Please return completed applications to:
EPK Benefits, 15375 S.E. 30th Place, Suite 380
Bellevue, WA 98007

LifeMap Assurance Company®
P.O. Box 1271, M/S E8L
Portland, OR 97207
(503) 721-7161 • (800) 794-5390

LifeMap Voluntary Benefits
Employee Enrollment and Change Form

BIAW HEALTH INSURANCE PROGRAM

Please complete using dark ink.

Employer Name			**Group Number** WA06810W
☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy)_____			☐ Change of Existing Enrollment
Employee's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Occupation			Annual Salary
Home Address (Street, City, State and Zip)			Telephone Number ( )
Within the past 2 years has you used cigarettes or other tobacco products? Employee ☐ Y ☐ N			

If you select an amount OVER the Guarantee Issue Amount or are making application for any coverage AFTER your initial 31-day eligibility period, you must also complete and submit a LifeMap Evidence of Insurability Form.

Please indicate the total amount of voluntary coverage you wish to have for initial enrollment or when making changes to coverage.

Voluntary Life Insurance

Select Amount in $10,000 increments a minimum of $30,000 to a maximum of $500,000. Guarantee issue is $50,000.

Employee $ _____

The beneficiary designation made for Basic Life Insurance, if provided, will apply unless you complete a separate beneficiary designation for Voluntary Life.

Note: If applicable, Accidental Death and Dismemberment (AD&D), Critical Illness, Accident Only and Critical Illness and Accident Insurance Certificates provide limited benefits. Review your certificate carefully.

IMPORTANT: Your application for coverage is not complete if this page is not signed, dated and returned.

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.

Insurance Fraud Warning:

Unless specific state language is provided below, the following general fraud notice applies: 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.

For residents of Washington: 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 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 Signed

LifeMap Assurance Company®
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 794-5390
Fax (855) 854-4750
Email: Medical.UW@LifeMapCo.com

LifeMap Evidence of Insurability Form

Section 1: Applicant Information. Please complete using dark ink.

Employer Name			**Group Number** WA06810W
☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy):			☐ Change of Existing Enrollment
Employee's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Occupation	Annual Salary		Height: ____ Ft. ____ In. / Weight: _____ lbs
Home Address (Street, City, State and Zip)			Telephone Number ( )

Section 2: Coverage Elections. Please indicate the total amount of coverage you wish to have for initial enrollment or when making changes to coverage.

Voluntary Life - Amount Elected

Employee $ _____

Guarantee Issue is $50,000.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, LifeMap Assurance Company will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, MIB Inc., and other insurance companies.

Information regarding your insurability will be treated as confidential. LifeMap Assurance Company or its reinsurers may, however, make a brief report 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. 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 50 Braintree Hill Park, Suite 400, Braintree, MA, 02184-8734 or they can be reached by email at infoline@mib.com.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. You have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO:

LIFEMAP ASSURANCE COMPANY
ATTN: INDIVIDUAL UNDERWRITING
200 SW MARKET STREET
P.O. Box 1271, M/S E8L
PORTLAND, OR 97207

IMPORTANT: Please continue completing form on the following page.

EMPLOYEE'S NAME:

Section 3: Health Questions
Each Applicant must answer each of the following questions to the best of their knowledge and belief.

	Employee
1. Within the past 2 years have you, if applying for coverage, used cigarettes or other tobacco products?	☐ Y ☐ N
2. Within the past 5 years has any person applying for coverage been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Y ☐ N
3. Within the past 5 years has any person applying for coverage been diagnosed with, received medical care, or taken medication for a disease or disorder of any of the following:	
a. **Cardiac or Cardiovascular** (such as Heart Disease, High Blood Pressure, Atherosclerosis, Coronary Artery Disease, Heart Attack, Chest Pain, Heart Murmur or Palpitations, Cardiomyopathy, Heart Valve Disorder or Heart Failure)?	☐ Y ☐ N
b. **Circulatory** (such as Stroke, Transient Ischemic Attack (TIA) or High Cholesterol)?	☐ Y ☐ N
c. **Blood** (such as Anemia, Leukemia, Multiple Myeloma or Thrombocytosis)?	☐ Y ☐ N
d. **Endocrine** (such as Diabetes, Thyroid, Adrenal or Pituitary Disorder)?	☐ Y ☐ N
e. **Respiratory** (such as Asthma, COPD, Emphysema or Cystic Fibrosis)?	☐ Y ☐ N
f. **Kidney, Urinary Tract or Prostate** (such as Proteinuria or PSA Abnormality)?	☐ Y ☐ N
g. **Gastrointestinal or Liver** (such as Hepatitis, Colitis, Diverticulosis, Crohn's Disease, Pancreatitis, Ulcer or Decreased Liver Function)?	☐ Y ☐ N
h. **Autoimmune or Connective Tissue** (such as Lupus, Rheumatoid Arthritis, Scleroderma, Multiple Sclerosis or Mixed Connective Tissue Disease)?	☐ Y ☐ N
i. **Nervous, Mental or Emotional** (such as Anxiety, Depression, Memory Loss, Schizophrenia, Mood Disorder or Attempted Suicide)?	☐ Y ☐ N
j. **Neurological or Central Nervous** (such as Epilepsy, Seizure, Dizziness, Motor Neuron Disease, ALS, Muscular Dystrophy, Cerebral Palsy, Paralysis or Parkinson's Disease)?	☐ Y ☐ N
k. **Musculoskeletal** (such as Arthritis, Osteoarthritis, Degenerative Disc or Joint Disease, Carpal Tunnel, or Knee, Hip, Shoulder or Other Joint Condition)?	☐ Y ☐ N
4. Within the past 5 years has any person applying for coverage been diagnosed with, received medical care, or taken medication for any of the following:	
a. **Cancer, Hodgkin's Disease, Lymphoma, Malignant Growth or Tumor?**	☐ Y ☐ N
b. **Epstein Barr, Chronic Fatigue Syndrome or Fibromyalgia?**	☐ Y ☐ N
c. **Alcohol, Drug or Substance Abuse?**	☐ Y ☐ N
5. Has any person applying for coverage been advised or recommended by a physician to have surgery or a test or evaluation which has not yet been performed? (except pregnancy or orthopedic)	☐ Y ☐ N
6. Within the past 5 years has any person applying for coverage had a condition that has lasted for 3 months or more for which care or treatment was recommended or received or for which medication was prescribed by a physician or health care provider?	☐ Y ☐ N
7. Is any person applying for coverage disabled or does any person applying for coverage have a condition which prevents or limits activities?	☐ Y ☐ N
8. If female, are you currently pregnant? If yes, anticipated due date (MM/DD/YY): _____	☐ Y ☐ N
9. During the past 5 years have you been absent from work for more than five consecutive working days because of your own illness or injury (excluding pregnancy)?	☐ Y ☐ N

IMPORTANT: Please continue completing form on the following page.

EMPLOYEE'S NAME:

Provide details of all 'YES' answers given to the health questions in Section 3.
If additional space is required, attach a separate signed and dated sheet.

Question Number	Individual	Illness/Reason for Checkup or Physician's Treatment/Consultation	Dates From - To	Full Name & Complete Address of Attending Physician or Other Practitioner

Section 4: Authorization to Disclose Personal Information & Application for Insurance

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, MIB Inc., insurance company or other organization, institution or person that has any records or knowledge of me or my health, gathered during the course and scope of their business, to give the LifeMap Assurance Company or its reinsurers any such information, including information about drug or alcohol use or abuse, mental illness, AIDS virus or other sexually transmitted diseases (with the exception of HIV records), in connection with prior testing for the purpose of obtaining insurance. 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.

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For residents of Washington: 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.

For your protection California law requires the following statement to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Information in this form 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.

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

THIS FORM IS NOT VALID UNTIL SIGNED AND DATED BY THE APPLICANT.

▶ _____ ▶ _____

Employee Signature Date Signed

To help ensure efficient processing send the completed form to:

EPK Benefits
15375 S.E. 30th Place
Suite 380
Bellevue, WA 98007

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize any physician, pharmacy benefit manager, retail pharmacy, clearing house, health plan or insurance company to disclose prescription drug information about me within their possession to Milliman IntelliScript on behalf of LifeMap Assurance Company ("LifeMap"). The purpose of this disclosure is for Milliman to provide the information to LifeMap to evaluate my application for Life, Disability, and/or Critical Illness insurance products.

I understand that this prescription drug information may contain sensitive data, including data related to the treatment of sexually transmitted diseases, HIV/AIDS, mental health and reproduction or contraception (including prenatal care and abortion). I specifically authorize the disclosure of prescription drug information that is related to alcohol or substance abuse and I understand that my alcohol and substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described below.

I understand and acknowledge the following:

- Once any person(s) or entity(ies) discloses my information to an authorized recipient the privacy protections provided by law may no longer apply.
- I may cancel this authorization at any time by sending written notice to LifeMap Assurance Company, Attn: Individual Underwriting, PO Box 1271 M/S E8L, Portland, OR 97207. Cancellation of this authorization will not affect any actions taken by any entity disclosing information before receiving the cancellation notice.
- Completing this authorization is a condition to be eligible for and enrolled in LifeMap Life, Disability and/or Critical Illness insurance products.
- None of the authorized person(s) and entity(ies) above nor Milliman are responsible for any action taken by an authorized recipient of my protected health information.

This authorization will expire two years from the date signed **unless a shorter time frame is requested here (mm/dd/yyyy)**: _____.

Applicant Full Name (please print clearly)	Date of Birth (MM/DD/YYYY)
BIAW	WA06810W
Group Name	Group Number
Applicant Signature	Date

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individuals (e.g., Power of Attorney, Guardianship, Conservatorship, etc.)

Name of Personal Representative	Relationship	Phone
Signature of Personal Representative		Date