



Please return completed applications to:  
**EPK Benefits, 15375 S.E. 30<sup>th</sup> Place, Suite 380,**  
**Bellevue, WA 98007**  
**TO AVOID DELAYS, PLEASE ANSWER ALL QUESTIONS**



P.O. Box 1271 (MS E3A)  
 Portland, OR 97207-1271

## ADDITIONAL LIFE INSURANCE APPLICATION

SECTION 1 – Member Basic Information																							
GROUP NO. <b>WA 06810W</b>	THIS APPLICANT IS: <input checked="" type="checkbox"/> Member	<input type="checkbox"/> Initial Application <input type="checkbox"/> Increasing Coverage	COVERAGE AMOUNT: Please select an amount between \$30,000 and \$500,000 in \$10,000 increments. If you are increasing coverage, please indicate the TOTAL amount of Additional Life Insurance you are applying for. \$ _____ Amount Selected (You may be eligible for a Guarantee Issue amount of \$50,000 if you are applying within your 31 day initial eligibility period.)																				
MEMBER NAME			MAILING ADDRESS (Street - City - State - Zip Code)				PHONE NUMBER (     )     (     )																
DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY NO.	SEX M   F	HEIGHT	WEIGHT	Have you gained or lost more than 20 lbs. in the last year? Give details below. <input type="checkbox"/> YES <input type="checkbox"/> NO																	
OCCUPATION		NAME OF EMPLOYER PROVIDING INSURANCE <b>BIAW Health Insurance Program</b>			HIRE DATE		SALARY																
SECTION 2 – Member Medical Information																							
FULL NAME & MAILING ADDRESS OF YOUR REGULAR PHYSICIAN							DATE LAST CONSULTED – give details below																
<p><b>YES NO</b> <span style="float: right;"><b>Give details for any "YES" answers below.</b></span></p> <p><input type="checkbox"/> <input type="checkbox"/> 1. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury?</p> <p><input type="checkbox"/> <input type="checkbox"/> 2. Are you now under regular medical observation or taking medical treatment or any kind of medication?</p> <p><input type="checkbox"/> <input type="checkbox"/> 3. Within the last five years, have you consulted a physician for any disease, injury or mental or emotional condition? Have you had or been advised to have any surgical operation or diagnostic test?</p> <p><input type="checkbox"/> <input type="checkbox"/> 4. Are you pregnant? <b>If "YES," give expected delivery date and describe any complications.</b></p> <p><input type="checkbox"/> <input type="checkbox"/> 5. Do you use tobacco products? If "NO," have you ever used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Stopped _____</p> <p><input type="checkbox"/> <input type="checkbox"/> 6. Within the last ten years, have you been treated for or diagnosed as having any immune deficiency?</p> <p><input type="checkbox"/> <input type="checkbox"/> 7. Have you been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?</p> <p><input type="checkbox"/> <input type="checkbox"/> 8. Have you tested positive for antibodies to the AIDS virus (including but not limited to Human T-Cell Lymphotropic Type III; HTLV-III; HTLV-IV; Human Immunodeficiency Virus (HIV))?</p> <p><input type="checkbox"/> <input type="checkbox"/> 9. Have you ever been diagnosed or treated for any of the following:</p> <table style="width: 100%; margin-left: 20px;"> <tr> <td style="width: 50%;"><b>YES NO</b></td> <td style="width: 50%;"><b>YES NO</b></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Nervous Disorder or Epilepsy</td> <td><input type="checkbox"/> <input type="checkbox"/> Asthma or Lung Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Arthritis or Related Joint Disease</td> <td><input type="checkbox"/> <input type="checkbox"/> Back Disorder</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Paralysis or Stroke</td> <td><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Cancer or Tumors</td> <td><input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Diabetes or Albumin or Sugar in the Urine</td> <td><input type="checkbox"/> <input type="checkbox"/> Kidney Disease</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> Disorder of the Stomach or Intestines or Liver</td> <td><input type="checkbox"/> <input type="checkbox"/> Heart Disease or Defects</td> </tr> </table>										<b>YES NO</b>	<b>YES NO</b>	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder or Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Asthma or Lung Disorder	<input type="checkbox"/> <input type="checkbox"/> Arthritis or Related Joint Disease	<input type="checkbox"/> <input type="checkbox"/> Back Disorder	<input type="checkbox"/> <input type="checkbox"/> Paralysis or Stroke	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Cancer or Tumors	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/> Diabetes or Albumin or Sugar in the Urine	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Disorder of the Stomach or Intestines or Liver	<input type="checkbox"/> <input type="checkbox"/> Heart Disease or Defects
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CONDITION	DATE	REMAINING EFFECTS	PHYSICIAN'S FULL NAME & ADDRESS																				

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance effective date; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) I must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

**Authorization to Release Information:** I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health to give the LifeMap Assurance Company or its reinsurers any such information (including information about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases). This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a copy of the Privacy Notice.

**Insurance Fraud Warning:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

If your answers on this application are incorrect or untrue, LifeMap Assurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**The beneficiary designation made for Basic Life Insurance will apply unless you complete a separate beneficiary designation for the Additional Life.**



## Privacy Notice

We, at LifeMap, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. Because we endeavor to earn and keep your trust, we have long-standing privacy policies, robust training, and full-time staff dedicated to protecting privacy. We also maintain physical, administrative, and technical safeguards to protect your personal information from unauthorized access. Even if you are no longer a LifeMap member, we protect the confidentiality of your personal information as if you were.

### Marketing

While other companies may sell or rent your contact information, LifeMap never sells or rents your personal information for marketing purposes. If you want LifeMap to share your personal information with a nonaffiliated third party so the third party can market to you, you must give us your express permission.

### Your Personal Information

We collect personal information such as your name, contact information, health information, and financial information from you, your providers, and other insurers that provide coverage to you. We use this information to provide services to you and to conduct insurance transactions. You may receive a copy of your personal information by contacting us at the phone number or address below. We will not disclose your personal information unless we are permitted or required by law or you give your permission. As permitted or required by law, we may provide personal information to our affiliates and agents, reinsurers, insurance administrators, consultants, or regulatory and governmental authorities. We obligate entities receiving this information on our behalf to protect it in the same way that we protect it.

### Changes to Our Practices

We may change our privacy practices in an effort to provide even better protection. If we change our privacy practices in a material way, we will notify current customers in writing.

### Contact Us

If you have any questions about our privacy program, you may contact us at (800) 794-5390 or write to:

LifeMap Privacy Official  
P.O. Box 1071, Mailstop E12B  
Portland, OR 97207