LIFE INSURANCE COMPANY OF NORTH AMERICA		
POLICYHOLDER Central Peninsula Hospit	al	POLICY NUMBER LK 963280
Long-Term Disability (LTD) Enrollment Form		
Name	First	Sex: 🗆 Male 🗆 Female
		ny No///////
Address	City State	Home Phone ()
Date Hired	Title or Occupation	Annual Salary \$
 from my earnings of th I have been offered LT participate at a later da coverage is subject to t 	te required contribution toward the D insurance and decline to purchate, I may be required to furnish ev the Insurance Company's approval	ase it at this time. I understand that if I wish to idence of insurability at my own expense and that l.
Late entrants must complet Insurance Company's appr		n. Coverage for late entrants is subject to the
If you are not in active service the date you return to activ		uld otherwise take effect, you will be covered on
consulted a physician (or for treatment, care or services expenses during the 3 mor	or which a reasonable person wou (including diagnostic measures), in this prior to the effective date of y will not receive benefits unless y	on is any injury or illness for which you have ld have consulted a physician), received medical taken prescribed drugs or medicines, or incurred your insurance. If you become disabled due to a your disability begins more than 12 months after
Signature of Applicant		Date
TL-004038 (BME)		_)(_ Cigna

Return original to your employer and make a copy for your records.