



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

Regence
 Life and Health Insurance Company

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

ADDITIONAL LIFE INSURANCE APPLICATION

SECTION 1 – Member Basic Information

GROUP NO. WA 06766W	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
OCCUPATION		NAME OF EMPLOYER PROVIDING INSURANCE MBA Health Insurance Trust
		HIRE DATE
		SALARY

SECTION 2 – Member Medical Information

FULL NAME & MAILING ADDRESS OF YOUR REGULAR PHYSICIAN	DATE LAST CONSULTED – give details below
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YES NO Give details for any "YES" answers below.

1. During the last five years, have you been absent from work more than five consecutive working days because of illness or injury?

2. Are you now under regular medical observation or taking medical treatment or any kind of medication?

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?

4. Are you pregnant? **If "YES," give expected delivery date and describe any complications.**

5. Do you use tobacco products? If "NO," have you ever used tobacco products? Yes No
Date Stopped _____

6. Within the last ten years, have you been treated for or diagnosed as having any immune deficiency?

7. Have you been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

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))?

9. Have you ever been diagnosed or treated for any of the following:

YES NO	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder or Epilepsy	YES NO	<input type="checkbox"/> <input type="checkbox"/> Asthma or Lung Disorder
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Arthritis or Related Joint Disease	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Back Disorder
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Paralysis or Stroke	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Cancer or Tumors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Diabetes or Albumin or Sugar in the Urine	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Disorder of the Stomach or Intestines or Liver	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> Heart Disease or Defects

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 knowledge and belief, to be true and complete. I understand that: (a) the insurance applied for shall not take effect until the application is approved; 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 coverage would become effective, my 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, the Medical Information Bureau (MIB) or other organization, institution or person that has any records or knowledge of me or my health to give the Regence Life and Health Insurance 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 Notice of Information Practices.

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

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.

Employee Signature _____ Date _____

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

Regence

Life and Health Insurance Company

100 SW Market Street
P.O. Box 1271 E-3A
Portland, Oregon 97207-1271

INFORMATION PRACTICES NOTICE

(retain with your insurance records)

Thank you for enrolling for Group Insurance with Regence Life and Health Insurance Company. As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. Regence Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 1-866-692-6901 (TTY 1-866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Regence Life and Health Insurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.