NLI America
BENEFIT FROM OUR DEDICATED SERVICE

NIPPON LIFE INSURANCECOMPANY OF AMERICA
650 8th Street
Des Moines, Iowa 50309

A. Employee Information

Coverage Applying For: ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Life** ☐ **Dependent Life** ☐ **Long Term Disability**

Print your name (last, first, middle initial)		Home phone number	Social Security number
Home address (street)	City	State	ZIP code

Date of birth	☐ male ☐ married ☐ female ☐ single	Occupation	Date of full time employment	Employee email address

Employer name	I am selecting coverage for: ☐ employee ☐ employee and spouse ☐ employee and children ☐ employee, spouse and child(ren) I am waiving coverage for: ☐ all ☐ spouse ☐ child(ren) Reason:

If coverage applied for replaces any individual or group health insurance, please provide the following:

The last date of coverage under that policy: ______________________________

Name of carrier: ____________________________________ Policy #: ________________________________

Is anyone applying for coverage eligible for Medicare A? ☐ yes ☐ no Medicare B? ☐ yes ☐ no

B. Health Information (Note: This information will not be used for any purpose prohibited by law.)

Please complete all information on you and family members applying for coverage. List additional children on a separate sheet and staple to this form.

Name (first MI last)	Relationship	Date of Birth	Gender	Height	Weight	Weight change in last year	Other Coverage	Student
	Employee					_______ loss _______ gain	Yes No	
	Spouse					_______ loss _______ gain	Yes No	
	Child						Yes No	Yes No
	Child						Yes No	Yes No

Answer only for those individuals requesting coverage. To prevent delays, answer each question and give full details to "yes" answers. All statements and descriptions on this form shall be deemed to be representations and not warranties.

1. ☐ yes ☐ no	Does anyone smoke?
2. ☐ yes ☐ no	Is anyone on whom coverage is requested currently receiving medical treatment, taking medication, or pregnant?
3. ☐ yes ☐ no	Has anyone been told of a need, or possible need for, or is anyone planning or scheduled for, physical therapy, a specialist consultation, surgery, hospitalization, medical treatment, psychotherapy, counseling, EKG, stress test, CT/MRI scan, blood test or any other medical tests or examinations?
4. ☐ yes ☐ no	Does anyone have any physical or mental birth defect, developmental or learning disability, behavior disorder, or physical or mental impairment or condition?
	In the past 5 years, has anyone:
5. ☐ yes ☐ no	• consulted a doctor, health care provider, or any medical specialist for persistent, lingering or prolonged fevers, night sweats, fatigue, tiredness or weakness?
☐ yes ☐ no	• been told by a doctor, health care provider, counselor, therapist, or any medical specialist of the need to reduce or discontinue the use of alcohol or drugs, or been treated for the use of alcohol or drugs?
☐ yes ☐ no	• been evaluated for infertility (male or female)?
	In the past 10 years, has anyone:
6. ☐ yes ☐ no	• had any surgery, hospitalization, observation room stay, or hospital emergency room treatment or minor emergency clinic, urgent care clinic or outpatient treatment?
☐ yes ☐ no	• been to or consulted a doctor, chiropractor, counselor, therapist, health care provider or any medical specialist, had blood tests (other than for HIV antibody), other medical tests or been referred to a medical specialist?
7.	**In the past 10 years**, has anyone on whom coverage is requested been diagnosed with or received treatment for any of the following (check all that apply)? ☐ cancer ☐ liver disorder ☐ bone disorder ☐ mental disorder ☐ digestive disorder ☐ tumors ☐ kidney disorder ☐ joint disorder ☐ nervous disorder ☐ infectious disease ☐ heart condition ☐ muscle disorder ☐ urinary disorder ☐ diabetes ☐ multiple sclerosis / neurological disorder ☐ high blood pressure ☐ stroke ☐ respiratory disorder ☐ hepatitis
8. ☐ yes ☐ no	**In the past 10 years**, has anyone on whom coverage is requested been treated or diagnosed by a physician or tested positive for HIV antibody, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC)?

Provide full details for all “yes” answers. If more space is needed, make a copy of this page and include it as an additional page. Sign and date all pages.

Name	Date diagnosed/treated	Duration of illness or condition
Diagnosis of illness or condition		
Any current symptoms or problems		
Names and addresses of doctors, hospitals or other providers		
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Names and addresses of doctors, hospitals or other providers		

Provide full details for all “yes” answers. If more space is needed, make a copy of this page and include it as an additional page. Sign and date all pages.

<u>Notice of Information Practices</u> (To be read before completing the Health Information section)

In order to properly underwrite, we must collect information. We will do this by having you complete the Health Information section. In addition, we may contact sources other than you for personal data about any proposed insured, including spouse, employer, medical professionals or institutions, and insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, habits and other personal characteristic information.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, with your written authorization, we may provide data to government agencies (e.g., an insurance department of your state), or attending physicians. We may also provide statistical / unidentifiable information to insurance organizations who conduct large studies of insurance practices.

Your or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

- to find out what personal information is contained in the NLIA America files (medical information may be disclosed only to your attending physician).
- To correct or amend information in NLIA America files.

Upon written request, NLIA America will furnish to you (or your dependent) information concerning:

- The nature and scope of personal data in our records;
- The types of disclosures that may be made; and
- Rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written requests within 30 days from the date of receipt.
For further information about your file or rights, you may contact Group Operations, Medical Underwriting, Total Plan Services, Inc., 14001 Dallas Parkway North, Suite 700, Dallas, Tx 75240.

<u>Authorization, Acknowledgment and Signatures</u>

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge and belief. They are a part of this request for coverage under the group policies. I agree Nippon Life Insurance Company of America (NLIA America) is not liable for anyone's claim that happens or begins before the effective date of coverage by NLIA America.
- I have read, or had read to me, the questions and responses, and realize that any false statements, omissions and/or material misrepresentations regarding age or health information could cause coverages, if issued, to be cancelled as never effective.
- I understand all group policy provisions for medical coverage will apply. If approved for life and disability coverages, all group policy provisions will apply including, but not limited to, preexisting conditions restriction, and the period of limited activity provisions.
- I understand an agent or broker cannot change or waive any rates, benefits, or provisions of any group policy, if issued, without the written approval of an officer of NLIA America.
- I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent proposed for coverage, to give to NLIA America, its underwriters along with its agents and employees performing business transactions, any such data.
- I authorize NLI America to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form may be as valid as the original.
- I understand the data obtained by use of this authorization will be used by NLIA America for claims administration and to determine eligibility for coverage. This information will not be used for any purposes prohibited by law.
- Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact materially thereto commits a fraudulent insurance act that is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

Employee signature required	Date signed

Employer instructions

After this form has been completed and signed, make two copies, send the original to Nippon Life Insurance Company of America, keep one copy for your records and give one copy to the employee.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The Health Insurance Portability & Accountability Act of 1996 (H.R. 3103) provides for federal penalties of up to 5 years imprisonment for intentional misrepresentation of information in any application for healthcare benefits.