

POLICYHOLDER

University of Virginia

Life Insurance Company of North America
Personal Accident Insurance

POLICY NO.

OKV-2110

Complete the following to enroll:

Full Name _____ Date of Birth _____ Social Security # _____

Address _____
STREET CITY STATE ZIPSelect Coverage Option: Employee and Family Employee Only

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

My Benefit Amount \$ _____

My 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. Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Signature _____ Date _____

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

TL-007112

PM-2155m (Enrollment Form)/AR-0010-12237(08/01)

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


CIGNA Group Insurance
 Life • Accident • Disability