

POLICYHOLDER
Indiana State University

Life Insurance Company of North America
Personal Accident Insurance

POLICY NO.
OK-961638

Complete the following to enroll:

Full Name _____ Date of Birth _____ Social Security # _____

Address _____
STREET CITY STATE ZIP

Select Employee 1 2 3 4 5 6 7 8 9 10 times salary, rounded to the next higher \$25,000 \$ _____

Coverage Spouse at 100% of my benefit *—or—* at 50% of my benefit

Options: Children at 10% of my benefit

My Benefit Amount \$ _____

Total Cost \$ _____ / per month

My Beneficiary _____ Relationship _____
PRINT FULL NAME(S)

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 my 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.

TL-007113

AR-0610-23700

Return to your employer. Be sure to make a copy for your records.



CIGNA Group Insurance
Life • Accident • Disability