POLICYHOLDER

Life Insurance Company of North America
Personal Accident Insurance

POLICY NO.

Complete the following to enroll:

Full Name ______________________ Date of Birth ______________ Social Security # ______________

Address ____
street city state zip

Select Coverage Option: ❑ Employee and Family ❑ Employee Only

My Benefit Amount $ __________ My Cost $ __________ / per month *

If you select coverage for your family, benefits for family members will be a percentage of yours.

My Beneficiary ______________________ Relationship ______________________

You will be your family members' beneficiary unless you tell us otherwise in writing.

I enroll and authorize my employer to deduct the premiums from my earnings. I understand that the insurance selected will begin on the effective date as described in the brochure. If I am not actively at work, or any family members are not actively at work, or they are unable to engage in all the usual duties of a person of like age and sex, the effective date of coverage will be delayed until the individual returns to work, or the family member resumes usual duties.

Signature ______________________________ Date ______________

❑ **DECLINATION** — Check here and sign above if you do not want this coverage.

SAMPLE ONLY

CIGNA Group Insurance
Life • Accident • Disability

TL-007112

Return first copy to your employer. Save second copy for your records.