/DD/YYY			Daytime Telephone Numbe	
	Effective date of clair insurance	mant's	Date of A (MM/DD/)		Describe accident and g medical records, toxicol				provide any police reports, ated to the accident.)	
	Were you hospitalized? ☐ Yes ☐ No If Yes, provide the name address of the hospital and the dates of confinement.									
	Please provide the hospital Admission and Discharge Summaries along with the results of any blood work performed.									
	Has a claim for benefits previously been submitted for this accident? Yes No. If Yes, provide the insured name and benefit claimed									
		ess(es), te	elephone n	umber(s) of a	Il attending physician(s	s).				
I las bask if Mars	Doctor's Name			Add	ess				Telephone Number	
Use back if More space is needed.										
	!							_	-	
8. Release to be Signed by Injured Person	administrators an concerning health AIDS/ARC/HIV). benefit calculation This authorization	ed to provide consulting care adversely. This information used in parties and the consultation of the cons	ide Aetna ng health vice, treatn mation will payment o or the term	professionals nent or suppl be used to e of this claim fo n of the policy	s and utilization review lies provided the patie evaluate claims for be or the purpose of revie y or contract under wh	organizations nt (including the nefits. Aetna me wing the expenich a claim has	with whom at relating t ay provide rience and been sub	Aetna h o mental the emp operation nitted. H	and any independent clai as contracted, information illness and/or loyer named above with a n of the policy or contract know that I have a right to is as valid as the original.	
	Patient's or A	thorizod	Dorcon's	Cianatura				Date	2000	
		son signi	ng this fo	rm is the gu			laimant fo	Date	e copy of the appointmen	
C 0050 (3.08) A DC	, papera to	- /		2007 10 111					no.	

Accidental Dismemberment/Personal Loss Claim Form

page 2 of 3

5. Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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.

Attention California, Ohio and Pennsylvania Residents: 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.

Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

GC-9059 (3-08) A-POD Page 2 of 3

Accidental Dismemberment/Personal Loss Claim Form

page 3 of 3

atien	t's Full Name			Da	ite of Accident (MIV	/DD/YYYY)	Place of	Accident	Date first const resulting from t	ulted for injuries this accident
Diagno	osis and complete description of	injuries s	sustained							
_										
	cident result in loss of:	Data	(MM/DD/Y		Logation of a	moutation	(at abou	re or below wrist)		
4.	Right hand? Left hand?	1.0000						re or below wrist)		
	Right foot?					0.000		e or below white)		
	Left foot?							e or below ankle)		
	Thumb and index finger					Charge Show	y many transfer	e or below metaca		
	(same hand)	-								-
	Sight of right eye? Sight of left eye?		/							
(G)	What was vision at last of			-/	_ is loss entire	and irreco	verable	-		
	With Glasses				O.S		Data	(MM/DD/YYYY)	1	7
	Without Glasses				O.S			(MM/DD/YYYY)		
					The second second	2000			man 200 g	
	Date corrected vision wa		iverably redu		O.S.			(MM/DD/YYYY)		
	Vision can be restored in		name or sende	-		07.2		Operations	☐ Not resto	
	Vision can be restored in	Whole		0.6.	Lenses Lenses	Trea		Operations	☐ Not resto	
(H)	Speech?	Date	(MM/DD/Y		Is loss total	and perma	anent?			
(1)	Hearing?	Date								
(J)	Quadriplegia?	Date		1				?		
	Paraplegia?		1					?		
(L)	Hemiplegia?	Date	/_	_/	Is loss entire	e and irrec	overable	?		
(M)	Uniplegia?	Date	/	_/				?		
(N)	Third Degree Burn?	Date		_/	How much o	of the body	received	third degree burn	s?	9
(0)		t Date	/	_/	_ Is the patier	t still in a	Coma?	☐ Yes ☐ No		
	If No, Enter End	Date	/	_/						
(P)	Any other covered loss,	as refer	enced in the	AD&D s	ection of the en	ployer's b	ooklet?			
	ne loss sustained due solely to t			Yes [o escarar		4 - 1 - 1 - 1 - 1 - 1		
"NO	o", please give details of a	any acti	ve medical o	condition	or disease whic	n caused o	or contrib	uted to the loss:		
Vas ti	ne hospitalization of the claiman	t due sole	ly to the above	accident?	☐ Yes ☐ ſ	Vo.		100-10		
	the inquiries or impairment caus	ed by an	accident or con-	dition assoc	iated with employee	's occupation	?	Yes No		
f "Ye	es", explain fully:									
hysic	cian's Address (street, city, state	, zip code							Daytime Telepl	hone Number
	ian's Signature								Date (MM/DD/	MANA

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Life Conversion

Employees who are covered for Life Insurance must be given the right to convert their coverage to a policy of individual insurance when coverage ceases because employment is terminated, when they are no longer part of a class of employees eligible for Life Insurance coverage, or because of age, pension or retirement. Dependent Life Insurance may be converted when the employee terminates employment or when the employee is no longer in a class eligible for Life Insurance coverage, and only in those situations.

The following terms apply in most instances; however, they may vary from state to state. Please refer to the conversion section of your Group Policy for the specific terms that apply to your Policy.

When should an employee apply for a life conversion policy?

During the 31 days immediately following one of the events described to the left, the person may convert his/her coverage to a Guaranteed Cost Whole Life Insurance policy, which is a cash-value policy, provided he or she submits the conversion application and remits the first premium payment for the conversion policy within the 31 days. If the person does not submit the application and the first premium payment within 31 days, the application may still be accepted; however, it will be subject to Medical Evidence of Insurability.

Some states allow more than 31 days for conversion in certain circumstances. For example, several states require employers to give written notice of termination of group coverage and conversion rights within 15 days of termination. If written notice is not provided, the application time period may be extended and the employer may be liable for claims incurred within this extended period. Please refer to the Conversion section of your Group Policy for the specific terms that apply conversion.

How does Premium Waiver affect life conversion?

If the employee terminates employment due to total disability and applies for extension under the Premium Waiver provision (see the Premium Waiver section for details on this provision), the conversion application and the first premium payment must be submitted by you within 31 days from the date coverage terminates. If the employee is subsequently approved for Premium Waiver coverage, the conversion policy will be cancelled and all premium payments will be returned.

Can employees convert to an individual policy when the policy discontinues?

In partial or complete policy discontinuance situations, employees who have been continuously insured for a period of time (generally five years) are entitled to convert a designated amount (generally \$2,000 or \$10,000, depending on the law of the state where the contract is issued) to an individual policy. If the employee has not been continuously insured for the time specified in the Group Policy, the employee (or former employee) will not be eligible to convert his/her coverage.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

What happens if a person dies during the 31-day life conversion application period?

If the person dies during the 31-day application period and before his/her individual policy goes into effect, the amount payable under the Group Policy will be limited to the maximum that could have been converted. This applies even if the person has not applied for the individual policy.

How does the employee apply for a policy of individual insurance?

The form that must be completed is a two-part form. The first part of the form is called the Conversion of Group Life Insurance form, which you must complete before giving the form to the employee. Even if the employee (or former employee) has no intention of converting his or her group Life Insurance coverage to a policy of individual insurance, you should still complete the Conversion of Group Life Insurance form and give it to the employee when he or she is eligible to convert. As noted above, failure to provide the form may result in the application time period being extended and the employer may be liable for claims incurred within this extended period.

The second part of the form is called the Application for Conversion of Group Term Life Insurance. The employee (or former employee) is responsible for completing this section and sending the entire form to the address shown on the form.

Both sections of the form provide stepby-step instructions for completing the form along with instructions for calculating the premium for the individual policy. If you or the employee (or former employee) needs assistance completing a Conversion form, call the toll-free number for the Life Insurance Service Center listed on this page.

Sample Conversion of Group Life Term Insurance and Application for Conversion of Group Term Life Insurance forms are shown on pages 97-100.

If you need to order additional Conversion forms, please refer to the Customer Service Information chapter of this handbook for ordering instructions.

page 1 of 4



Conversion of Group Term Life Insurance

Aetna Life Insurance Company

Life · Disability · Long Term Care

Application and payment of the first premium must be made within the time limit shown in your certificate or policy.

BRIEF DESCRIPTION OF CONVERSION PRIVILEGE

Subject to the terms of the Group Policy (as described in your group insurance certificate): (1) you may apply for an individual life insurance policy in conversion of your Group Term Life Insurance and (2) the individual policy may be for the same amount which you are losing by termination of your insurance under the Group Policy, or for a lesser amount, depending upon the circumstances of the

No medical examination is required, but application and payment of the first premium must be made within 31 days of the date your Group Term Insurance terminates.

Premiums may be paid annually, semi-annually, or quarterly by direct bill; or monthly by Aetna's Automatic Check Plan (ACP). Premiums may be paid other than annually only if the periodic premium is at least \$15.

	s (crede)		A-FOII.
GR-6610	0.(5.00)	J.	, A-POD
Pooled (Group Life	Control/Suffix	Claim/Account
Regular	Group Life	Control/Suffix	Claim/Account
Group C	Control Number	SCD	
		*2000	
Name	OTTION OF OTHER		
HOME	OFFICE USE ONLY		
Addres	SS		Telephone Number
	ure (Employer Authorized Representative)		Date
13.	Employee Home Telephone Number		The state of the s
b.	Amount of dependent Life Insurance canceled		
12, a.	Complete for Dependent Conversion Name of dependent		
b.	If notice not furnished, show "None Given"		
11.a.	Date written notice of conversion right given to	The state of the second	
10.	Beneficiary (Name and Relationship)		A CONTRACTOR OF THE CONTRACTOR
0.	reduction rule)		
b.	Amount of insurance remaining in force (when		
9. a.	Amount of insurance canceled Supplement		
8. a. b.	Date life insurance canceled (Do not include 3 Reason for cancellation of Group Insurance		A STATE OF THE STA
C.	Last day worked if other than date in 7(a)		
b.	If totally disabled at this time, please state spec		
7. a.	Date employment or eligibility terminated		
6.	Date life insurance began		
5.	Employee Social Security Number		
4,	Name of Employee		
3.	Suffix and Account Number (example 12-345)	C	
	Group Policy (Control) Number or Employee	Policy Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
2.			

WHERE TO SEND YOUR APPLICATION

You should send your application and check or money order for the initial premium to:

Aetna Life Insurance Company Life Conversion Unit 151 Farmington Avenue Hartford, CT 06156-1992

NOTE: Be sure the above NOTICE OF ELIGIBILITY STATEMENT has been completed by the employer.

NOTE: This folder shows premium rates for a non-participating permanent type life insurance plan. It is offered in accordance with the conversion privilege contained in the group policy. The premiums for this plan do not vary based on the sex of the applicant.

If other than the Proposed Insured is to be the policyowner, the person who will be the policyowner should sign the application as Applicant. (Where this occurs, use Section 7 "Additional Information" to designate a contingent policyowner.)

GR-66109 (5-02) A-POD

Application For Conversion of XAetna **Group Term Life Insurance** Aetna Life Insurance Company, Hartford, Connecticut 06156 I hereby apply for a policy of insurance upon my life in accordance with the provisions of Group Policy Number insuring my life as an employee of 1. Proposed Insured (Print Name - First, Initial, Last) Date of Birth (MM/DD/YYYY) Telephone Number Male Female 2. Residence (Number, Street, City, County, State, Zip) Social Security Number 3. a. Date employment terminated with above employer? b. Occupation when employment terminated. Full Details Day What is your new occupation? Full Details d. Name of New Employer 4. a. Plan b. Amount of Insurance (Must not exceed amount of term insurance when Whole Life Insurance d. Make Automatic Premium Loan Provision operative, if available. c. Premium Payable □ Annual □ Semi-Annual □ Quarterly □ ACP/Monthly[®] No Yes *Complete Deduction Form e. Has any premium been paid and conditional receipt given on Form 265? Yes No If "Yes," the terms of the receipt are hereby agreed to. If "No," no insurance will be effective until the entire first premium for the policy is paid within 30 days from the date of this application during the lifetime of the proposed insured, nor until the term insurance under the Group Policy ends (if If "Yes," amount \$ under the terms of the Group Policy such insurance extends beyond the date of this application). 5. Premium Notices to be sent ☐ Insured at Residence Other 6. a. Beneficiary (NAME AND RELATIONSHIP TO PROPOSED INSURED) (NAME AND RELATIONSHIP TO PROPOSED INSURED) Contingent Unless otherwise requested herein, payment is to be made to primary beneficiaries who survive the Insured, equally, or if none survives, to contingent beneficiaries who survive, equally, or if none survives, to Insured's estate 7. Additional Information (Refer to specific question number.) IT IS MUTUALLY AGREED THAT: (1) the statements and answers made herein are complete and true to the best of my knowledge and belief; (2) issuance of the policy applied for shall be exchanged for all privileges and benefits with respect to the full amount of term insurance on my life under the Group Policy; (3) no person other than an officer of Aetna can make, modify, or discharge a contract or waive any of Aetna's rights or requirements. Signed at (City, State) (Month-Day-Year) Witness Signature - May Not be a Named Beneficiary Signature of Proposed Insured Print Witness Name Signature of Applicant (if other than Proposed Insured) FOR HOME OFFICE USE ONLY RECEIVED INDIVIDUAL POLICY TO BE DATED GR-66109 (5-02) A-POD DO NOT COMPLETE OR DETACH UNLESS ADVANCE PAYMENT IS MADE OF AT LEAST THE PREMIUM FOR ONE MONTH CONDITIONAL RECEIPT in connection with an Application to Aetna Life Insurance Company for Conversion of Group Term Life Received S. Insurance on the life of Notice: If you do not IT IS MUTUALLY AGREED THAT: (1) no insurance will be effective unless this application and premium payment have been made in accordance with the terms of the Group Policy referred to in the application, if not, any payment received will Company concerning the proposed insurance within 60 be refunded; (2) the effective date of insurance applied for will be the LATER of the following dates: (a) the date of this receipt, or (b) the date the Group Term Insurance ends; and (3) if the payment is less than the first premium under the days, notify Aema at its Home Office at Hartford, policy, the balance of that premium may be paid within 60 days from the date of this receipt. If any balance due is not paid, any insurance provided will continue only for the period which the payment will purchase on a pro rata basis. READ YOUR POLICY. (City, State) (Month-Day-Year) (Agent) Form 265 GR-66109 (5-02) A-POD

PREMIUM RATES FOR THE NONPARTICIPATING WHOLE LIFE PLAN

Description: Premium rates are based upon your age (nearest birthday) when the policy takes effect and do not change thereafter.

The rates included in the tables below were appropriate for the plans at the time they were prepared. The rates are subject to change without notice. You may confirm that the rates shown are the current rates by calling 1-800-523-5065.

If your policy will be $\underline{at\ least}\ \$10,\!000,\ Tables\ 1\ \&\ 3$ are used.

If your policy will be less than \$10,000, Tables 1, 2, & 3 are used.

TABLE 1 BASIC PREMIUM RATES FOR EACH \$1,000 OF INSURANCE									
Age As of Your Nearest Birthday	Annual	Semi- Annual	Quarterly	ACP/ Monthly	Age As of Your Nearest Birthday	Annual	Semi- Annual	Quarterly	ACP/ Monthly
0-1	5.12	2.64	1.34	0.44	41	20.68	10.65	5.43	1.76
2	5.04	2.60	1.32	0.43	42	21.66	11.15	5.69	1.84
3	5.23	2.69	1.37	0.44	43	22.69	11.69	5,96	1.93
4	5.43	2.80	1,43	0.46	44	23.77	12.24	6.24	2.02
5	5.64	2.90	1.48	0.48	45	24.89	12.82	6.53	2.12
6	5.85	3.01	1.54	0.50	46	26.06	13.42	6.84	2.22
7	6.07	3.13	1.59	0.52	47	27.29	14.05	7.16	2.32
8	6.30	3.24	1.65	0.54	48	28.57	14.71	7.50	2.43
9	6.54 6.80	3.37 3.50	1.72 1.79	0.56 0.58	49 50	29.91 31.31	15.40 16.12	7.85 8,22	2.54 2.66
									100
11	7.07	3.64	1.86	0.60	51	32.80	16.89	8.61	2.79
12	7.34	3.78	1.93	0.62	52	34.36	17.70	9.02	2.92
13 14	7.61 7.88	3.92 4.06	2.00 2.07	0.65 0.67	53 54	36.00 37.74	18.54 19.44	9,45 9,91	3.06 3.21
15	8.16	4.06	2.07	0.69	55	39.59	20.39	10.39	3.21
16	8.45	4,35	2,22	0.72	56	41.54	21.39	10.90	3,53
17	8.45	4.55	2.22	0.72	57	43.61	22.46	11.45	3.71
18	9.04	4.66	2.37	0.77	58	45.81	23.59	12.03	3.89
19	9.34	4.81	2,45	0.79	59	48.13	24.79	12.63	4.09
20	9.64	4.96	2.53	0.82	60	50.59	26.05	13,28	4.30
21	10.01	5.16	2,63	0.85	61	53.18	27.39	13.96	4.52
22	10.33	5.32	2.71	0.88	62	55.94	28.81	14.68	4.75
23	10.66	5.49	2.80	0.91	63	58.88	30.32	15.46	5.00
24	11.02	5.68	2.89	0.94	64	61.98	31.92	16.27	5.27
25	11.40	5.87	2.99	0.97	65	65.29	33.62	17.14	5.55
26	11.79	6.07	3.09	1.00	66	68.80	35.43	18,06	5.85
27	12.19	6.28	3,20	1.04	67	72.53	37.35	19,04	6.17
28	12.60	6.49	3,31	1.07	68	76.47	39.38	20.07	6.50
29	13.02	6.71	3.42	1.11	69	80.62	41.52	21.16	6.85
30	13.46	6.93	3.53	1.14	70	85.01	43.78	22.32	7.23
31	13.90	7.16	3.65	1.18	71	89.63	46.16	23.53	7.62
32	14.37	7.40	3.77	1.22	72	94.46	48.65	24.80	8.03
33	14.87	7.66	3.90	1.26	73	99.65	51.32	26.16	8.47
34 35	15.40 15.99	7.93 8.23	4.04 4.20	1.31 1.36	74 75	105.21 111.07	54.18 57.20	27.62 29.16	8.94 9.44
0.7		1.00				323/95	27,20		-2017
36	16.62	8.56	4.36	1.41					
37	17.31	8.91	4.54	1.47					
38 39	18.07 18.88	9.31 9.72	4.74 4.96	1.54 1.60			1 4 4 4 4		
40	19.75	10.17	5.18	1.68	10 41		40.1		
		TARLES					TABLE 3		-
TABLE 2 Annual Premium Surcharge				-		Policy Fee			
			than \$10,000: surcharge show						
iacs shown I	n rapic rafe			ii ociow,		Annual Semi-Annu	ral	\$ 15.00 8.00	
Annual Premium If your Policy will be: Surcharge					Quarterly		4.50		
\$ 9,000 - 9,99	If your Policy will be:		\$ 1.00			ACP/Mont	hly	2.00	
8,000 - 9,99			2.00						
7,000 - 7,99			3.00						
6,000 - 6,99			4.00						
Less than \$			5.00						

page 4 of 4

HOW TO CALCULATE YOUR PREMIUM FOR THE NONPARTICIPATING WHOLE LIFE PLAN

IF YOUR POLICY WILL BE AT LEAST \$10,000

All of the following premium modes (premium frequencies) are available to you if your policy will be at least \$10,000. Use Annual if you wish to pay your premiums annually, Semi-Annual if you wish to pay semi-annually, Quarterly if you wish to pay quarterly, or ACP/Monthly if you wish to pay monthly by Aetna's Automatic Check Plan.

TO CALCULATE your cost estimate use the appropriate age, policy amount, and selected premium mode.

EXAMPLE OUTLINED BELOW: AGE 40 - \$20,000 Policy - Annual Premium payments.

		EXAMPLE	YOUR COST ESTIMATE
1.	Enter the amount of insurance requested:	\$20,000	
2.	Amount of insurance requested in #1 divided by 1,000 equals;	20	
3.	From Table 1, enter premium rate which corresponds with your age and selected premium mode:	19.75	
4.	Multiply #2 x #3:	395.00	
5.	From Table 3, enter appropriate policy fee based on the selected premium mode;	15,00	
6.	Add #4 + #5. This equals your periodic premium payment for the premium mode you selected;	\$410.00	

IF YOUR POLICY WILL BE LESS THAN \$10,000

If you wish to pay your premiums Annually, omit steps #6 + #7. If you wish to pay your premiums Semi-Annually, Quarterly, or ACP/Monthly, include steps #6 + #7.

TO CALCULATE your cost estimate use the appropriate age and policy amount.

 $\textbf{EXAMPLE OUTLINED BELOW:} \ \ AGE\ 40-\$8500\ Policy-\textbf{Semi-Annual Premium payments}.$

		EXAMPLE	YOUR COST ESTIMATE
L	Enter the amount of insurance requested:	\$8,500	
2.	Amount of insurance requested in #1 divided by 1,000 equals:	8.5	
3.	From Table 1, enter Annual premium rate (regardless of premium mode selected) which corresponds with your age:	19.75	
4.	From Table 2, enter Annual Premium Surcharge based on the amount of your policy:	2,00	
5.	Add #3 + #4,	21.75	
	If you wish to pay your premiums Annually, omit steps #6 & #7.		
6.	If your premium is to be paid Semi-Annually, enter .5150 If your premium is to be paid Quarterly, enter .2625 If your premium is to be paid ACP/Monthly, enter .085	,5150	
7.	Multiply #5 x #6:	11.20	
8.	Multiply #2 x (#5 for Annual Payments) or (#7 for any other payment mode):	95.20	
9.	From Table 3, enter appropriate policy fee based on the selected premium mode:	8.00	
10.	Add $\#8 + \#9$. This equals your periodic premium payment for the premium mode selected,	\$103.20	

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

Portability

If your Group Policy includes the Portability feature for Life Insurance, employees can take their 100 percent contributory Life Insurance with them when they cease their employment with you or are still actively employed and no longer belong to a class of employees eligible for Life Insurance coverage, providing they are 15-98 years old. Employees who are both disabled and away from work on the date coverage ceases are not eligible. This applies in most instances; however, requirements may vary from state to state. Please refer to your Group Policy for the specific terms that apply to your Policy.

Who is eligible?

Employees are eligible for portability if they:

- Terminate employment or no longer belong to a class of eligible employees for Life Insurance coverage;
- Are covered for (Aetna) Life Insurance;
- Are 15-98 years of age; and
- Are not disabled and away from work on the date coverage would cease.

Dependents are eligible for portability if they:

- Meet the Policy's definition of a dependent on the date the employee terminates or is no longer in an eligible class, and if they are covered for Aetna Life Insurance on such date.
- Are under age 64 if a spouse; or
- Are up to the age that is one year younger than the Policy's limiting age for dependent child eligibility.

In addition, the employee must port his/her coverage in order to port a dependent's coverage.

What is the application process?

- Portability may be elected within 31 days of losing Life Insurance coverage.
- As soon as possible, provide employee with a completed Portability Option for Group Term Life Insurance form and Portability Kit (includes forms, cost and billing information). A sample form is shown later in this chapter.
- Employees who elect portability must complete the Request for Portability of Group Term Life Insurance form and return it to Aetna with the first premium contribution within the 31-day window.
- For Portability Kits, contact your Aetna service representative.
- Employees may call Aetna at the toll-free number 1-800-826-7448 with any questions.

If elected, when does portability take effect?

• At the end of the 31-day election period.

What coverage may be ported?

- 100 percent of the amount of the employee's contributory term Life Insurance for which the employee or dependent is covered on the date the employee's active coverage terminated. (On occasion, Group Policies may allow portability of noncontributory coverage. Please refer to your Group Policy to verify what coverage may be transferred.)
- Portability minimums, maximums and age reductions apply. Please see your Group Policy for details.

What if there is a death during portability?

File a standard claim form for Life Insurance. Please see the Life Claims chapter for the claim filing requirements.

What happens when portability ceases?

Employees and dependents will have a 31-day period in which to convert to an individual Life Insurance policy. Please see the conversion information described in the Life Conversion chapter for the requirements concerning conversion.

page 1 of 4



Portability Option for Group Term Life Insurance

Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7448

Read This Instruction Page Carefully

Instructions

1. Employer

Please Print

- Complete the "Portability Option for Group Term Life Insurance" section of the application.
- Be sure that:
- All items are completed.
 - · The form is signed by your authorized representative.
- Return the application to your employee instructing them to complete the "Request for Portability of Group Term Life Insurance" section of the application.

2. Employee

Please read the Fraud Notice on the back of the form, before completing.

Please Print

- Complete the "Request for Portability of Group Term Life Insurance" section of the application in its entirety.
 - Consult the Rate Tables and instructions (included in the kit) to determine insurance amounts and costs.
 - · Consult the Portability Plan Outline for the:
 - Guaranteed Standard Issue amount (GSI); and
 - Portability Maximum

If the two amounts are the same, evidence of good health will **not** be required for the coverage that you are requesting. If the Portability Maximum is more than the GSI and you are requesting more than the GSI, evidence of good health will be required for amounts above the GSI. If Aetna sees on your application that you are applying for more than the GSI, Aetna will send you an Evidence of Insurability form which you must complete and return to Aetna within 31-days of the date the form is sent to you.

If after Aetna reviews the medical information you are approved for the coverage that you have requested, Aetna will send you a bill for the additional coverage, so the check that you are sending to Aetna with the application should **not** be for more than the GSI. Once you receive the bill you will have 31 days to pay for the amount that is above the GSI. If your payment is not received within 31 days, your coverage amount will be limited to the GSI.

If Aetna is not able to approve your request for the amount that is above the GSI, your coverage will be limited to the GSI, however, you will have the option to convert the coverage that Aetna was not able to approve to an individual whole life policy, provided your application for conversion coverage is returned to Aetna within 31 days of the date on the conversion letter.

- Be sure that:
 - All items are completed.
 - The form is signed by you.
- . Make a copy of the application for your records and mail the original to

Aetna Life Insurance Company Group Insurance 151 Farmington Avenue Hartford, CT 06156-7350

If you have any questions, call us toll-free at:

1-800-826-7448

Please call Aetna's toll-free number if you have any questions about how to complete the Request for Portability of Group Term Life Insurance form.

GR-67113 (9-07)

Life · Disability · Long Term Care

Portability Option for Group Term Life Insurance page 2 of 4

Actna Portability Option for Group Term Life Insurance Aetna Life Insurance Company - Hartford, Connecticut 06156-7350 1-800-826-7							
	ly and payment of the fil ployee's group insuranc	rst premium due for the frequency chosen must be r ce terminates.	nade within <u>31</u> days				
lote: Shaded fields a	re required fields and M	MUST be completed for your Application to be proces	ssed.				
Brief Description of P	ortability Feature						
Insurance coverage. The Fi the Guaranteed Standard I the employee must not be I amount, Aetna will require an Evidence of Insurability statement is approved, Aet Premiums must be paid an	Request for Portability of Group ssue amount) for the frequence both disabled and away from v evidence of the person's good form which the person must re tha will bill separately for the ad inually, semi-annually, or quart	terly by direct bill (nominal per bill fee).	nt should not be for more than Life Insurance terminates, ar the Guaranteed Standard Issu person, under separate cover				
The second secon	atement - To be Comple	eted by the Employer (Please Print) 2. Group Policy (Control) Number 3. Division Name	(If Applicable)				
Employer Name		Group Policy (Control) Number	(II Applicable)				
4. Employee Name (First, I	Middle Initial, Last)	5. Employee Address					
6. Employee Home Teleph	one Number						
7. Employee Social Securi		Was employee actively at work (i.e., not disabled and aw	ay from work due to illness or				
]-	injury) on date of termination? Yes No 8a. Was termination due to retirement? Yes No 8b. Was the employee insured for dependent life at termination	on? 🗆 Yes 🗀 No				
Overage Termination	Date		Salary at Time of Termination				
Month	Day Year	\$10a. Amount of Supplemental Life Coverage					
		\$ \$ \$\$ 10b. Amount of Dependent Life Insurance \$Spouse \$ Child					
b. Employee Selecte	edule, i.e., 1X, 2X, 3X salary, election of Salary Multiple at Time of Tolerounded? Yes Norounded amount \$	ermination	unt schedule:ted by employee \$				
	ecent Beneficiary Designation Middle Initial, Last)	(S) Social Security Number Birthdate (MM/DD/YY	Relationship to Employe				
a. Primary							
b. Contingent							
If term life insurance h	as been assigned, provide nar	me, address and Social Security Number of assignee.					
		, relationship to the employee, amounts of coverage and Social Sec	curity Numbers.				
16. For dependent covera	ge, provide dependent names						
17. Check other current be	ge, provide dependent names, enefit provisions employee has Benefit (Waiver of Premi		nt \$				
17. Check other current be	enefit provisions employee has Benefit (Waiver of Premi eath & Dismemberment A	ium) Accidental Death Amou					
17. Check other current be	enefit provisions employee has Benefit (Waiver of Premi eath & Dismemberment A	ium)					
17. Check other current be	enefit provisions employee has Benefit (Waiver of Premi eath & Dismemberment A	ium)					
17. Check other current be	enefit provisions employee has Benefit (Waiver of Premi eath & Dismemberment A	ium)					
17. Check other current be Life Disability Accidental De Signature (Employer Author) X Aetna Home Office Us	enefit provisions employee has Benefit (Waiver of Premi eath & Dismemberment A crized Representative)	ium)					
17. Check other current be Life Disability Accidental De Signature (Employer Autho	enefit provisions employee has Benefit (Waiver of Premi eath & Dismemberment A crized Representative)	ium)					
17. Check other current be Life Disability Accidental De Signature (Employer Author) X Aetna Home Office Us	enefit provisions employee has Benefit (Waiver of Premi eath & Dismemberment A crized Representative)	ium)					

Portability Option for Group Term Life Insurance page 3 of 4

X Aetna*	Request for Group Terral Aetna Life Insura	m Life Insu	irance	Connectic	ut 06156-73	350 1-800-	-826-7448
Request for Portability after the date your gro Standard Issue amoun hereby apply for covers	up insurance termina t, if you are eligible f	ntes. The first prei for and are applyin	mium payme g for more t	nt should i han that an	not be for mo nount.		
Former Employer's Nam							
Employee Coverage (F		areas are required t		ST be comp			
1. Employee Name (First, M				☐ Female	3. Birthdate	(MM/DD/YYYY)	
Residence (Number, Stre	Social Security Number G. Telephone Numbers (Include Area Code)						
4a. Email Address			Home () -	W	ork ()	~
7. Coverage Termination Da	ate	8. Were you actively	at work on you	date of termin	nation? Ye	s No	
Month D	ay Year	Actively at work m	If "No," please explain in Number 3 under "Other" (at bottor Actively at work means you were not disabled and away fro injury on the date of termination.				or
Amount of Insurance Rec Life Insurance when cove described in your certifica	erage terminated and is sub		of termin	ation.)	ounts (Check o	nly the benefits yo	ou had at tim
e. Guaranteed Standard Is b. Portability Maximum at		n: \$	☐ Life	Disability Ber	efit (Waiver of I	Premium)	
Have you (employee) u Yes No	The Part College N	rettes, cigars, pipe, che	ewing tobacco, e	tc.) within the	past 12 months	?	
pouse Coverage (Plea	ase Print)						
I. Spouse Name (First, Mid		2. Sex Male	Female	3. Birthdate	(MM/DD/YYYY)		
 Residence (Number, Streenployee only. 	et, City, County, State, Zip	Code) If different than	above	5. Social Sec	urity Number	1- -	10
employee coverage termi insurance. Subject to the \$	hich the employee paid the inated, and must not excee I limits described in the emp	e entire cost when d amount of employee oloyee certificate.)	terminatio	n.) ental Death A	mount \$		had at time
3. Has spouse used tobacco		And the second second second second			nths?	Yes No	
Child Coverage - Provi 1. Child Name (First, Middle		e Youngest Child	Only (Please	Print)			
2. Social Security Number		3. Age	4. Birthdate	MM/DD/YYYY).	5. Sex Male	☐ Female
	equested (Must not exceed minated, and must not exce						
Beneficiary Information	n (Please Print)						
Beneficiary(s) under Portable Portability Option for Group Name (First M)	t recent designa	tion reported (o insurer by En	nployer. See Num Relationship	
					(MM/DD/YY		
a. Primary b. Contingent Beneficiary for the depende	nt coverage(s) applied for i	s the employee unless	the coverage is	assigned in w	hich case the a	ssignee will be be	neficiary
Other (Please Print)	nicovaraga(a) applica for t	o the simpleyee dimede	tho soverege to	acoignos, iii ii	THOIT GOOD TIO	ooigiido viii bo bo	monoidiy.
Premium Payable	☐ Annual ☐ :	Semi-annual	Quarterly	2. Pren	nium Amount Er	nclosed	
3. Additional Information (Re		THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	Suchony	- 1	*		
HE UNDERSIGNED UNDE f my knowledge and belief, nocluding the conversion pro lischarge a contract or waive equired have been made in overage applied for will be 3 aid, any portable coverage	(2) issuance of the portable vision, with respect to the pe e any of Aetna's rights or re accordance with the terms 31 days following the group	e coverage applied for ortability amount reque equirements; (4) no por of the Group Policy; if ocoverage termination	shall be exchangsted; (3) no per rtable coverage not, any payment date, otherwise	ged for all privison other than will be effectived will known as the	ileges and bene n an officer of Ar e unless this en be refunded; (5 'portability date.	efits under the Gro etna can make, m rollment form and 5) the effective da	oup Policy, odify, or premium ite of portab
				v			
Signed at	City, State	on Date		х	Facilian	e Signature	

Portability Option for Group Term Life Insurance

page 4 of 4

Privacy Notice

In evaluating your insurability, we rely primarily on the health information you furnish to us in this statement.

Disclosure of Information

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding) and to request correction, amendment or deletion of recorded personal information in states which provide such right and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right or if you wish to have a more detailed explanation of our information practices, please contact: Aetna Life Insurance Company

Group Insurance 151 Farmington Avenue Hartford, CT 06156-7350

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention Arkansas, Louisiana and West Virginia Residents: 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. Attention California, Ohio and Pennsylvania Residents: 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. Attention Colorado Residents: 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.

Attention Florida Residents: 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.

Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: 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 may subject such person to criminal and civil penalties.

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

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties. Attention Oklahoma Residents: 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.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet 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.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties. Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: 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.

If you have any questions, please contact our Life Insurance Service Center at 1-800-523-5065

In many instances, employees will be given an opportunity to continue their group coverage for a limited period of time following certain qualifying events. For example, employees not actively at work due to disease or injury or who are otherwise absent from work in order to care for a newborn or a sick family member may be allowed to continue their coverage and their dependents' coverage.

Can coverage be continued if an employee is away from work due to disease or injury?

If an employee is absent from work due to disease or injury, coverage may be continued for a limited period of time, as stated in your Group Policy. This continuation of coverage may be on a premium-paying basis, which would require continued premium payments to maintain coverage even if the employee is not actively at work. If the employee does not return to work when this "administrative" continuation period ends, the employee (and any covered dependents) may be eligible for any other continuation provision of your Group Policy (for example, FMLA) for terminated employees. After any continuation provision ends, the employee (and any covered dependents) may be eligible to convert his/her coverage to a policy of individual insurance.

Continuation

Coverage for a totally disabled employee may be continued beyond any of the limits shown in your Group Policy if your Group Policy includes a total disability feature applicable to Life Insurance coverage. If this Premium Waiver disability provision were in effect on your Group Policy, you would not be required to submit premium in order for the employee's coverage to continue while they remain totally disabled. If your Group Policy does not offer a total disability feature for Life Insurance, the employee will need to convert his/her coverage to a policy of individual insurance as stated earlier. Premium payments must continue until Premium Waiver is approved.

If your Group Policy discontinues while the employee's (and any dependents') coverage is being administratively continued, coverage will cease on the date your Group Policy discontinues.

Important: As the employer, you have the discretion to decide whether you will allow coverage to continue up to the limits stated in your Group Policy or whether you will continue coverage at all. As such, we will rely upon you to notify us when you terminate the employee. Please refer to the Enrollment chapter of this handbook for instructions for terminating coverage (see item #4).

If an employee is laid off, is eligible for severance pay or on a leave of absence, can coverage be continued?

If an employee stops working because of a temporary layoff or leave of absence, coverage may be continued until the end of the month following the month in which the layoff or leave began. This is Aetna's standard policy. If Group Policies specify additional coverage, it will be honored as approved by Aetna. Premium payments must continue to be made to Aetna on behalf of the employee for coverage to continue under Severance or Leave of Absence.

If the Group Policy discontinues while the employee's coverage is being continued, coverage will cease on the date the Policy discontinues.

If you elect not to allow the employee to continue coverage or if the employee decides he or she does not want to pay for coverage to be continued, the employee's coverage should be discontinued. Please refer to the Enrollment chapter of this handbook for instructions for terminating coverage.

Examples:

- If the employee takes a short-term leave of absence on February 10, coverage can continue until March 31 of that year.
- If the employee takes a short-term leave of absence on February 10 and the Group Policy terminates on February 28, the employee's coverage will cease on February 28, the day the Policy terminates.

Can coverage be continued for handicapped dependent children?

If an employee has a child who is fully handicapped or who becomes fully handicapped before reaching the limiting age of your Group Policy for dependent children, the child's Life Insurance coverage may be continued beyond the limiting age (for example, age 19; age 23 if attending school full time) provided they have not been issued a policy of individual insurance. In order to be eligible to have coverage continued beyond your Group Policy's limiting age, the dependent child must be fully handicapped due to mental retardation or physical handicap.

A child is deemed to be fully handicapped if he or she is not able to earn his/her own living because of mental retardation or physical handicap and must depend chiefly on the employee for support and maintenance.

If the dependent child meets the definition of a fully handicapped child, proof must be submitted to Aetna no later than 31 days after the child reaches the limiting/maximum age for coverage under the Policy. The standard process is to require the completion of a medical statement by the child's attending physician. This is an Aetna form and has been tailored

specifically to this need. We also reserve the right to examine the child as often as necessary to determine ongoing eligibility. An exam may not be required more than once each year after two years from the date the dependent child reached the limiting/maximum age.

Coverage for a fully handicapped dependent child will cease when the first of the following occurs:

- The date the handicap ceases.
- The date the employee or child fails to provide proof that the handicap continues when requested.
- The date the child fails to have a required exam.
- The date dependent coverage ceases under your Group Policy (except for reaching the limiting age).
- The date any required premiums cease.

The above terms apply in most instances; however, they may vary from state to state. Please refer to the General Information About Your Coverage section of your Group Policy for the specific terms that apply to your Group Policy.

If a handicapped dependent child is eligible for any Life Insurance and/or AD&PL coverage, the Aetna Life Insurance Service Center will contact the employee if proof of the handicap is required.

The Family and Medical Leave Act (FMLA)

This section is not intended for, nor should it be interpreted as, legal advice as to an employer's legal obligations under the Family and Medical Leave Act. However, if you, as an employer, determine that you will offer an employee the option to continue basic-term Life benefits during the terms of a FMLA leave of absence, then the following information describes how this will affect the Aetna Group Life Insurance coverage.

If you grant an employee a leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), the employee may be allowed to continue the Basic Term Life benefits they were covered for on the day before the FMLA leave starts. At your discretion, you may also allow the employee to continue additional benefits the FMLA does not require (for example, Supplemental Life Insurance and AD&PL coverage). This also includes coverage for the employee's eligible dependents. If the employee acquires a new dependent while their coverage is being continued under the FMLA, the new dependent may be eligible for coverage.

At the time the employee requests a leave, you must make arrangements with the employee to collect any contributions you may require for the continued coverage.

Continuation (continued)

If your group has any benefits that are affected by an age or retirement reduction, the employee's coverage will be subject to those rules while on a FMLA leave.

Coverage for an employee may not be continued beyond when the first of the following occurs:

- The date any required contributions cease.
- The date you determine their approved FMLA leave has ended.*
- The date coverage ceases as to the employee's eligible class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

When an employee returns to work from an approved FMLA leave, coverage under your Group Policy may continue as though the employee had continued in active employment, provided the employee makes a request for such coverage within 31 days of the date the FMLA leave terminates. This request is with respect to those Supplemental coverages that may not have continued during the FMLA leave because you were unable to make premium payments on behalf of the employee. If the employee does not make such a request within 31 days, coverage may again be effective under your Group Policy only if Aetna gives its written consent. (An employee must request coverage in order to authorize future payroll deductions for such coverage.)

If your Group Policy provides any other continuation of coverage (for example, upon termination of employment) the employee (or eligible dependents) may be eligible for such continuation on the date their approved FMLA leave has ended. If the employee is eligible for any such continuation provision, any conversion provision will be available on the same terms as those for when employment is terminated.

State-required continuation

If your Group Policy is full-risk (or splitfunded), the insurance laws of the state in which your Group Policy is issued (called the contract state) may mandate that you offer continuation to employees and/or covered dependents in certain situations. In addition, insurance law(s) of the contract state(s) may also apply to your Group Policy if the law(s) are written to apply to residents of that state, regardless of the state where the contract is issued. These are known as "extraterritorial" laws, and if they apply, employees impacted by the particular law may be eligible for continuation as prescribed.

^{*}If you grant an approved FMLA leave for a period in excess of the FMLA-required period, any extended continuation of coverage during the excess period will be subject to approval by Aetna.

Life Claims

When an employee or dependent dies

Life benefits

Please refer to your Group Policy for the coverage amounts and specific terms that apply to your Group Policy.

Completing the life claim process

In the unfortunate event of the death or accidental death of an employee (or a retired employee) or a dependent who is covered for Life Insurance and/or Accident Death and Personal Loss Insurance, a claim for Life Insurance will have to be filed. This claim form is called the Proof of Death form. A sample form is shown later in this chapter.

In addition to the Proof of Death form, the following items are required to process a request for a Life Insurance benefit. Please use this checklist to help you assemble and attach all pertinent data before filing the claim. The items outlined below MUST accompany the Proof of Death form.

■ The insured's or dependent's final death certificate with cause.* A clear photocopy is acceptable. However, if death occurs outside the United States, a certified death certificate is required.

- Current beneficiary designation and any or all prior change of beneficiary designations.
- If Life Insurance benefits have been assigned, include the registered Assignment of Group Coverage form.
- Enrollment forms for the past two enrollment periods (current and prior year) on all contributory/ voluntary benefits.
- Is the beneficiary a minor child? If so, please include a copy of the child's birth certificate and letters of guardianship* of the estate of the minor or court order* to release the proceeds for the benefit of the minor.
- If the beneficiary is the insured's estate, please attach the Letters of Testamentary or Administration.*
- If the designated beneficiary predeceased the employee, please attach a copy of the beneficiary's death certificate. Depending upon the beneficiary provision of your policy, a sole survivor affidavit executed by a family member may be necessary.
- If the death is an accidental death and Accidental Death benefits are being claimed, submit any available newspaper clippings and obituary notices concerning the accident. Additional information such as police reports, fire reports or coroner's reports may be required upon request by Aetna.*

- Complete the deceased's name and Social Security number on the top of page 2 of the Proof of Death form before submitting the claim to the Life Insurance Service Center.
- By fax Aetna recommends that you fax the Proof of Death form and other required information to the Aetna Life Insurance Service Center at 1-800-238-6239. Please include a cover letter indicating the number of pages being faxed. If you fax information in, there is no need to mail in the originals.
- By mail If you elect to mail the Proof of Death form and other required information to us, please mail the originals to:

 Aetna Life Insurance Service Center P.O. Box 14549

 Lexington, KY 40512-4549

^{*}The beneficiary or the beneficiary's representative should supply this information to you.

Life Claims (continued)

Proof of Death form

Section A: Complete all boxes of this section. It includes:

- 1. Deceased's name (last, first, middle initial).
- 2. Relationship to employee (that is, self, spouse, child, etc.).
- 3. Deceased's Social Security number.
- 4. Deceased's date of birth.
- 5. Deceased's date of death.
- 6. Deceased's age at death.
- 7. Last residence of deceased, including street, city, state and zip code.

Section B: Complete all boxes of this section. Although all data in this section specifically refers to the employee, this information is useful for dependent claims as well:

- 8. Employee's name (last, first, middle initial).
- 9. Employee's Social Security number.
- 10. Employee's date of birth.
- 11. Date employed.
- 12. Hourly/salaried status.
- 13. Date employee last worked (indicate active if employee still working).
- 14. Reason employee did not return to work after last day worked (would not apply if employee is still active and claim is on a dependent).
- 15. Employee residence, including street, city, state and zip code.

Section C: Employer section of form:

- 16. Complete employer's name.
- 17. Complete local HR representative's name as the contact person.
- 18. Include street address, including city, state and zip code for contact person.
- 19. Complete telephone number for contact person (so we can contact you if we need additional information).
- 20. Check yes or no if claim was previously submitted for Accelerated Death Benefits (if applicable on your Policy).
- 21. Reply yes or no if waiver of premium was submitted prior to death (if applicable on your Policy).

The next section is VERY important! Please be sure to complete the appropriate information regarding the submission of each claim.

Check the appropriate box(s) on the Proof of Death form as to what insurance coverages are being submitted. If the claim is for a dependent, then the dependent should be noted. If claim is for an employee, then term life should be noted. If employee elected optional Life Insurance, then the term life and optional life boxes should both be marked.

Complete the control, suffix, account and plan number for each coverage (control, suffix, account and plan can vary depending on the employee status and/or location).

The effective date of employee's insurance must be completed. This is the original effective date of the employee becoming insured for Life Insurance.

Amount of Life Insurance in force as of date last worked. Indicate the amount of insurance being requested for each coverage being filed (make sure to calculate any plan reduction due to age).

Employee's earnings on last day worked are required when submitted coverage is calculated based on earnings.

Note: Please indicate whether the employee's pay is based on per week, per hour, per month. If insurance is based on other than earnings (that is, union negotiated benefit), then complete the box to the left of the question.

Complete HR questions regarding last payroll increase (required for salaried life); insurance percentage increase (that is, yes or no); Evidence of Insurability; last contributions (employee or employer contributions); date insurance was cancelled (if applicable); and conversion policy information provided to employee (if insurance was cancelled).

Section D: Information about the beneficiary(ies).

Note beneficiary information including name, address, Social Security number,* relationship to employee, date of birth and telephone numbers on the lines indicated.

Section E: Benefit distribution instructions.

Indicate where you would like the benefits payment directed (beneficiary, employer, beneficiary with copy to employer, other).

^{*}Missing Social Security numbers may delay the claim payment.

Section F: General instructions on information required with the filing of life claims.

Section G: Employer's authorized representative needs to sign and date the form before submission to the Life Insurance Service Center.

If you have any questions concerning the completion of a Proof of Death form or simply want to check on the status of a claim, you may call the Life Insurance Service Center at the number listed on this page.

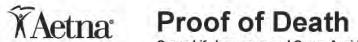
Investigating a claim

Claims are investigated to establish that benefits are payable in accordance with the insurance Policy. During the investigation, the beneficiary will be kept informed.

If it is determined that the beneficiary is not entitled to the benefit, he or she will be notified in writing, explaining the reason for the adverse claim determination and the process for requesting a review should they disagree.

The beneficiary will be provided an opportunity to appeal our decision and will be asked to document the reason he or she believes the claim should be paid.

page 1 of 3



Please fax or mail this claim to: Aetna Life Insurance Company P.O. Box 14549

A. Information About the Deceased's Name (Last, First, Middle In Relationship to Employee Sci	- COCCOC	d		side)						
Relationship to Employee So	nitial)	u		If deceased	is knowr	by any othe	er name, provide	Name (Las	st, First, Middle Initial)	
veiationship to Employee 150	ocial Security I	Number	Righdoto (A	/IM/DD/YYYY)	IDat	Date of Death (MM/DD/YYYY)		To to		
	ocial Security I	Number	Diffidate (ii	NIVED DETECT!	Dat	ie of Death (WIIW/DD/11(1)	Age	Male ☐ Female	
ast Residence: Street				City				State	Zip	
3. Information About the	Employe	e								
mployee's Name (Last, First, Middle In	nitial)			Social Secur	rity Numl	ber			Birthdate (MM/DD/YYYY)	
ast Residence: Street				City				State	Zip	
Date Employed (MM/DD/YYYY) W	Vork Location N	Name/Number			Occ	cupation/Cla	ss		Hourly	
Date Last Worked (MM/DD/YYYY) Re	to work after	last day worked	,				│			
Lufomatica Abasa de	Considerate	ala Osiusia								
C. Information About the Employer's Name	⊏mpioye	e s Covera	ye	Representat	ive's / Co	ontact's Nam	ne / Email Addre	ss		
Street Address				City	200		W	State	Zip	
Misel Address		City				State	2.10			
Re	eattachment,	Third Degree Bu							matic Brain Injury, Surgical	
		Yes remium claim su	ibmitted prior t	lo death?						
Coverages for which benefits are in effe	☐ No ☐	Yes	- 1.0							
				Effective date of employee's insurance ccount Plan (MM/DD/YYYY)		Amount of insurance in for as of the date last worked				
Group Coverage		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
Group Coverage ☐ Basic Life	_	Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
☐ Basic Life		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
☐ Basic Life ☐ ☐ ☐ Supplemental Life		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
☐ Basic Life ☐ ☐ Supplemental Life ☐		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
☐ Basic Life ☐ ☐ ☐ Supplemental Life		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
☐ Basic Life ☐ ☐ ☐ Supplemental Life ☐ ☐ ☐ Dependent Life		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
□ Basic Life □ □ Supplemental Life □ □ □ Dependent Life □ Accidental Death		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		
□ Basic Life □ Supplemental Life □ Dependent Life □ Accidental Death □ Group Accident		Control	Suffix	Account	Plan	emp	loyee's urance	The second second		

Proof of Death

page 2 of 3

			Deceased Information	Page 2
			Name (Last, First, Middle Initial)	
			Social Security Number	
). Information About The Be	neficiary/ies)			
. Information About the Be	1.	2.	3.	
Name				
Street		_		
City		<u> </u>		
State/Zip		_		
Social Security Number				
Relationship to Employee Birthdate (MM/DD/YYYY)				
Telephone Number:				
Home				
VVork				
Has benefit/ownership been assigned?	Yes, to whom? (send copy of assignment)		Assignee's Social Security Number	
Benefit Distribution Instru	ctions			
Return the benefit payment directly	y to:			
☐ Beneficiary ☐ Employ	yer			
	Employer's Claim S	Submission Ch	necklist	
☐ Insured's certified death certifi☐ Original and all the change of☐ Enrollment forms or screen pr	beneficiary designation forms ints confirming contributory cover	rage elections for the	he current and prior two years	
 ☐ Original and all the change of ☐ Enrollment forms or screen pr periods. If Aetna's plan effect 	beneficiary designation forms	rage elections for the current and most	he <u>current and prior two years</u> recent prior carrier enrollmer	nt cards.
☐ Insured's certified death certifi☐ Original and all the change of☐ Enrollment forms or screen pr periods. If Aetna's plan effect☐ Please check if there was a fa	beneficiary designation forms ints confirming <i>contributory</i> cover ive date is 3 years or less, includ imily status change (marriage, bir	rage elections for the e current and most th, adoption) and in	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan	nt cards. ge date:
	beneficiary designation forms ints confirming contributory cover ive date is 3 years or less, include a mily status change (marriage, birdox on the question "Were premit provide:	rage elections for the e current and most th, adoption) and in	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan	nt cards. ge date:
Insured's certified death certifi Original and all the change of Enrollment forms or screen pr periods. If Aetna's plan effect Please check if there was a fa /// Did you check the Yes or No blift the beneficiary is a minor child, A copy of the birth certifica	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, include a mily status change (marriage, birdox on the question "Were premit provide: ate & Social Security Number	rage elections for the current and most th, adoption) and in the current paid through the current through the current paid through the current pai	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan	nt cards. ge date:
Insured's certified death certification Original and all the change of Enrollment forms or screen preperiods. If Aetna's plan effect Please check if there was a factory of Did you check the Yes or No lift the beneficiary is a minor child, A copy of the birth certification Letters of Guardianship or	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, include a mily status change (marriage, bird box on the question "Were premit provide: ate & Social Security Number Conservatorship of the estate of	rage elections for the current and most th, adoption) and in the current through the current the minor child or	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan	nt cards. ge date:
Insured's certified death certifi Original and all the change of Enrollment forms or screen pr periods. If Aetna's plan effect Please check if there was a fa /// Did you check the Yes or No blif the beneficiary is a minor child, A copy of the birth certificatory Letters of Guardianship or A completed Uniform Trans	beneficiary designation forms ints confirming contributory cover ive date is 3 years or less, included in the status change (marriage, birds) box on the question. "Were premit provide: ate & Social Security Number Conservatorship of the estate of sfers to Minors Affidavit, if applications."	rage elections for the current and most th, adoption) and in the current through the current the minor child or	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan	nt cards. ge date:
Insured's certified death certifi Original and all the change of Enrollment forms or screen pr periods. If Aetna's plan effect Please check if there was a fa/ Did you check the Yes or No to If the beneficiary is a minor child, A copy of the birth certificat Letters of Guardianship or A completed Uniform Trans If the beneficiary is the insured's	beneficiary designation forms ints confirming contributory cover ive date is 3 years or less, included in the status change (marriage, birds) box on the question. "Were premit provide: ate & Social Security Number Conservatorship of the estate of sfers to Minors Affidavit, if applications."	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan he date of death for this insur	nt cards. ge date: red?"
Insured's certified death certifi Original and all the change of Enrollment forms or screen pr periods. If Aetna's plan effect Please check if there was a fa /// Did you check the Yes or No ble the beneficiary is a minor child, A copy of the birth certificate Letters of Guardianship or A completed Uniform Translif the beneficiary is the insured's The letters of administration If the beneficiary is a trust, provide	beneficiary designation forms into confirming contributory cover tive date is 3 years or less, included amily status change (marriage, bird box on the question "Were premit provide: ate & Social Security Number Conservatorship of the estate of sfers to Minors Affidavit, if applicates approvide: on or letters testamentary (Court Me).	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able.	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan he date of death for this insur Administrator or Executor of	nt cards. ge date: red?"
Insured's certified death certification Original and all the change of Enrollment forms or screen prepariods. If Aetna's plan effect Please check if there was a far / / / Did you check the Yes or No build the beneficiary is a minor child, A copy of the birth certification A completed Uniform Translif the beneficiary is the insured's The letters of administration The letters of administration Copies of trust and letter of Copies of trust and letters.	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, included in the confirming contributory cover in the contributory cover in the contributory contributory on the question "Were premit provide: at a Social Security Number Conservatorship of the estate of sfers to Minors Affidavit, if applicates the contributory of the countributory of the cou	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able.	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan he date of death for this insur Administrator or Executor of	nt cards. ge date: red?"
Insured's certified death certification Original and all the change of Enrollment forms or screen prepariods. If Aetna's plan effect Please check if there was a far / / / Did you check the Yes or No build the beneficiary is a minor child, A copy of the birth certification A completed Uniform Translif the beneficiary is the insured's The letters of administration The letters of administration Copies of trust and letter of Copies of trust and letters.	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, included in the confirming contributory cover in the contributory cover in the contributory contributory contributory contributory contributory conservatorship of the estate of sfers to Minors Affidavit, if applicates the contributory countributory contributory	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able.	he <u>current and prior two years</u> recent prior carrier enrollmen nclude the family status chan he date of death for this insur Administrator or Executor of	nt cards. ge date: red?"
Insured's certified death certification Original and all the change of Enrollment forms or screen preperiods. If Aetna's plan effect Please check if there was a far and please check if there was a far and please check the Yes or No build the beneficiary is a minor child, A copy of the birth certification A completed Uniform Transfit the beneficiary is the insured's The letters of administration The letters of administration of the beneficiary is a trust, providing Copies of trust and letter of the designated beneficiary has A copy of the beneficiary's If no beneficiary was named or no member(s), submit:	beneficiary designation forms into confirming contributory cover tive date is 3 years or less, included a mily status change (marriage, birds) box on the question "Were premit provide: ate & Social Security Number Conservatorship of the estate of sfers to Minors Affidavit, if applicates the provide: on or letters testamentary (Court Meter of acceptance from the trustee with died, provide: death certificate or beneficiary survives the insured	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able Papers naming the the the Trust ID numer than the	the current and prior two years recent prior carrier enrollment include the family status chan the date of death for this insur Administrator or Executor of other	nt cards. ge date: ed?" the Estate)
Insured's certified death certification Original and all the change of Enrollment forms or screen preperiods. If Aetna's plan effect Please check if there was a far and provided in the beneficiary is a minor child, A copy of the birth certification A completed Uniform Transfit the beneficiary is the insured's The letters of administration If the beneficiary is a trust, providing Copies of trust and letter of Copies of trust and letter of the designated beneficiary has A copy of the beneficiary's If no beneficiary was named or not member(s), submit: A notarized Aetna Affidavi	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, included in its status change (marriage, bird box on the question "Were premit provide: ate & Social Security Number Conservatorship of the estate of sfers to Minors Affidavit, if applicates the provide: on or letters testamentary (Court I let: of acceptance from the trustee with died, provide: a death certificate of beneficiary survives the insured	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able. Papers naming the the Trust ID number and your policy propresents a family represents.	the current and prior two years recent prior carrier enrollment include the family status chan the date of death for this insurface. Administrator or Executor of the content in the cont	nt cards. ge date: red?" the Estate)
Insured's certified death certification Original and all the change of Enrollment forms or screen preperiods. If Aetna's plan effect Please check if there was a far and provided in the beneficiary is a minor child, A copy of the birth certification A completed Uniform Transfer the beneficiary is the insured's The letters of administration if the designated beneficiary has A copy of the beneficiary's if no beneficiary was named or not member(s), submit: A notarized Aetna Affidavition beneficiary was named or not be in the letters of administration.	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, included in into contributory cover in the date is 3 years or less, included in into contributory cover in the contributory cover in the contributory of the question "Were premit provide: In the angle of the estate of the estate of the estate of the estate, provide: In the contributory of the estate of the estate, provide: In the contributory of the estate of the estate, provide: In the contributory of the estate of th	rage elections for the current and most th, adoption) and in the minor child or able Papers naming the that the Trust ID number and your policy propers a family representation.	the current and prior two years recent prior carrier enrollment include the family status chan the date of death for this insurface. Administrator or Executor of the covides for payment to next in active or revides for payment to the Estatus and prior to the Estatus carriers.	nt cards. ge date: ed?" the Estate)
Insured's certified death certification Original and all the change of Enrollment forms or screen preperiods. If Aetna's plan effect Please check if there was a far and provided in the beneficiary is a minor child, A copy of the birth certification A completed Uniform Translet the beneficiary is the insured's The letters of administration Copies of trust and letter of Copies of trust and letter of A copy of the beneficiary's If the designated beneficiary has A copy of the beneficiary's If no beneficiary was named or not member(s), submit: A notarized Aetna Affidavion of the Interest of Accidental Death benefits are benef	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, included in into contributory cover in the date is 3 years or less, included in into contributory cover in the contributory cover in the contributory of the question "Were premit provide: In the angle of the estate of the estate of the estate of the estate, provide: In the contributory of the estate of the estate, provide: In the contributory of the estate of the estate, provide: In the contributory of the estate of th	rage elections for the current and most th, adoption) and in the minor child or able Papers naming the that the Trust ID number and your policy propers a family representation.	the current and prior two years recent prior carrier enrollment include the family status chan the date of death for this insurface. Administrator or Executor of the covides for payment to next in active or revides for payment to the Estatus and prior to the Estatus carriers.	nt cards. ge date: red?" the Estate) line family tate, provide;
Insured's certified death certification Original and all the change of Enrollment forms or screen preperiods. If Aetna's plan effect Please check if there was a far and process. If Aetna's plan effect Please check if there was a far and process. If the beneficiary is a minor child, A copy of the birth certification Letters of Guardianship or A completed Uniform Translif the beneficiary is the insured's The letters of administration Copies of trust and letter of the designated beneficiary has A copy of the beneficiary's If no beneficiary was named or numember(s), submit: A notarized Aetna Affidavi If no beneficiary was named or numember of the letters of administration of the letters of administration of the police/accident report autopsy report	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, included in into contributory cover in the date is 3 years or less, included in into contributory cover in the contributory cover in the contributory of the question "Were premit provide: In the angle of the estate of the estate of the estate of the estate, provide: In the contributory of the estate of the estate, provide: In the contributory of the estate of the estate, provide: In the contributory of the estate of th	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able. Papers naming the that the Trust ID numbers and your policy propers naming the land your policy propers naming the papers naming the papers naming the	he current and prior two years recent prior carrier enrollment and prior two years recent prior carrier enrollment and the family status chan the date of death for this insur additional content of the	nt cards. ge date: red?" the Estate) line family tate, provide;
Insured's certified death certification Insured's certified death certification Insured's certified death certification Insured's certified death certification Insured's If Aetna's plan effect Insured's Insured Insured's Insured I	beneficiary designation forms into confirming contributory cover tive date is 3 years or less, included amily status change (marriage, bird box on the question "Were premit provide: ate & Social Security Number Conservatorship of the estate of sfers to Minors Affidavit, if applicates the provide: and or letters testamentary (Court Meter of acceptance from the trustee with died, provide: a death certificate to beneficiary survives the insured at of Sole Survivors completed by the provide: a death certificate to beneficiary survives the insured at of sole Survivors completed by the provide: the state of services the state of services the insured at the services	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able. Papers naming the that the Trust ID number a family representation and your policy prepapers naming the senger in a motor of available.	the current and prior two years recent prior carrier enrollment and prior two years recent prior carrier enrollment and the family status chan the date of death for this insurface. Administrator or Executor of aber revides for payment to next in ative or revides for payment to the Esta Administrator or Executor of the enrollment according to the end of the enrollment according to the enroll	nt cards. ge date: red?" the Estate) tate, provide: the Estate)
Insured's certified death certification or original and all the change of Enrollment forms or screen preperiods. If Aetna's plan effect Please check if there was a fare of Did you check the Yes or Note of the beneficiary is a minor child, and a copy of the birth certification of Letters of Guardianship or A completed Uniform Transfit the beneficiary is the insured's of The letters of administration of the beneficiary is a trust, provided completed of the designated beneficiary has a copy of the beneficiary's of the designated beneficiary has a copy of the beneficiary's of the beneficiary was named or not beneficiary w	beneficiary designation forms into confirming contributory cover ive date is 3 years or less, included in the confirming contributory cover in the contributory cover in the contributory cover in the contributory contributory on the question "Were premit provide: In the contributory of the estate of sters to Minors Affidavit, if applicated as the contributory of the estate, provide: In the contributory of the estate of sters to Minors Affidavit, if applicated as the contributory of the contributory of acceptance from the trustee with died, provide: In the contributory of the insured of the contributory of the contrib	rage elections for the current and most th, adoption) and in the ums paid through the the minor child or able. Papers naming the the Trust ID number a family represented and your policy prepares naming the papers naming the senger in a motor of available. Life insurance clair al documents.	the current and prior two years recent prior carrier enrollment include the family status chan the date of death for this insurface. Administrator or Executor of aber revides for payment to next in ative or revides for payment to the Esta Administrator or Executor of vehicle accident)	nt cards. ge date: red?" the Estate) tate, provide: the Estate)

Proof of Death

page 3 of 3

	Page 3
F. Employer's Authorized Representative Any person who knowingly and with intent to injure, defraud or deceive any insurance compinsurance or statement of claim containing any materially false information or conceals, for any fact material thereto commits a fraudulent insurance act, which is a crime and subjects Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowingly of a loss or benefit or knowingly presents false information in an application for insurance is confinement in prison. Attention California, Ohio and Pennsylvania Residents: Any person who knowingly and other person files an application for insurance or statement of claim containing any material misleading, information concerning any fact material thereto commits a fraudulent insurance criminal and oxivil penalties. It is unlawful to knowingly provide false, incomplete, or mompany for the purpose of defrauding or attempting to defraud the company. Penalties m and civil damages. Any insurance company or agent of an insurance company who knowlro information to a policyholder or claimant for the purpose of defrauding or attempting to dissettlement or award payable from insurance proceeds shall be reported to the Colorado divergulatory agencies. Attention Florida Residents: Any person who knowingly and with intent to injure, defraud or an application containing any false, incomplete or misleading information is guilty of a fel Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or an application containing any false, incomplete or misleading information is guilty of a fel Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud person submits an enrollment form for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance and mapplication for insurance or statement of claim containing any materially false information or information concerning any fact material thereto com	Deceased Information Jame (Last, First, Middle Initial)
F. Employer's Authorized Representative Any person who knowingly and with intent to injure, defraud or deceive any insurance compinsurance or statement of claim containing any materially false information or conceals, for any fact material thereto commits a fraudulent insurance act, which is a crime and subjects Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowing of a loss or benefit or knowingly presents false information in an application for insurance is confinement in prison. Attention California, Ohio and Pennsylvania Residents: Any person who knowingly and other person files an application for insurance or statement of claim containing any material mislading, information concerning any fact material thereto commits a fraudulent insurance criminal and civil penalties. Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or mompany for the purpose of defrauding or attempting to defraud the company. Penalties mand civil damages. Any insurance company or agent of an insurance company who knowlro in information to a policyholder or claimant for the purpose of defrauding or attempting to dissettlement or award payable from insurance proceeds shall be reported to the Colorado divergulatory agencies. Attention Florida Residents: Any person who knowingly and with intent to injure, defraud or an application containing any false, incomplete or misleading information is guilty of a fel Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or an application containing any false, incomplete or misleading information is guilty of a fel Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud preson submits an enrollment form for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance of misleading information concerning any fact material thereto commits a praudulent insurance of statement of claim contain	
Any person who knowingly and with intent to injure, defraud or deceive any insurance compinsurance or statement of claim containing any materially false information or conceals, for any fact material thereto commits a fraudulent insurance act, which is a crime and subjects Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowing of a loss or benefit or knowingly presents false information in an application for insurance is confinement in prison. Attention California, Ohio and Pennsylvania Residents: Any person who knowingly and other person flies an application for insurance or statement of claim containing any material misleading, information concerning any fact material thereto commits a fraudulent insurance criminal and civil penalties. Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or mocmpany for the purpose of defrauding or attempting to defraud the company. Penalties and civil damages. Any insurance company or agent of an insurance company who knowing or information to a policyholder or claimant for the purpose of defrauding or attempting to disettlement or award payable from insurance proceeds shall be reported to the Colorado diversellation containing any false, incomplete or misleading information is guilty of a fel Attention Florida Residents: Any person who knowingly and with intent to injure, defraud or an application containing any false, incomplete or misleading information is guilty of a fel Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud of an application containing any false, incomplete or misleading information is guilty of a fel Attention Kentucky Residents: Any person who knowingly and with intent to injure, defraud of misleading, information concerning any fact material thereto may have violated state law Attention Kentucky Residents: Any person who knowingly and with intent to defraud any application for insurance or statement of claim containing any materially false information inform	Social Security Number
Any person who knowingly and with intent to injure, defraud or deceive any insurance comprisurance or statement of claim containing any materially false information or conceals, for any fact material thereto commits a fraudulent insurance act, which is a crime and subjects Attention Arkansas, Louisiana and West Virginia Residents: Any person who knowing of a loss or benefit or knowingly presents false information in an application for insurance is confinement in prison. Attention California, Ohio and Pennsylvania Residents: Any person who knowingly and other person files an application for insurance or statement of claim containing any material misleading, information concerning any fact material thereto commits a fraudulent insurance criminal and civil penalties. Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or mompany for the purpose of defrauding or attempting to defraud the company. Penalties and civil damages. Any insurance company or agent of an insurance company who knowing or information to a policyholder or claimant for the purpose of defrauding or attempting to disettlement or award payable from insurance proceeds shall be reported to the Colorado divegulatory agencies. Attention Florida Residents: Any person who knowingly and with intent to injure, defraud or an application containing any false, incomplete or misleading, information is guilty of a fel Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud or an application containing any false, incomplete or misleading, information is guilty of a fel Attention Kansas Residents: Any person who knowingly and with intent to injure, defraud of misleading, information concerning any fact material thereto may have violated state law Attention Kentucky Residents: Any person who knowingly and with intent to defraud any application for insurance or statement of claim containing any materially false information, company for the purpose of defrauding the company. Penalties may include im	
Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud person files an application for insurance or statement of claim containing any materially fals misleading, information concerning any fact material thereto commits a fraudulent act, which and civil penalties. Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or for the purpose of defrauding the company. Penalties include imprisonment, fines, and der Name Signature	the purpose of misleading, information concerning such person to criminal and civil penalties. It is presents a false or fraudulent claim for payment guilty of a crime and may be subject to fines and a with intent to defraud any insurance company or ly false information or conceals, for the purpose of eact, which is a crime and subjects such person to eact, which is a crime and subjects such person to isleading facts or information to an insurance and include imprisonment, fines, denial of insurance gly provides false, incomplete, or misleading facts of insurance within the department of a provides false, incomplete, or misleading facts of insurance within the department of a provides false, incomplete, or misleading facts or deceive any insurer, files a statement of claim only of the third degree. If or deceive any insurance company or other rially false information or conceals, for the purpose of misleading, is a crime and may subject such person to criminal misles, for the purpose of misleading, is a crime and may subject such person to criminal and civil penalties. In conceals for the purpose of misleading, is a crime, and shall be subject to a civil penalty defraud or deceive any insurance company or only false information or conceals, for the purpose of a cat, which may be a crime and subjects such to injure, defraud or deceive any insurance company or other person submits an on or conceals for the purpose of misleading, fraud includes false information in an application oss or other benefit, or files more than one claim his violation with a fine of no less than five thousand on of three (3) years, or both. If aggravating if mitigating circumstances are present, the jail and or deceive any insurance company or other einformation or conceals, for the purpose of a cat, which may be a crime and may subject such and or deceive any insurance company or other einformation or conceals, for the purpose of a cat, which may be a crime and may subject such and or deceive any insurance company or other einformation

GC-1373 (4-07) K

Aetna Beneficiary Solutions TM

What is Aetna Beneficiary Solutions?

When a loved one dies, beneficiaries shouldn't have to face overwhelming financial and legal decisions alone. As a standard feature of Aetna Group Life policies, Aetna Beneficiary Solutions provides enhanced, confidential resources that enable beneficiaries to clearly and conveniently handle these important decisions – at their own pace.

Aetna Beneficiary Solutions

All Aetna Group Life policy sponsors and beneficiaries can receive the following essential services at no extra cost.

Financial counseling and investment services

All beneficiaries, no matter the payout amount, will receive free financial counseling from Chase Investment Services Corp. (CISC*), a subsidiary of JPMorgan Chase Bank. CISC is a full-service brokerdealer and registered investment advisor.

- The CISC financial consultants receive bereavement training and seek to understand the beneficiaries' shortand long-term goals, help them develop financial priorities, and then can set up an investment program to meet their objectives.
- Beneficiaries can choose from a range of investments - mutual funds, bonds, annuities, stocks/options, unit investment trusts and more.

Free Web-based legal information and discounted legal services

■ A core legal services program, Legal ReferenceTM,** will now be available to beneficiaries. Legal Reference offers access to free and discounted legal services and information that will be independently administered by Advisory Communications Systems, Inc. (ACS).

Aetna Benefits Checkbook®

- Beneficiaries receiving payouts of \$5,000 or more receive an interestbearing checking account into which the Life Insurance or AD&PL proceeds are deposited.
- The checkbook program offers beneficiaries immediate access to their funds, but allows them to take the time to make important decisions.

^{*}Financial counseling, securities and investment advisory services are independently offered through Chase Investment Services Corp. (CISC). A member of NASD/SIPC and a subsidiary of JPMorgan Chase Bank, CISC is a full-services broker-dealer and registered investment advisor. Aetna does not warrant or guarantee and makes no representations as to the quality of services offered by CISC.

^{**}The Legal Reference Program is independently offered and administered by Advisory Communications Systems, Inc. (ACS). Aetna Life Insurance Company does not participate in attorney selection or review and does not monitor ACS services, content or network. Aetna does not warrant or guarantees, or make any representation as to the quality of the services of ACS, or of any attorney in the ACS network.

Bill Payment

Understanding and paying your List Bill

What is a List Bill?

Under the List Bill process, statements are produced based on the benefits, the rate for each benefit and the number of employees and dependent lives (if applicable) that our administrative system indicates are enrolled in your Group Policy. The List Bill statement is also designed to maintain a list of your members for claim verification within our administrative billing system. You will receive a billing statement in advance of the statement due date.

If you have any questions regarding the information shown on your statement, please contact your Aetna representative at the number listed on your billing statement.

How do I read my List Bill?

A List Bill statement consists of eight sections. A more detailed description of each section and an example of a List Bill statement are shown on the following pages.

A. Payment Stub and Remittance section

The payment stub provides a recap of any prior balance due amounts, the current due and the total amount due. The following is a brief summary of each item found on the payment stub.

- Change space
 For address and phone number changes.
- SCD number Self-checking digit for internal use only.
- Control number
 Identifies your account. It should be included on all correspondence and forms.
- 4. Account name

 The identifying name on the account.
- Account phone Your business phone number.
- Servicing field office
 The name and number representing the field office that services your account.

7. Statement date

The due date for which the statement is being prepared and for which payment is expected.

8. Grace period expires

The date payment of this statement must be received by Aetna to ensure continuation of your group coverage and to prevent late-charge assessment or possible cancellation.

- Customer name and mailing address Your company's name and mailing address.
- 10.Lock box remittance address Address to which payment and stub should be sent.
- 11. Prior balances due Any unpaid balances will be reflected here.

12. Current due

Indicates the amount of the current month's charge.

13. Total amount due

Represents the sum of the prior balance due plus the current due. This is the total amount that should be paid.

Note: The payment stub must always be detached and remitted with your payment.

B. Statement of Account section

The Statement of Account is a summary of all due and paid activity that occurs on your account and can be produced with your statement. The statement on account details the following.

1. Statement date

The due date(s) of the statement(s) with prior balances that are indicated on the statement of account.

2. Prep/paid date

Either the prepared date of a statement or the date a payment was applied.

3. Transaction type

The type of transaction that is applicable (that is, payment).

4. Statement due amount

The amount due for the statement date indicated.

5. Paid amount

The amount paid for the statement date indicated.

6. Cumulative balance

The balance accumulated (if any) on the account as of a particular statement date.

7. Total amount due

The total amount due on the account as a result of the cumulative balance.

C. Message section

This section of your statement will contain any message that would be applicable to your account. Examples of various types of messages are indicated below:

1. The symbol "*" indicates a change to an Enrollee or dependents.

- 2. "CR" placed after an amount indicates a credit.
- 3. FOR QUESTIONS REGARDING THIS STATEMENT PLEASE CONTACT: (the individual listed on your billing statement).

D. Account/Benefit Adjustment Information section

The Account/Benefit Adjustment Information section of the statement provides details as to any adjustments made to your account for that billing period. This section will only appear on your statement when an account or benefit adjustment is applicable. This section is detailed as follows.

1. Account/benefit

The type of adjustment made. An adjustment can be made to a specific benefit or to the entire account.

2. Reason

The reason for the account/benefit adjustment. For example, a benefits rate revision to the entire account.

3. Effective date of change

The effective date used to calculate the account/benefit adjustment.

4. Adjustment amount

The amount of the adjustment applied to your account. This could be either a credit or debit adjustment.

Subtotal account/benefit adjustments The subtotal of all adjustments applied to the account for that billing period.

E. Enrollee Transaction Activity section

The Enrollee Transaction Activity portion of the statements displays enrollments, changes and terminations that have been processed during the current billing period. Information on this section is detailed as follows.

1. Name, SSN, sex and birth date

Indicates the name, Social Security number, sex and birth date of each Enrollee.

2. Chng-Type

The type of transaction (that is, New = enrollment, CHHG = change, Term = Termination).

3. Change Eff Date

The effective date of the transaction.

4. Pln

The plan of benefits the Enrollee is or was enrolled in.

5. Dep

Indicates the number of covered dependents.

"H" = Husband

"W" = Wife

The number = total number of children (for example, H1 = Husband and 1 child covered).

6. Current Charge

Enrollee's current charge for that billing period.

Note: If the effective date of the Enrollee transaction occurs on a date other than a statement due date, we will not charge or credit for the days in the initial short month. Also, retroactive enrollments are assessed charges based on current rates.

Bill Payment (continued)

7. Back adjustment

The amount of the back adjustment if applicable. Credit or debits will be for no more than three months.

8. Enrollee transactions

A subtotal of current charges and back adjustments for all transactions reflected.

F. Active/Retired Enrollees section

The Active/Retired Enrollee section of your statement, if applicable, reflects all Enrollees currently insured for that month. The following is a summary of the items displayed in this section:

1. Name, SSN, sex and birth date Indicates the name, Social Security number, and sex and birth date of each Enrollee.

2. Effective date

The effective date of new coverage or last change, whichever is later, for each Enrollee insured for that billing period.

3. Pln

The plan of benefits the Enrollee is or was enrolled in.

4. Dep

Indicates number of covered dependents.

"H" = Husband

"W" = Wife

"X" = Spouse over age 65

The number = total number of children (for example, H1 = Husband and 1 child covered).

5. Current charge

Enrollee's current charge for the billing period.

6. Life ins amount

Amount of Life Insurance for each Enrollee, if applicable.

7. Currently active

The number of currently active Enrollees.

8. Current Charges

The subtotal of current charges for all Enrollees.

G. Benefit and Service Analysis section

The Benefit and Service Analysis section of your statement displays a summary of benefits for active Enrollees and/ or dependents on your account. The following is an explanation of this portion of the statement.

1. Benefit or service

Reflects each benefit or service billed on your account and for whom the benefit/service applies (for example, employee and/or dependent).

2. Number

The total number of Enrollees/ dependents billed for each benefit/service.

3. Volume

The total volume of insurance if applicable to that benefit/service (for example, Life Insurance volume of \$10,000 each for six Enrollees equals a total volume of \$60,000).

4. Rate/rate base

The rate and rate base for each benefit/service. For example, the life benefit may be billed on a per \$1,000 basis.

5. Current charge

The total current charge for all active Enrollees for each benefit/service.

6. Adjustment

Total adjustment for each benefit/service.

7. Current due

The total current due for each benefit. The current due is the sum of current charges plus or minus any adjustments.

H. Due Summary section

The Due Summary is the final section of your statement. It provides a recap of due amounts as follows.

1. Total adjustments

The total amount of all adjustments for the current period.

2. Current charges

The total current charges for all Enrollee and/or dependent activity.

3. Statement due amount

The sum of total adjustments plus or minus current charges.

How do I pay my List Bill?

To ensure uninterrupted claims service, the total amount due reflected on your payment stub should be mailed to Aetna by the due date. This date is prior to the expiration date. Checks should be made payable to Aetna Inc. Your check should also include your control, suffix and account numbers. Detach the payment stub from the statement and mail with your check to the remittance address shown on the stub.

* Aetna

PAYMENT STUB SCD: 1

Ætna's Administrative System

PAGE 1 930081-010-00002

CONTROL NUMBER ACCOUNT NAME ACCOUNT PHONE

TEST 000-000-0000 SERV FIELD OFFICE 076 MIDDLETOWN PAYMENT DUE DATE NOV 1, 2003

Mandladalddaladhaddaddadhalladladadl

PLEASE INDICATE ADDRESS/PHONE CHANGE BELOW

TEST AAS TESTING QA ATTN: *TEST* AAS TESTING 1000 MIIDDLE ST MIDDLETOWN CT

06457-7527

AETNA INC. ATTN: AETNA - MIDDLETOWN P.O. BOX 70966 CHICAGO IL

IL 60673-0966

CURRENT DUE GRACE PERIOD EXPIRES DEC 2, 2003

PRIOR BALANCES DUE REFLECTING PAYMENTS THRU OCT 27, 2003	REBILLED ADJUSTMENT AMOUNT	TOTAL AMOUNT DUE
\$3,919.80	\$.00	\$3,919.80

PLEASE DETACH STUB AT PERFORATION AND MAIL ALONG WITH YOUR PAYMENT FOR THE TOTAL AMOUNT DUE.

STATEMENT OF ACCOUNT

TEST AAS TESTING QA

CONTROL NUMBER 930081-010-00002 ACCOUNT NAME TEST ACCOUNT PHONE 000-000-0000 SERV FIELD OFFICE 076 MIDDLETOWN PAYMENT DUE DATE NOV 1, 2003

THE FOLLOWING LISTS YOUR PAYMENT DUE AMOUNTS AND PAYMENTS RECEIVED.

PAYM			PRE	P/P		TRANSACTION TYPE	PAYMENT DUE AMOUNT	PAID AMOUNT	CUMULATIVE BALANCE	
NOV	21 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		03	VOID DUE VOID DUE REBILL	783.30 3,919.80 3,919.80	3,919.80				
							TOTA	L AMOUNT DUE	\$3,919.80	

MESSAGES

PAYMENT DUE AMOUNTS HAVE BEEN RECALCULATED DUE TO A POLICY REVISION.

IMPORTANT - PLEASE READ: THE TOTAL PREMIUM IS DUE ON THE FIRST DAY OF THE MONTHLY COVERAGE PERIOD. IF NOT RECEIVED BY THE END OF THE GRACE PERIOD, THE CONTRACT MAY BE TERMINATED. YOU WILL BE LIABLE FOR THE PREMIUM FOR ALL PERIODS OF COVERAGE (INCLUDING THE GRACE PERIOD) UNLESS YOU PROVIDE AT LEAST 30 DAYS ADVANCE WRITTEN NOTICE OF YOUR INTENT TO TERMINATE.

CR PLACED AFTER AN AMOUNT INDICATES A CREDIT.

FOR QUESTIONS REGARDING THIS STATEMENT, OR TO REPORT AN ENROLLEE TRANSACTION PLEASE CONTACT: AETNA PLAN SPONSOR SERVICES & 888-287-4295

YOU MAY ALSO FAX EMPLOYEE TRANSACTIONS TOLL FREE TO OUR SERVICE REPRESENTATIVES AT 866-682-3862.

THIS STATEMENT REFLECTS ALL PAYMENTS AND CHANGES RECORDED AS OF THE PREPARED DATE SHOWN BELOW.

REGION: 06 SGB ADMIN ILE

00,000,042 PREPARED DATE OCT 27, 2003

etna					EME	oi ny	FE RENE	FITS STA	TEMENT	A	tnas Adr	ninistrative P	
		TEST AA	S TESTING	QA	2		habe areatty		CONTROL NO ACCOUNT PO ACCOUNT PO SERV FIELD PAYMENT DO	AME HONE D OFFICE	930081- TEST 000-000- 076 MIDD NOV 1,	010-00002 0000 LETOWN	
					ENF	OLLE	E TRANSA	CTION ACTIV	TITY				
	_	ENROLLEE	NAME	SSN OF	ID	SEX	BIRTH		CHANGE EFF DATE	PLN DEP	CHARGE	BACK ADJUSTMENT	
	JLKSA	CARR CARTER CASS CASSELL CATT		930-08- 930-08- 930-08- 930-08- 930-08-	1011 1003 1013		3/30/72 10/01/64 4/15/70 3/01/70 12/20/66	NEW NEW	11/01/03 11/01/03 11/01/03 11/01/03 11/01/03	5 W1 5 H 5 2 5 2	870.10 553.10 261.10 580.10 261.10	.00	
	K	GRANT KNIGHTLEY LESLIE		930-08- 930-08- 930-08-	1006		6/01/55 12/10/75 9/14/50	NEW	11/01/03 11/01/03 11/01/03	5 1 5 5 W	580.10 261.10 553.10		
								ENROLLEE	TRANSACT	CONS			
							0	ENROLLMENT CHANGES TERMINATIO			.00 .00 .00		
							SUBTOTAL	OF ENROLLE	E TRANSAC	TIONS		\$.00	
						ACTI	VE/RETIR	ED ENROLLEE	S				
		ENROLLEE	NAME	SSN_OF	RID	SEX	BIRTH DATE		EFFECTIVE DATE	PLN DEP	CURRENT	LIFE INS	
	LKSA	CARR CARTER CASS CASSELL CATT		930-08- 930-08- 930-08- 930-08- 930-08-	1011 1003 1013	F	3/30/72 10/01/64 4/15/70 3/01/70 12/20/66		11/01/03 11/01/03 11/01/03 11/01/03 11/01/03	5 W1 5 H 5 2 5 2	870.10 553.10 261.10 580.10 261.10	1,000	
	W K D	GRANT KNIGHTLEY LESLIE		930-08- 930-08- 930-08-	1006		6/01/55 12/10/75 9/14/50		11/01/03 11/01/03 11/01/03	5 1 5 5 W	580.10 261.10 553.10	1,000	
		cu	RRENTLY AC	TIVE		8	cu cu	RRENT CHARG	ES		\$3,919.80	,	
	BENEFIT AND SERVICE ANALYSIS												
		BENEFIT OR	SERVICE	LIVES	VOL	IME	RATE/RA	TE BASE	CHARGE	ADJUST	MENT C	URRENT DUE	
	TE	RM LIFE	EMPL	8		3,000	.5	00/1000	4.0	0	.00	4.00	
			DEP	5			2.D	00/EMPL	10.0	0	.00	10.00	
	AC	CIDENT	EMPL	8		3,000	,6	00/1000	4.8	0	.00	4.80	
	ME	DICAL EXPEN	SE EMPL	8			260.0	00/EMPL	2,080.0	0	.00	2,080.00	
			SP	2			290.0	00/EMPL	580.0	0	.00	580.00	
			c	2			317.0	00/EMPL	634.0	0	.00	634.00	
			SPC	1			607.0	00/EHPL	607.0	0	.00	607.00	
9							τ	OTALS	\$3,919.8	0 \$1	0.00	\$3,919.80	
							NOV DUE	SUMMARY					
		TOTAL	ADJUSTMEN	rs •	1-		CURRENT	CHARGES		PAYME	NT DUE AN	OUNT	

00,000,043 PREPARED DATE DCT 27, 2003

REGION: 06 SGB ADMIN ILE

Bill Payment (continued)

Understanding and paying your Summary Bill

You will receive a billing statement based on the billing frequency of your policy, in advance of the statement due date. All statements you receive are estimated statements. You will be expected to make adjustments to each statement, calculate premium due and forward the "total premium due" directly to the remittance address on your statement along with your updated statement.

Please contact your Aetna representative upon receipt of your first bill to assist you in calculating the total premium due.

Payment must be made by the due date to ensure continued coverage for your employees.

How do I read my Summary Bill?

The following describes each section of your statement to help you understand and read your statement. A sample statement is also shown at the end of this section.

Change space Used to report a change of address.

SCD number Self-checking digit for internal use.

3. Control number

Identifies your account. Consists of the control, suffix and account numbers. This information should be included in all correspondence to Aetna Inc.

4. Statement date

The due date for which the statement is being prepared and on which payment is to be expected.

5. Account name

The identifying name on the account.

6. Account phone

Will be displayed if provided.

7. Servicing field office

The name and number representing the field office responsible for your account.

8. Customer team name

Applicable to National Accounts customers only.

9. Prep date

Date the Summary Billing Statement was prepared.

10.Grace period expires

The date payment of this statement must be received by Aetna to ensure continuation of your group coverage in order to prevent a late charge assessment as outlined in your fee scheduler.

11. Contact name

The name and phone number of the individual responsible for your Group Policy. If an individual is not assigned to your Group Policy, it will show a toll-free number to call.

12. Customer name and address

Identifies your name, address and the person to whose attention the summary statement is being sent. Please notify your Aetna service representative should this information change.

13. Billing line name

Identifies coverage contained in the billing line.

14. Billing line code

Internal code for company use to further identify the billing line.

15. Number of employees

Number of employees who are covered as of the statement date. The number in the shaded area reflects the estimated number of covered employees, based on the latest finalized statement.

16. Volume

Reflects the total amount of coverage for all covered employees. For example, if you have 10 employees and each has \$10,000 worth of insurance, your total volume would be \$100,000.

17.Rate

Represents the rate that is charged for the line of coverage.

18.Amount

New amount that is due for that line of coverage.

19. Adjustment

Used to correct errors in payments for previous statements. The error could be a result of incorrect reporting of lives and volume. Correction is accomplished by taking credit or charge by billing line. To avoid any delays in processing your payments, please provide an explanation of the adjustments in the space provided.

20. Explanation of adjustment

When making any type of adjustment exceeding three percent of the total premium, please provide us with an explanation in this space.

21. Total amount due

Recalculated amount for any change or adjustment made. If you have a multiple-page statement, total amount due goes on the last page of the statement.

22. Estimated amount due

Estimated amount according to last updated figures.

23. To properly credit your account send statement with payment

This is an important item: You must include a copy of the entire statement to ensure proper posting of your payment to your account and to avoid any applicable late charges.

24. Lock box remittance address

The address to which the payment and completed statement must be sent.

25. Please provide control number on your check

In order to ensure proper posting of your check, it is very important that you include your Group Policy's control number on your check.

26. Signature of an authorized company representative

The statement must be signed by a representative of your company having the proper authority to sign such statement.

How do I complete my Summary Bill?

1. Complete number of employees

Above the shaded area to the right of the asterisk, enter the total amount of employees who are covered as of the statement date.

2. Complete volume, if applicable

Above the shaded area to the right of the asterisk, enter the total volume as of the statement date. The volume equals the total amount of coverage for all employees enrolled in the benefit being calculated. If the number of employees increases, the volume should also increase.

3. Rate

Multiply the rate by the entry for the number of employees or volume, whichever is followed by an "X," and enter the result in the amount column. If your benefit line is calculated by volume, multiply the volume by the rate and divide by the rate basis. For example, to calculate the amount for the life benefit on the sample statement: Multiply the volume (100,000) by the rate (.090) and divide by the rate basis (\$1,000) = 9.00. If your line is calculated based on number of employees, multiply the number of employees by the rate. Should you need assistance with this section, please contact your Aetna service representative.

Note: Do not enter the result in the adjustment column.

4. The adjustment column

Should be used to enter any charge (+) or credit (-) by billing line not accounted for on previous statements. Place the amount in the adjustment column next to the appropriate billing line. Adjustments should be included in calculating the total amount due. When making an adjustment, please provide an explanation for the adjustment in the space provided at the top of the statement.

5. Total amount due

The recalculated net total of all billing line amounts and adjustments should be entered in the total amount due box, located in the lower right corner on the last page of the statement, if there are multiple pages. Do not total each page. All pages must be returned.

6. Checks

Please make your check payable to Aetna Inc. and remit both the statement and check to the lock box address indicated on your statement.

Ætna's Administrative System **Summary Statement** PAGE 001 SCD: 3 Please indicate change of address below Control Number: 930081-10-00001 NOV 01, 2003 Statement Date: Account Name: TEST Account Phone: 000-000-0000 Serv. Field Office ILE MID 076 076/MIDDLETOWN Customer Team: *TEST* AAS TESTING QA N/A ATIN: *TEST* AAS TESTING Prep Date: DCT 27, 2003 1000 MIIDDLE ST MIDDLETOWN CT 06457 GRACE PERIOD EXPIRES: DEC 02, 2003 * * * * SEE REVERSE SIDE FOR ILLUSTRATION AND COMPLETE INSTRUCTIONS * * * *

^{*} Please provide explanations for any large fluctuations in total figures and/or adjustments in this space. (I.E. terminations, rate revisions, schedule changes, etc.) Enter the adjustment amounts opposite the appropriate billing lines.

BILLING LINE		T	TAL INS	URED	X RATE	=	AMOUNT	*ADJUSTMEN
NAME	CODE	NO, OF EMPLOYER	S	VOLUME		1		
TATEMENT RECALCUL HIS BILL DOES NOT HIS STATEMENT DAT ILL MUST BE PAID	EXTE	ND THE	GRACE	E IN AMOUNT	ANY AMOUNT DU S DUE BETWEEN			
EMPLOYEE LIFE	100	*		X 100,000	.550/\$1000	*	55.00	
DEPS LIFE	110	*		APPLIC.	2.000/EMPL	*	6.00	
AD&D	200	* 10		100.000 X	.067/\$1000	*	6.70	
EMPLOYEE PPO MED UNDER 65	400	* 10		APPLIC.	325.000/EMPL	*	3,250.00	
EMPLUYEE PPO MED OVER 65	401	*		APPLIC.	325.000/EMPL	*	3,250.00	
DEP PPU MED	500	*		APPLIC.	230.000/EMPL	*	1,150.00	
DEP PPO MED TIER 03	501	*	X NOT	APPLIC.	200.000/EMPL	*	600.00	
DEP PPO MED TIER 04	502	*	X NOT	APPLIC.	430.000/EMPL	*	430.00	

To properly credit your account, send statement with payment.

AETNA INC. AETNA - MIDDLETOWN P.O. BUX 70966 CHICAGO IL

IL 60673-0966

* TOTAL AMOUNT DUE

* PLEASE ENTER TOTAL *

**** ON LAST PAGE ****
CONTINUED

Please provide control number on your check

AETNA COPY

Signature of Customer's Representative

X Aetna [®]			Summary Sta	atement		ACUIA S	Administrative System PAGE 002	
ILE MID (TEST* AAS TEST!	ILE MID 076 ESI* AAS TESTING QA IN: *TEST* AAS TESTING			Control Number: Statement Date: Account Name: Account Phone: Serv. Field Office Customer Team: Prep Date:		930081-10-0000 NOV 01, 2003 TEST 000-000-0000 076/MIDDLETOWN N/A		
IDDLETOWN	DDLETOWN CT 06457			GRACE	PERIOD E			
* Please provide explan	ations fo	or any large fl	R ILLUSTRATIO fuctuations in total) Enter the adjustn	figures and	or adjustme	ents in this s	space. (I.I	E. terminations
BILLING LINE		TOTA	L INSURED	X	RATE	= AMO	UNT	*ADJUSTMENT
NAME	CODE	NO, OF EMPLOYEES	VOLUME	1	10.10	1	****	120,120,100,000
DEP PPU MED OVER 65	503	* X	NOT APPLIC.	230.0	00/EMPL		0.00	
To properly credit your	r accoun	t, send state	ment with paymer	nt.			OTAL AMO	OUNT DUE

The material contained in the Life Administrative Handbook is for informational purposes only and contains only a partial, general description of plan benefits or programs and does not constitute a contract.

Consult the plan documents (e.g., Schedule of Benefits, Certificate of Coverage, Evidence of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to the plan.

The availability of a plan or program may vary by geographic service area and by plan design.

Aetna assumes no responsibility for any circumstances arising out of the misuse, interpretation or application of any information supplied by Aetna as part of the Life Administrative Handbook.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

26.20.001.1 (05/08)

©2008 Aetna Inc.

We want you to know

Actna

www.aetna.com