Life Insurance Company of North America (LINA)

GROUP TERM LIFE INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any requested information below. Don't forget to include your Social Security Number, herein shown as SSN, Birthdate, sign your name and enter today's date.

Return completed form to: Benefits Department

EMPLOYER: Bi-State Development Agency

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ SSN _____ Date of birth _____

Home Address _____ City _____ State _____ Zip _____

Email _____ Home/Cell Phone _____ Employee ID # _____ Gender: _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is _____

Spouse Name _____ SSN _____ Date of birth _____ Gender _____

YOUR COVERAGE ELECTIONS

View the Summary of Benefits for costs and instructions for how to calculate premium.

Employee-Paid Term Life Insurance – Policy # FLX0970854 Underwritten by LINA		
Choose your desired coverage amount below and who you would like to cover. See the Summary of Benefits for costs.		
Who You Want to Cover	**Coverage Amount**	**Accept your desired coverage amount or decline coverage below.**
❑ Spouse (Spouse Option must correlate with Child Option)	❑ Option 1 - $10,000 ❑ Option 2 - $20,000 ❑ Option 3 - $25,000**** Guaranteed Issue Amount***: $25,000	❑ Decline Coverage
❑ Children (Child Option must correlate with Spouse Option)	❑ Option 1 - $2,500 ❑ Option 2 - $5,000 ❑ Option 3 - $7,000**** Guaranteed Issue Amount***: All amounts	❑ Decline Coverage

If Children are elected, all eligible dependent children will be covered.

*** Guaranteed Issue Amount is only available if enrolling within the first 31 days of eligibility. Amounts of insurance may be limited by state law.

****This is the maximum coverage amount that you can choose under this plan. Coverage elected during this enrollment period will take effect on the later of 01/01/2026, or the date your election form is received by your Employer.

SIGN TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. I understand that coverage is subject to the insurance company's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Please Sign Here Signature _____ Date _____

Created on 09/2025.