DMBA

SUPPLEMENTAL GROUP TERM LIFE APPLICATION

PARTICIPANT INFORMATION (REQUIRED)

Employee name: _____

DMBA ID number: _____ Birth date: _____

Address: _____

Home phone: _____ Work phone: _____

I would like to enroll in Supplemental Group Term Life. I agree to pay the entire premium and understand that my benefit and premium may change each year as my age and salary change. I understand that to be eligible for Supplemental Group Term Life, I must be enrolled in Group Term Life.

EMPLOYEE OPTION DESIRED:

- ☐ No coverage
- ☐ 1 X Salary Level
- ☐ 2 X Salary Level
- ☐ 3 X Salary Level
- ☐ 4 X Salary Level
- ☐ 5 X Salary Level
- ☐ 6 X Salary Level

The maximum benefit is $1,500,000. This reduces for employees aged 60 or older. For more information, see your summary plan description (benefits handbook).

SPOUSE OPTION DESIRED:

☐ No coverage	☐ $ 80,000	☐ $ 180,000
☐ $ 10,000*	☐ $ 100,000	☐ $ 200,000
☐ $ 20,000	☐ $ 120,000	☐ $220,000
☐ $ 40,000	☐ $ 140,000	☐ $240,000
☐ $ 60,000	☐ $ 160,000	☐ $260,000

CHILDREN OPTION DESIRED:

- ☐ No coverage
- ☐ $ 5,000* 6 months and older ($ 1,000* Birth to 6 months)
- ☐ $ 10,000 6 months and older
- ☐ $ 15,000 6 months and older

Children 6 months of age and older must meet health standards before they can be eligible for a higher benefit level.

IT IS MUTUALLY AGREED THAT:

- The representations in this application are correctly recorded, complete, and true to the best knowledge and belief of the undersigned.
- Voluntary change to this benefit requires agreement between the employee and DMBA. Employees who choose to increase their salary level multiple must meet health standards.
- No representative of any participating employer (except DMBA) is authorized to accept risks, pass upon eligibility, or waive any of plan rights or requirements.
- The benefit applied for herein shall not go into force or take effect unless and until the application has been approved and the first premium has been collected during the good health of the person(s) to be enrolled.
- The benefit applied for herein, if approved, shall end upon failure to pay the premiums or as provided for in the plan.
- Salary level is equal to the previous year's annual salary rounded up to the next $10,000 (current salary is used for newly hired employees).
- Once the salary level has been reduced, the applicant must meet health standards to increase the salary level in the future.

I AUTHORIZE MY EMPLOYER, UNTIL THIS AUTHORIZATION IS REVOKED BY ME IN WRITING, TO DEDUCT FROM ANY EARNINGS DUE ME THE AMOUNT NECESSARY FOR SUPPLEMENTAL GROUP TERM LIFE PREMIUMS DUE TO DMBA.

Signature: _____

Date: _____

* Applicant does not need to meet health standards for this benefit level if application is made within 30 days of the eligibility date.

DMBA USE ONLY

☐ APPROVED: _____ ☐ DECLINED: _____

EFFECTIVE DATE: _____ INITIALS: _____

EMPLOYER USE ONLY

☐ NEW HIRE ☐ CHANGE

ANNUAL SALARY: _____ HIRE DATE: _____

BENEFICIARY INFORMATION

To designate your beneficiaries, complete a *Beneficiary Form* or log onto www.dmba.com.

HEALTH QUESTIONNAIRE

APPLICANT NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE (MM/DD/YYYY)	AGE	HEIGHT (FT., IN.)	WEIGHT (LBS.)	WEIGHT ONE YEAR AGO	OCCUPATION	IN GOOD HEALTH NOW?
EMPLOYEE	SELF							
	SPOUSE							

Do any of the persons listed here have (or have they had) any of the following? (Check "Yes" or "No.") If you answer "yes" to any of the items listed, give full details on the next page.	YES	NO
1. Current prescription medication	☐	☐
2. High blood pressure	☐	☐
3. Chest pain or heart disorder	☐	☐
4. Ulcers or disorders of the stomach, intestines, or rectum	☐	☐
5. Hepatitis or disorders of the liver, pancreas, thyroid, gallbladder, kidneys, or urinary tract	☐	☐
6. Diabetes, blood sugar problems or other blood disorders	☐	☐
7. Cancer of any type, tumors, cysts, or unexplained growths	☐	☐
8. Asthma, shortness of breath, pneumonia, or other lung disease	☐	☐
9. Neurological disorder	☐	☐
10. Has been admitted to a hospital	☐	☐
11. AIDS, AIDS-related complex, HIV positive, or other immune deficiency disorders	☐	☐
12. Has been declined for life insurance coverage	☐	☐
13. Smoke or use (or have used) tobacco products (list type, amount, and duration on next page)	☐	☐
14. None of these conditions have ever applied	☐	☐

(Attach a separate sheet of paper if necessary.)

ITEM #	PATIENT NAME	INITIAL DATE OF ILLNESS OR MEDICATION	DURATION OF ILLNESS OR MEDICATION	DESCRIBE IN DETAIL THE ILLNESS OR REASON FOR MEDICATION	PRESENT CONDITION

AUTHORIZATION

I have carefully read all of the above questions, statements, and answers, and agree all such statements and answers are correct and true. I authorize the use of this questionnaire in connection with any benefit applied for in this application and I understand any misstatement or omission in this application may void such benefit. I understand I may be contacted to undergo a medical exam, paid for by DMBA, in conjunction with benefits applied for in this application. I understand and agree that there will be no additional Supplemental Group Term Life (SGTL) in effect until DMBA approves the applicant(s) for such benefit. Coverage will be effective the first of the month following the month the applicant is approved. I authorize any licensed physician, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, or other organization, institution, or person who has any records or knowledge of me or my health (or of any persons proposed for SGTL) to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to DMBA for the purpose of evaluating my application for SGTL. A photocopy of this authorization and request form shall be as valid as the original. In all circumstances, my authorized agent or representative or I may request a copy of this authorization. This authorization may be used for a period of six months from the date signed, unless sooner revoked. On behalf of me and my dependents, I waive any action for such disclosure.

Participant signature: _____ Date: _____

Spouse signature: _____ Date: _____
SIGN ONLY IF SPOUSE BENEFIT IS REQUESTED

Dependent signature: _____ Date: _____
SIGN ONLY IF DEPENDENT CHILD BENEFIT IS REQUESTED AND CHILD IS AGE 18 OR OLDER

WAIVER OF BENEFIT (SIGN *ONLY* IF YOU REJECT BENEFITS)

Employee name: _____ DMBA ID number: _____

☐ I do not wish to enroll at this time. ☐ I wish to discontinue participation in SGTL.

I hereby acknowledge that I have been given an opportunity to apply for SGTL as offered by my employer and, after careful consideration, I have decided not to take advantage of this offer. I understand if I want to apply in the future, I will be required to meet DMBA's health standards and DMBA reserves the right to refuse to grant coverage.

Participant signature: _____ Date: _____

Please return this completed form to enrollmenthelp@dmba.com. You may also mail it DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800 777 3622.