LIFE INSURANCE COMPANY OF NORTH AMERICA

POLICYHOLDER	***POLICY NUMBER***
Central Peninsula Hospital	**FLK 960406**

Short-Term Disability (STD)
Enrollment Form

Name ______________ ______________ ______________ Sex: ☐ Male ☐ Female
Last First M. I.

Date of Birth ______________ Social Security No. ______________ /__

Address ______________ Home Phone (____)__________
Number and Street City

Date Hired ______________ Title or Occupation ______________ Annual Salary $ __________

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Please check the appropriate box.

☐ I understand that basic STD insurance is provided by my employer.

☐ I accept the optional STD insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

☐ I have been offered optional STD insurance and decline to purchase it at this time. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.

Late entrants must complete an Evidence of Insurability Form. Coverage for late entrants is subject to the Insurance Company's approval.

If you are not in active service on the date your coverage would otherwise take effect, you will be covered on the date you return to active service.

Signature of Applicant ______________________________ Date ______________

Cigna

TL-007117 (Core Buy-up)

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