Genworth Financial

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Employee Benefits Group

GE Group Life Assurance Company
Attn: New Business-GT-3
P.O. Box 9122
Des Moines, IA 50306

VOLUNTARY BENEFITS GROUP LIFE ENROLLMENT REQUEST

☐ **Add** ☐ **Change** ☐ **Termination** ☐ **Correction** **Date:** _____ **Reason:** _____

1. Employer Information - to be completed by Employer

Group Account Number	Other Group Account Number(s)	Class

Name of Employer

Employer's Address (Number, Street, City, State, ZIP Code)

2. Employee Information - to be completed by Employee in its entirety ☐ **Life Only** ☐ **Life with AD&D**

Name of Employee (Last, First, M.I.) | Social Security Number

Employee's Address (Number, Street, City, State, ZIP Code) | Employee's Home Phone No.

Sex ☐ Male ☐ Female	Date of Birth (Mo., Day, Yr.)	Marital Status ☐ Single ☐ Married	My employment is covered under Union Collective Bargaining ☐ Yes

Hours worked weekly for this employer (Excluding Overtime)_____ ☐ Active ☐ Retired

Date Employed (Mo., Day, Yr.) ☐ Full-Time ___/___/___ ☐ Part-time___/___/___ ☐ Rehire ___/___/___ ☐ Return from Layoff ___/___/___

Basic Earnings $ _____ ☐ Hourly _____ Hrs/Wk ☐ Monthly ☐ Weekly ☐ Annually

Employee's Occupation (Title)

☐ I elect to enroll in the Voluntary Life Plan for $ _____ or, for salary based plans, _____ times salary (Employee Life Amount)

NOTE: If you refuse Life benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate, or you may be required to provide evidence of good health.

3. Spouse Information ☐ **Life Only** ☐ **Life with AD&D**

Name of Spouse (Last, First, M.I.)	Social Security Number	Date of Birth	Sex ☐ Male ☐ Female

4. Beneficiary Designation - (See plan administrator for beneficiary instructions)

Primary Beneficiary (Last Name, First Name & M.I.)/Relationship to Employee	Address
Contingent Beneficiary (Last Name, First Name & M.I.)/Relationship to Employee	Address

5. Coverage Information

Coverage Requested: ☐ Employee Only ☐ Employee and Children ☐ Employee and Spouse ☐ Employee and Eligible Dependents

Benefit Requested: Employees or spouses may elect an amount as outlined in the Group Voluntary Life Plan (check with your employer for the available non-medical issue amount).

If sections 1-6 are incomplete, your benefit will be limited to the non-medical issue amount. Please see reverse side of this form if benefits elected are in excess of the non-medical issue amount.

Employee- $_____,000.00** **Spouse-** $_____,000.00** **Child-** $_____

NOTE: To become covered, a dependent spouse or child must not be confined in any institution for medical care or treatment or confined at home or elsewhere on the effective date.

*In Texas, the total amount of Life Insurance (basic life plus voluntary life) cannot exceed the greater of $250,000 or seven times salary. In Wisconsin, the total amount of Life Insurance (basic life plus voluntary life) cannot exceed $200,000.

6. Have you or your dependents used any tobacco products in the past 12 months?

Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

7. Authorization Section

I have read and personally responded to each of the preceding questions and have confirmed that the information is correct as to myself and my dependents.

I request insurance under the group coverage issued to my employer by GE Group Life Assurance Company (GEGLAC); authorize deductions from my earnings of any required contributions for any insurance for which I am or may later become eligible; and designate the beneficiary(ies) shown to receive all sums which may become due on account of my death under this group coverage. I certify that: (1) I am employed by the employer listed and at present am working at least 30 hours per week for this employer at the regular place of business; (2) the information shown is correct; **(3) I understand that any incorrect statements may result in my coverage or my dependents' coverage being terminated, rescinded and/or claims not paid;** (4) I have read this form; (5) I authorize GEGLAC to verify all information.

I hereby authorize any health care practitioner, health care facility, the Medical Information Bureau or similar organization, any employer, group policyholder or certificateholder to disclose or furnish to GE Group Life Assurance Company (GEGLAC) and its legal representatives, any and all information with respect to my employment and the physical or mental health of me or my dependents. I understand that the information released to GEGLAC will be used to determine eligibility for the insurance requested. GEGLAC may redisclose such information for that purpose to the employer or union sponsoring the group insurance coverage, the group policyholder or certificate holder, or their legal representatives, to any reinsurer, and to any person or entity performing a business or legal function for the benefit of GEGLAC. The information may also be redisclosed as otherwise specifically permitted or required by law. The information will not be given, sold or transferred to any other person or entity.

This authorization extends to **records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS)** or information relating to alcohol or drug abuse or mental health care to the extent permitted by law.

This authorization is valid for up to 24 months from the date it was signed. I understand that I have the right to revoke this authorization at any time by writing to GEGLAC at the address listed at the top of this form. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. Revocation of or failure to sign this authorization may impair GEGLAC's ability to evaluate an application and may result in a denial of coverage. A photocopy of this authorization shall be as valid as the original. I understand that I am entitled to a photocopy of this authorization upon request.

Signature of Employee **Date**

Complete the following statement only if you and/or your spouse are applying for benefits in excess of the non-medical issue amount.

Health Statement

The questions that follow must be answered for each employee and spouse requesting coverage which exceeds the non-medical issue amount (check with your employer for the available non-medical issue amount). Failure to provide complete responses may result in underwriting delays, rescission of coverage and/or non-payment of claims. This request for coverage is not effective until approved by GE Group Life Assurance Company (GEGLAC). No information provided by you to your agent shall bind GEGLAC unless you also provide such information in writing on this form. No agent or broker has the authority to alter the contents of this form.

Please answer the following questions by checking the appropriate boxes:

	Yes	No	
1.	☐	☐	Have you or your spouse ever had or been told that he/she had elevated blood pressure, chest pain, heart murmur, circulatory or other heart disorder, blood, pus or sugar in the urine; diabetes; kidney, liver or bladder disorder; ob/gyn disorder including diagnosis of or treatment for infertility; blood disorder; acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or other immunological disease or disorder; cancer or tumor; ulcer or other gastrointestinal disorder; disorder of the neck, back, knees; epilepsy or severe headache; asthma or respiratory disorder; alcoholism, chemical dependency or substance use, abuse and/or dependency?
2.	☐	☐	Within the past 2 years have you or your spouse experienced unexplained persistent diarrhea, unexplained unintentional weight loss or night sweats, or persistent swollen glands?
3.	☐	☐	In the past 5 years, have you or your spouse been hospitalized, had surgery, taken medication regularly or at frequent intervals or been treated by a physical or psychological health care practitioner for anything other than preventive care?
4.	☐	☐	Have you or your spouse had medical expenses in excess of $2,000 in the last 12 months?
5.	☐	☐	Have you or your spouse been told or had reason to believe that medical or surgical, psychiatric or rehabilitative care may be required during the next 12 months?
6.	☐	☐	Has any request for coverage for Life, Accident or Health insurance or reinstatement of such insurance on you or your spouse been declined, postponed, rated, ridered or modified?
7.	☐	☐	Have you or your dependents used any type of tobacco products in the past 36 months?

8. EMPLOYEE: Height: _____ Weight: _____

9. SPOUSE: Height: _____ Weight: _____

If you answered "yes" to any of the questions above, please provide details as requested below.

Question No.	Person Treated	Nature of ailment or condition	Treatment Dates (from-to) and Degree of Recovery	Name, Address and Phone Number of Attending Physician

Based on your age and the size of the firm, you may be eligible to receive a benefit amount without providing evidence of good health. Acceptance for any additional benefit amounts will be subject to underwriting approval. If you apply for a benefit amount that is $150,000 or more than the amount you can elect without providing evidence of good health, a physical exam with blood test will be required and acceptance will be subject to underwriting approval. Employees age 70 or older must complete a health statement for all coverage amounts and acceptance is determined by underwriting approval.