Nippon Life Benefits®

**Nippon Life Insurance Company of America**
P.O. Box 25951
Shawnee Mission, KS 66225-5951

***Nonmedical Enrollment & Waiver Form***

| Company name | Group Number | Div/Loc | Class |
|---|---|---|---|
| | | | |

**A. Employee Information**

| Your name (Last, First, Middle initial) | Social Security Number | Effective Date | Hours per week |
|---|---|---|---|
| | | | |

| Address Street or PO Box | City | ST | Zip-code | Salary | Ann | Mnthy | Wkly |
|---|---|---|---|---|---|---|---|
| | | | | | ☐ | ☐ | ☐ |

| Date of Birth (mm/dd/yy) | Gender | Marital Status | Date of Hire |
|---|---|---|---|
| | ☐ Male ☐ Female | ☐ Single ☐ Married | |

**B. Complete for Life and/or Disability** Check the box ☑ if Electing Coverage

☐ Basic Life ☐ Accidental Death & Dismemberment ☐ Dependent Life ☐ Supplemental Life ☐ Supplemental AD&D

☐ Voluntary Life ☐ Voluntary AD&D ☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary Long Term Disability

| Amount Selected | Voluntary or Supplemental Life | Voluntary or Supplemental AD&D | | Dependent Voluntary or Dependent Supplemental Life | Dependent Voluntary or Dependent Supplemental AD&D | | Dependent Voluntary or Dependent Supplemental Life |
|---|---|---|---|---|---|---|---|
| Employee: | $ | $ | Spouse | $ | $ | Child(ren) | $ |

| Dependent/Voluntary/Supp. Life Only — Last, First , MI | Date of Birth (mm/dd/yy) |
|---|---|
| Spouse name | |
| Child name | |
| Child name | |
| Child name | |

**Beneficiary for Employee Coverage/Relationship** (*Employee is Beneficiary for spouse and child coverage*) Print as "Doe, Mary A.", not "Mrs. John Doe")

| Last Name | First Name | MI | Relationship to you | Percentage |
|---|---|---|---|---|
| | | | | |
| | | | | |

Note: If you have chosen Life coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete a Statement of Health form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date Nippon Life Benefits approves your Statement of Health form.

**C. Complete for Dental and/or Vision** Check the box ☑ if Electing Coverage **If Employer offers two Plans:** ☐ Option 1 ☐ Option 2

| Coverage Requested | Dental | Vision |
|---|---|---|
| | ☐ Dental for Employee Only | ☐ Vision for Employee Only |
| | Please enroll the following Dependents | Please enroll the following Dependents |
| | ☐ Dental for Employee and Spouse | ☐ Vision for Employee and Spouse |
| | ☐ Dental for Employee and Child(ren) | ☐ Vision for Employee and Child(ren) |
| | ☐ Dental for Employee and Family | ☐ Vision for Employee and Family |
| | ☐ Waive Dental for _____ | ☐ Waive Vision for _____ |

***Reason for waiving coverage(s)** Please read the Waiving Coverage in Section F. for information relating to consequences of refusing Initial coverage: ☐ COBRA, USERRA or State Continuation ☐ Spouse's Group ☐ Other _____

| D. Complete for Dependent Coverage | | Date of Birth | Gender |
|---|---|---|---|
| Spouse Name (Last, First, MI) | | (mm/dd/yy) | M F |
| | | | ☐ ☐ |
| Dependents 1) | | | ☐ ☐ |
| 2) | | | ☐ ☐ |
| 3) | | | ☐ ☐ |
| 4) | | | ☐ ☐ |

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

**E. Prior Dental Coverage:**

Do you or any of your eligible dependents applying for coverage have prior dental coverage? ☐ Yes ☐ No

If yes, please provide the information requested below, including proof of any prior dental coverage. An acceptable form of proof is a copy of your ID card applicable to your prior dental coverage. Failure to provide proof of prior dental coverage may subject you and/or your eligible dependents, if applicable, to the full deferred coverage period with no credit for prior dental coverage.

**Please identify each person applying for coverage and include information for all previous dental coverage during the last 24 months.**

| Name of Covered Individual | Carrier Name | Group Number | Effective Date | Termination Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**F. Waiving or Electing Coverage**

**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 dental coverage later; however, such enrollment could affect my initial level of dental benefits. (d) I (and my dependents) may enroll for Life and/or Disability 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 understand and agree with the following statements:

My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. If the group policy requires my contributions, I authorize my employer to deduct from my pay. I represent all information on this form and attachments are complete and true to the best of my knowledge and belief. They are part of this request for coverage and will be used by Nippon Life Benefits to determine insurability. I agree Nippon Life Benefits is not liable for a claim before the effective date of coverage and all group policy provisions apply. I have read, or had read to me, the information and my answers on this form. 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 authorize Nippon Life Benefits to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Nippon Life Benefits for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law. Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of my social security number will be used by Nippon Life Benefits only as allowed by law.

**F. Waiving or Electing Coverage** (continued)

**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 presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

**Employee signature required** _____ **Date signed** _____

**Requested date of change** _____ **Signed at (City, State)** _____

**Instructions**

After this form has been completed and signed, send the original to Nippon Life Insurance Company of America, and keep a copy for your records.