Nippon Life Benefits

Nippon Life Insurance Company
of America
PO Box 25951
Shawnee Mission, KS 66225-5951

Large Employer Enrollment, Health & Waiver Form – GA

Company name _____ **Group number** _____

A. Employee Information

Your name (last, first, middle initial) | Social security number

Address (street or P.O. box) | City | State | ZIP code

Date of birth | ☐ male ☐ female ☐ single ☐ married | Phone number | County

B. Benefit Election: Ask your employer what coverages the group policy has. Check your election option(s) below.

	Medical	Dental	Vision	Basic Life	Dependent Life	Short Term Disability	Long Term Disability
Myself	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect
	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*
Spouse	☐ Elect	☐ Elect	☐ Elect	Amount	Elect	Elect	Elect
	☐ Waive*	☐ Waive*	☐ Waive*	$ _____	Waive*	Waive*	Waive*
Children	☐ Elect	☐ Elect	☐ Elect	or Multiple	Elect	Elect	Elect
	☐ Waive*	☐ Waive*	☐ Waive*	_____ X	Waive*	Waive*	Waive*

	Supplemental Life	Supp Life Amount	Supplemental AD&D	Supp AD&D Amount
Myself	Elect	$ _____	Elect	$ _____
	Waive*	or _____ X	Waive*	or _____ X
Spouse	Elect	$ _____	Elect	$ _____
	Waive*	or _____ X	Waive*	or _____ X
Children	Elect	$ _____	Elect	$ _____
	Waive*	or _____ X	Waive*	or _____ X

Medical options (if applicable to your group policy): Deductible choice _____ PPO network choice _____

If your employer offers a high option and a low option plan, please select the medical plan option which you are electing. _____

*** Reason for waiving coverages(s): (Please read the Waiving Coverage in Section E for information relating to consequences of refusing initial coverage.)**

If Waiving Coverage, Information Will Appear on the Following Page(s)

C. Beneficiary Designation: Complete if your coverages include group term life insurance.

Beneficiary for employee group term life insurance (Print as "Doe, Mary A.", not "Mrs. John Doe")

last name	first name	middle initial	relationship to you

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

D. Dependent Information: Please list your spouse and all eligible children that are applying for coverage. **110**

Spouse's name (last, first, middle initial)	Social Security Number	Date of Birth	☐ Male ☐ Female

Do you and your spouse work for the same employer? Yes No

NOTE: The Full-time student information below is not applicable to dependent children less than 26 years of age who are applying for Medical coverage.

Full name of dependent child(ren)	Date of Birth (mm/dd/yyyy)	Social Security Number (Applicants 18 & Over)	Full-time student (If yes, please complete questions a. through h. below)	Foster child	Handicapped child*	Male	Female
1.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
2.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
3.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
4.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
5.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐

If you need additional space please attach a separate piece of paper.

Are any of the dependents listed above full-time employees who are eligible for an employer sponsored health plan? **Yes** **No**

If yes, please identify: _____

To Be Completed By Member	Dependent 1	Dependent 2	Dependent 3	Dependent 4	Dependent 5
a. Does this child reside in the United States?	Yes No	Yes No	Yes No	Yes No	Yes No
b. Does this child live with you when not attending school?	Yes No	Yes No	Yes No	Yes No	Yes No
c. Was the child placed with you by an authorized state placement agency or by order of a court?	Yes No	Yes No	Yes No	Yes No	Yes No
d. Does this child reside in your home permanently?	Yes No	Yes No	Yes No	Yes No	Yes No
e. Do you provide more than one-half of this child's financial support?	Yes No	Yes No	Yes No	Yes No	Yes No
f. Is this child claimed as a dependent by you for federal income taxes?	Yes No	Yes No	Yes No	Yes No	Yes No
g. Please provide the date legal guardianship began (mm/dd/yyyy).					
h. Under what circumstances did you receive legal guardianship of this child?					

Is there any other pertinent information not covered above? (If so, please provide on a separate sheet of paper.)

Dependents must meet eligibility requirements. Foster child eligibility may be subject to approval by Nippon Life Insurance Company of America (Nippon Life Benefits).

*__With respect to Medical or Vision coverage:__ If you have developmentally disabled/physically handicapped children over age 26 or any other age as required by state law, complete an Application to Continue Handicapped Child.

**__With respect to Dental coverage:__ If you have developmentally disabled/physically handicapped children over age 19 or any other age as required by state law, complete an Application to Continue Handicapped Child.

Contact your employer for assistance with any questions.

Dependent coverage may be extended beyond the group policy limiting age if your child is or would be enrolled at a postsecondary institution of higher education as required by state law.

NOTE: Future verification of full-time student status will be required at the time of claim submission. (If more than one student, please provide this information on a separate sheet of paper.)

Full-Time Student Name	Name & Address of School, College or University	
Beginning Date of Attendance	**Anticipated Graduation Date**	**No. of Current Credit Hours**

Employee Name: _____ SSN: _____

Full name of dependent child(ren)	Date of Birth (mm/dd/yyyy)	Social Security Number	Full-time student	Foster child	Handicapped child*	Male	Female
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		

E. Notice of Information Practices (To be read before completing the Health Information Section.) 110

In order to properly underwrite, we must collect information. **Please complete the Health Information in section F on page 3**. In addition, we may contact sources besides yourself for personal data about any proposed insured, including spouse, employer, medical professionals or institutions, and insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, with your written authorization, we may provide data to government agencies (e.g., an insurance department of your state), or attending physicians. We may also provide statistical/unidentifiable information to insurance organizations who conduct large studies of insurance practices. You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are: (A) To find out what personal information is contained in Nippon Life Benefits files (medical information may be disclosed only to your attending physician); and (B) To correct or amend information in Nippon Life Benefits files. Upon written request, Nippon Life Benefits will furnish to you (or your dependent) information concerning: (A) The nature and scope of personal data in our records; (B) The types of disclosures which may be made; and (C) Rights of access to the information collected and how such information may be corrected or amended. We will respond to such written request within 30 days from the date of receipt.

F. Health Information (Read the Notice of Information Practices before completing)

Answer only for those individuals requesting coverage. To prevent delays, answer each question and give full details to "yes" answers. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height _____ ft. _____ in. weight _____ lbs.	Spouse's height _____ ft. _____ in. weight _____ lbs.

1. ☐ Yes ☐ No — Are you or any dependent disabled; hospital confined; pregnant; receiving treatment; taking medication; receiving follow up care; been scheduled for or are awaiting results of any tests, biopsies, procedures or lab work; or been advised of a condition that will require attention in the next twenty-four (24) months?

   Pregnant? Due date _____ C-Section date _____ Multiple births? ☐ yes ☐ no

2. ☐ Yes ☐ No — In the last five (5) years have you or any member of your family listed on this application had surgery or incurred medical/pharmacy claims in excess of $5,000 or been treated for or advised that they have a serious illness? Examples include but are not limited to any of the following.

☐ Cancer	☐ High Blood Pressure	☐ Digestive/Intestinal/Eating	☐ Heart/Circulatory Condition
☐ Tumors	☐ High Cholesterol	☐ Organ/Tissue Transplant	☐ Endocrine Disorder
☐ Alcohol/Drug Abuse	☐ Infertility	☐ Liver/Hepatitis Disorder	☐ Mental/Nervous
☐ Blood Disorder	☐ Infectious Disease	☐ Multiple Sclerosis	
☐ Kidney/Bladder/Urinary Disorder	☐ Skin/Eye/Nose/Throat Disorder	☐ Stroke/Neurological/Nervous System	
☐ Allergy/Respiratory/Asthma Disorder	☐ Birth Defects/Congenital Disorders	☐ Arthritis/Muscle/Bone/Joint Disorder	

☐ Diabetes – Last HbA1c reading and date _____

☐ Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV antibody

☐ Other – Including other medicines _____

If you answered yes to any of the above questions please provide full details below.

Name of person	Date diagnosed/treated	Duration of illness or condition

Diagnosis of illness or condition: explain treatment given, receiving or planned

Medications prescribed

Any current symptoms or

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

Names and addresses of doctors, hospitals or other providers

If more space is needed, please attach a separate piece of paper.

G. Waiving or Electing Coverage 110

Waiving Coverage – Important information, please read if you are waiving any coverage:

I declare that I have been given an opportunity to apply for coverage. I understand if I refuse coverage:

(a) My dependents are not eligible for any coverage for which I am not covered.

(b) I cannot under any conditions reenter as a retired person.

(c) I (and my dependents) may enroll for medical coverage later; however, unless eligible for the special enrollment rights described in the Notice to Enrollees, I (and my dependents) will be subject to the late enrollee provisions.

(d) If I am enrolled in a health maintenance organization (HMO) sponsored by my employer, and if there is an open enrollment period under the policyholder or employer plan or the Nippon Life Benefits medical policy, I may transfer to the Nippon Life Benefits medical policy during that time.

(e) I (and my dependents) may enroll for dental coverage later; however, such enrollment could affect my initial level of dental benefits.

(f) I (and my dependents) may enroll for nonmedical coverage later; however, necessary proof of good health must be provided at my own expense and coverage will not become effective until approved by Nippon Life Benefits, subject to actively at work and period of limited activity provisions. Health conditions which may be present now or develop later may prevent me (or my dependents) from ever being approved for coverage.

Electing Coverage – Please read if you are electing any coverage:

I represent information, statements, and answers on this form and any attachments are complete and true to the best of my knowledge and belief. They are part of this request for coverage under the group policies. I agree Nippon Life Benefits is not liable for anyone's claim which happens or begins before the effective date of coverage by Nippon Life Benefits. I have read, or had read to me, the questions and responses and realize my coverage can be cancelled at any time if I commit an act or practice that constitutes fraud or make an intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage. I understand all group policy provisions for medical coverage will apply. If approved for life and disability coverages, all group policy provisions will apply including, but not limited to, preexisting conditions restriction, the actively at work and period of limited activity provisions. I further understand an agent or broker cannot change or waive any rates, benefits, or provisions of any group policy, if issued, without the written approval of an officer of Nippon Life Benefits. The date obtained by use of this authorization will be used by Nippon Life Benefits for claims administration and to determine eligibility for coverage. This information will not be used for any purposes prohibited by law.

- I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Nippon Life Benefits, its underwriters along with its agents and employees performing business transactions, any such data.
- I authorize Nippon Life Benefits to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.

Applicable to all enrollees:

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Nippon Life Benefits.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

Employee signature required _____ **Date signed** _____

Requested date of change _____

Employer to Complete this Section			**Nippon Life Benefits to Complete**	
Company name as it appears on your billing			Employee effective date	Dependent effective date
Date employed	Job/class			Hours worked per week
Location		Earnings $	☐ yr ☐ wk ☐ mo ☐ hr	

Employee Instructions

BEFORE SUBMITTING THIS COMPLETED FORM TO YOUR EMPLOYER, YOU MAY WISH TO PROTECT THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION ON PAGE 3 BY TAPING OR STAPLING THOSE PAGES TO ENSURE THE INFORMATION IS NOT VISIBLE.