



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

**Enrollment, Statement
of Insurability & Waiver
Form**

BEFORE PROVIDING THIS FORM TO YOUR EMPLOYER PROTECT THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION.

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 Mnthly Wkly
Date of Birth (mm/dd/yy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Hire	
B. Complete for Life and/or Disability Check the box <input checked="" type="checkbox"/> if Electing Coverage							
<input type="checkbox"/> Basic Life <input type="checkbox"/> Accidental Death & Dismemberment <input type="checkbox"/> Dependent Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Voluntary or Supplemental AD&D <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> 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 Supplemental or Dependent Voluntary 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							
Beneficiary for Employee Coverage/Relationship (<i>Employee is Beneficiary for spouse and child coverage</i>) Print as "Doe, Mary A.", not "Mrs. John Doe")							
Last Name		First Name		MI	Relationship to you		Percentage
C. Complete for Dental and/or Vision Check the box <input checked="" type="checkbox"/> if Electing Coverage If Employer offers two Plans: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2							
Dental Employee Only				<input type="checkbox"/> Vision for Employee Only			
Please enroll the following Dependents				Please enroll the following Dependents			
Coverage Requested	<input type="checkbox"/> Dental for Employee and Spouse			<input type="checkbox"/> Vision for Employee and Spouse			
	<input type="checkbox"/> Dental for Employee and Child(ren)			<input type="checkbox"/> Vision for Employee and Child(ren)			
	<input type="checkbox"/> Dental for Employee and Family			<input type="checkbox"/> Vision for Employee and Family			
	<input type="checkbox"/> Waive Dental for _____			<input type="checkbox"/> Waive Vision for _____			
*Reason for waiving coverage(s)							
Please read the Waiving Coverage in Section G. for information relating to consequences of refusing Initial coverage:							
<input type="checkbox"/> COBRA, USERRA or State Continuation <input type="checkbox"/> Spouse's Group <input type="checkbox"/> Other _____							
D. Complete for Dependent Coverage					Date of Birth		Gender
Spouse Name (Last, First, MI)					(mm/dd/yy)		M F
Dependents	1)						
	2)						
	3)						

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

E. Health Information – (Note: This information will not be used for any purpose prohibited by law.)

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.
Weight change in last year?	lbs.	loss	gain		Weight change in last year?	lbs.	loss	gain	

1. <input type="checkbox"/> yes <input type="checkbox"/> no	Is anyone currently using tobacco products, including cigarette, pipe, cigar or chewing tobacco?																
2. <input type="checkbox"/> yes <input type="checkbox"/> no	Is anyone on whom coverage is requested currently receiving medical treatment, taking medication, or pregnant?																
3. <input type="checkbox"/> yes <input type="checkbox"/> no	Has anyone been advised by a member of the medical profession to get specified medical care which was not completed, such as any hospitalization, surgery or diagnostic test, except those tests related to the Human Immunodeficiency Virus (AIDS virus)?																
4. <input type="checkbox"/> yes <input type="checkbox"/> no	Has anyone been diagnosed by a medical professional as having any physical or mental defect, developmental or learning disability, behavior disorder, or physical or mental impairment or condition?																
5. <input type="checkbox"/> yes <input type="checkbox"/> no	In the past 5 years, has anyone:																
<input type="checkbox"/> yes <input type="checkbox"/> no	<ul style="list-style-type: none"> been told by a doctor, health care provider, counselor, therapist, or any medical specialist of the need to reduce or discontinue the use of alcohol or drugs, or been treated for the use of alcohol or drugs? 																
<input type="checkbox"/> yes <input type="checkbox"/> no	<ul style="list-style-type: none"> had any surgery, hospitalization, observation room stay, or hospital emergency room treatment or outpatient treatment? 																
<input type="checkbox"/> yes <input type="checkbox"/> no	<ul style="list-style-type: none"> been to or consulted a doctor, chiropractor, counselor, therapist, health care provider or any medical specialist, had blood tests (other than for HIV antibody), other medical tests or been referred to a medical specialist? 																
<input type="checkbox"/> yes <input type="checkbox"/> no	<ul style="list-style-type: none"> has anyone on whom coverage is requested been diagnosed by a physician or tested positive for HIV antibody, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)? 																
6.	<p>In the past 5 years, has anyone on whom coverage is requested been diagnosed with or treated by a medical professional for any of the following (check all that apply)?</p> <table border="0"> <tr> <td><input type="checkbox"/> Cancer/Tumors</td> <td><input type="checkbox"/> Infertility</td> <td><input type="checkbox"/> Bone/Joint/Muscles</td> <td><input type="checkbox"/> Mental/Nervous/Substance</td> </tr> <tr> <td><input type="checkbox"/> Heart/Circulatory/Stroke</td> <td><input type="checkbox"/> Intestinal</td> <td><input type="checkbox"/> Infectious Disease</td> <td><input type="checkbox"/> Endocrine/Metabolism/diabetes</td> </tr> <tr> <td><input type="checkbox"/> Transplants</td> <td><input type="checkbox"/> Lung/Respiratory</td> <td><input type="checkbox"/> Liver/Kidney/Urinary</td> <td><input type="checkbox"/> Other Medical Condition</td> </tr> <tr> <td><input type="checkbox"/> Immune</td> <td><input type="checkbox"/> Neurological</td> <td><input type="checkbox"/> High Risk Pregnancy</td> <td></td> </tr> </table>	<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Infertility	<input type="checkbox"/> Bone/Joint/Muscles	<input type="checkbox"/> Mental/Nervous/Substance	<input type="checkbox"/> Heart/Circulatory/Stroke	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Endocrine/Metabolism/diabetes	<input type="checkbox"/> Transplants	<input type="checkbox"/> Lung/Respiratory	<input type="checkbox"/> Liver/Kidney/Urinary	<input type="checkbox"/> Other Medical Condition	<input type="checkbox"/> Immune	<input type="checkbox"/> Neurological	<input type="checkbox"/> High Risk Pregnancy	
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<input type="checkbox"/> Immune	<input type="checkbox"/> Neurological	<input type="checkbox"/> High Risk Pregnancy															

Provide full details for all “yes” answers on the next page. If more space is needed, make a copy of page 3 and include it as an additional page.

Name	Date diaanosed/treated	Duration of illness or condition			
Diagnosis of illness or condition					
Any current symptoms or problems					
Names and addresses of doctors, hospitals or other providers					
Name	Date diagnosed/treated	Duration of illness or condition			
Diagnosis of illness or condition					
Any current symptoms or problems					
Names and addresses of doctors, hospitals or other providers					
Name	Date diagnosed/treated	Duration of illness or condition			
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Any current symptoms or problems					
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Name	Date diagnosed/treated	Duration of illness or condition			
Diagnosis of illness or condition					
Any current symptoms or problems					
Names and addresses of doctors, hospitals or other providers					
MEDICATIONS: Including all oral, topical, optical, nasal, injected or IV infused therapies					
Are you or your dependent(s) taking any prescription medications (Including all oral, topical, optical, nasal, injected or IV infused therapies)?					
<input type="checkbox"/> Yes <input type="checkbox"/> No If YES, provide information on all medications currently being taken (attach and sign an additional sheet if necessary).					
Name of Member	Medicine Being Taken	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

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

In order to properly underwrite, we must collect information. We will do this by having you complete the Health Information Section. 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 Insurance Company of America (Nippon Life Benefits) files (medical information may be disclosed only to your attending physician); (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:

the nature and scope of personal data in our records; the types of disclosures which may be made; and 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.

For further information about your file or rights, you may contact Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, KS 66225-5951.

Authorization, Acknowledgment, and Signatures

- 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 a part of this request for coverage under the group policies and will be used by Nippon Life Benefits to determine insurability. 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 any false statements, omissions and/or material misrepresentation regarding age or health information could cause coverages, if issued, to be cancelled as never effective.
- 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 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.
- 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.
- I understand the data 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.

G. 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. 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.

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, provide the original to your Employer, and keep a copy for your records. **TO PROTECT THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION ON PAGES 2 AND 3, TAPE OR STAPLE THOSE PAGES TO ENSURE THE INFORMATION IS NOT VISABLE.**