DESERET MUTUAL
BENEFIT ADMINISTRATORS

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RETIREE SUPPLEMENTAL GROUP TERM LIFE INSURANCE APPLICATION

Retiree name: ______________________________ Deseret Mutual ID number: ____________
First Middle Last

Address: ____

Home phone: (________) ______________________ Birth date: ______________________

I would like to enroll in the Retiree Supplemental Group Term Life insurance program. I understand that my enrollment must occur within one month of my retirement.

RETIREE OPTION DESIRED:

- ❑ No coverage
- ❑ $ 5,000
- ❑ $ 10,000
- ❑ $ 15,000
- ❑ $ 25,000

SPOUSE OPTION DESIRED:

- ❑ No coverage
- ❑ $ 5,000
- ❑ $ 10,000
- ❑ $ 15,000
- ❑ $ 25,000

CHILDREN OPTION DESIRED:

- ❑ No coverage
- ❑ $ 3,000
- ❑ $ 5,000
- ❑ $ 10,000

You must meet health standards to be eligible for Retiree Supplemental Group Term Life coverage. However, if Supplemental Group Term Life coverage was in effect immediately before your retirement, you do not need to meet health standards for the $5,000 benefit level.

IT IS MUTUALLY AGREED THAT:

(a) the representations in this application are correctly recorded, complete, and true to the best knowledge and belief of the undersigned;

(b) voluntary change in the insurance coverage requires agreement between the employee and Deseret Mutual;

(c) no representative of any Deseret Mutual participating employer is authorized to accept risks, pass upon insurability, or waive any of Deseret Mutual's requirements;

(d) no insurance applied for herein shall go into force or take effect until application for coverage has been approved and initial premium has been collected; and

(e) the insurance applied for herein, if approved, shall terminate upon failure to pay the premiums or as provided for in the policy.

Signed: ______________________ Date: ____________

WAIVER OF RETIREE SUPPLEMENTAL GROUP TERM LIFE INSURANCE

- ❑ I do not want to enroll.
- ❑ I want to discontinue my Retiree Supplemental Group Term Life insurance.

I hereby acknowledge that I have been given an opportunity to apply for Retiree Supplemental Group Term Life insurance as offered by my former employer, and after careful consideration, I have decided not to take advantage of this offer. **I understand that I am not eligible to apply for coverage after retirement has been in effect for one month.**

Signed: ______________________________
(Sign only if you reject the benefits.)

Date: ______________________________

BENEFICIARY INFORMATION

To name the needed primary and alternate beneficiaries for *Retiree Supplemental Group Term Life insurance*, please complete the *Basic and Supplemental Life Insurance Beneficiary Designation Form*.

FOR DESERET MUTUAL USE ONLY

Retirement Date: Month ________ Day ________ Year ________

Was SGTL coverage in effect before retirement? Y / N

Retiree ________ Spouse ________ Children ________

❑ APPROVED

❑ DECLINED: ______________________________

____

Underwriters initials: ______________________________

Date: ____________________ Effective date: ____________________

RETIREE SUPPLEMENTAL GROUP TERM LIFE INSURANCE HEALTH QUESTIONNAIRE

Insurance applicant (include yourself, spouse, and eligible dependent children)	Relationship to retiree	Birth date	Age	Height (Ft., in.)	Weight (Lbs.)	Weight one year ago	Occupation	In good health now? Yes or No

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 below.

	YES	NO		YES	NO
1. Current prescription medication			12. Diabetes, blood-sugar problem		
2. Surgical operations / hospitalization / serious accidents			13. Arthritis (state type), lupus, bone disease or infection		
3. High or low blood pressure, artery or vein disorder, blood disorder			14. Stroke, epilepsy, seizures		
4. Heart disorder, enlarged heart, murmur, irregular heart beats, chest pain			15. Eye disease, hearing problem		
5. Hospitalization for depression / mental illness, psychiatric care, depression			16. Reproductive organ ailment		
6. Malaria, typhoid fevers, tuberculosis, spinal meningitis, venereal disease			17. Cancer of any type, tumors, unexplained growths		
7. Stomach ulcers, disorders of the stomach or intestines, colon, rectal diseases			18. Alcoholism		
8. Liver, kidney, ureter, gallbladder, pancreas, thyroid disorders, hepatitis			19. Head or internal injuries		
9. AIDS, AIDS-related complex, HIV positive, other immune deficiency disorders			20. Physical disabilities, paralysis, congenital abnormalities, amputation, muscular disorders		
10. Smoke or use (have used) tobacco products within past three years			21. Respiratory or lung disease, asthma, shortness of breath, pneumonia		
11. Ever used LSD, heroin, cocaine, marijuana or other such drugs			22. Disease or disorder not already identified		

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

(Attach a separate sheet of paper if necessary.)

I have carefully read all of the above questions, statements, and answers, and all such statements and answers are correct and true. I authorize the use of this questionnaire in connection with any insurance applied for in this application, and I understand any misstatement or omission in this questionnaire may void such coverage. I understand and agree that there will be no additional Retiree Supplemental Group Term Life insurance in effect until Deseret Mutual approves the applicant(s) as insurable risks. Coverage will be effective the 1st of the month following the month that coverage is approved. I authorize any physician, hospital official, or person who has or may attend or examine or who may be consulted by me or any dependent listed above, to disclose any knowledge or information acquired to Deseret Mutual. On behalf of me and my dependents, I waive any action for such disclosure.

Printed name:______________________________ DMID: ______________

Retiree signature:______________________________ Date: ______________