



WAEPA Additional Life Insurance

Additional Life Insurance for Current WAEPA Members

Increase
Your
Coverage.

...See *below*

Most
Popular Plans.

...See *Page 2*

Apply
Now!

...See *Page 3*

Time for a Change?

You're a real person with a real life. Which means as things change in your world, your life insurance needs change as well. Fortunately, you're a WAEPA member and you have coverage that can keep up when:

- You get married or have a child
- You get a new job or a big promotion
- You buy a new house
- You have other types of new financial obligations

With WAEPA, you can adjust your coverage whenever and however you need to. You don't have to wait for an open season. Just select the coverage you need and fill out the enclosed form – it's that easy!

See page two for a listing of our most popular coverage options.

How to Adjust Your WAEPA Life Insurance Coverage

Select the level of coverage that best suits your needs. Although the charts on page two list just our most popular options, you can set your coverage as follows:

Coverage for you	\$25,000 to \$750,000 in \$25,000 increments	Provided on one low-cost policy
Coverage for your dependent spouse or domestic partner	\$10,000 to \$250,000 in \$10,000 increments (up to 50% of your coverage)	
Coverage for your dependent children	Up to \$25,000 available. Coverage depends on age, and is tied to level of spousal coverage	

Complete and sign the application forms enclosed in this brochure. As part of our underwriting process, we may request further information about your medical history or require you to take a medical exam.

Please mail pages three, four and five in the enclosed envelope to:

WAEPA
433 Park Avenue
Falls Church, VA 22046



Better Insurance.

Better Prices.

Better Value.[®]

Coverage Options

Most Popular Plans...

Member Life Insurance Schedule of Benefits									
Levels	2	4	8	12	16	20	24	28	30
Life Insurance	\$50,000	\$100,000	\$200,000	\$300,000	\$400,000	\$500,000	\$600,000	\$700,000	\$750,000
AD & D	\$10,000	\$20,000	\$40,000	\$60,000	\$80,000	\$100,000	\$120,000	\$140,000	\$150,000
Additional Accident	\$20,000	\$40,000	\$80,000	\$120,000	\$160,000	\$200,000	\$240,000	\$280,000	\$300,000
Quarterly Premiums Based on Member/Associate Member's Age									
Under 25	\$6.00	\$12.00	\$24.00	\$36.00	\$48.00	\$60.00	\$72.00	\$84.00	\$90.00
25-29	\$7.50	\$15.00	\$30.00	\$45.00	\$60.00	\$75.00	\$90.00	\$105.00	\$112.50
30-34	\$8.50	\$17.00	\$34.00	\$51.00	\$68.00	\$85.00	\$102.00	\$119.00	\$127.50
35-39	\$10.00	\$20.00	\$40.00	\$60.00	\$80.00	\$100.00	\$120.00	\$140.00	\$150.00
40-44	\$14.00	\$28.00	\$56.00	\$84.00	\$112.00	\$140.00	\$168.00	\$196.00	\$210.00
45-49	\$20.00	\$40.00	\$80.00	\$120.00	\$160.00	\$200.00	\$240.00	\$280.00	\$300.00
50-54	\$30.50	\$61.00	\$122.00	\$183.00	\$244.00	\$305.00	\$366.00	\$427.00	\$457.50
55-59	\$46.50	\$93.00	\$186.00	\$279.00	\$372.00	\$465.00	\$558.00	\$651.00	\$697.50

Please visit www.waepa.org for a complete listing of benefits and rates.

Dependent Life Insurance (Spouse Life Insurance)							
Levels	1	2	5	10	15	20	25
	\$10,000	\$20,000	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Dependent Life Insurance (Children)							
2wks - 2yrs	\$1,000	\$2,000	\$5,000	\$10,000	\$10,000	\$10,000	\$10,000
2yrs - 5yrs	\$2,000	\$4,000	\$10,000	\$20,000	\$20,000	\$20,000	\$20,000
5yrs - 19yrs	\$2,500	\$5,000	\$12,500	\$25,000	\$25,000	\$25,000	\$25,000
Quarterly Premiums Based on Member/Associate Member's Age							
Under 25	\$1.50	\$3.00	\$7.50	\$15.00	\$22.50	\$30.00	\$37.50
25-29	\$2.00	\$4.00	\$10.00	\$20.00	\$30.00	\$40.00	\$50.00
30-34	\$2.25	\$4.50	\$11.25	\$22.50	\$33.75	\$45.00	\$56.25
35-39	\$3.00	\$6.00	\$15.00	\$30.00	\$45.00	\$60.00	\$75.00
40-44	\$4.00	\$8.00	\$20.00	\$40.00	\$60.00	\$80.00	\$100.00
45-49	\$5.50	\$11.00	\$27.50	\$55.00	\$82.50	\$110.00	\$137.50
50-54	\$8.00	\$16.00	\$40.00	\$80.00	\$120.00	\$160.00	\$200.00
55-59	\$12.00	\$24.00	\$60.00	\$120.00	\$180.00	\$240.00	\$300.00

Please visit www.waepa.org for a complete listing of benefits and rates.

FOR CURRENT WAEPA MEMBERS ONLY

MEMBER NAME: (Please Print) _____ (First) (M.I.) (Last)

1. I am a member of WAEPA, presently insured under Certificate Number _____, and wish to change my present Group Insurance coverage to the Group Insurance coverage selected below.

2. Amount of insurance coverage selected:

a. Basic Group Life Insurance (Amount of Member/Associate Member Life Insurance) \$ _____ Level _____

b. Dependent Group Life (DGL) Insurance (Amount of Spouse/Domestic Partner* Life Insurance) \$ _____ Level _____

Note: Your spouse/domestic partner's coverage may not be greater than one half (50%) of your coverage.

Full-time members of the Armed Forces are not eligible for member, Associate Member, or dependent coverage.

Domestic partners must complete the Domestic Partner Affidavit.*

3. Your sex: Male Female

4. Your date of birth ____/____/____ Age ____ Agency/Grade ____ (MM/DD/YY - You must be less than age 65)

Your spouse's date of birth ____ Age ____ Occupation ____ (Your spouse/domestic partner must be less than age 65)

5. Your Social Security Number _____

6. Your Spouses Social Security Number (ONLY if applying for spousal coverage) _____

7. I will pay premiums: Annually Semi-Annually Quarterly Monthly Payroll Deduction

8. Send No Money!

Once your application has been received and approved, we will advise you of the amount due.

An authorization form permitting us to transfer funds from your checking account will be mailed to you.

Information regarding payroll deduction will be mailed to you after your application is processed.

9. I designate as my beneficiary (please list legal name, e.g., Mary White Jones not Mrs. John Jones)

Primary _____ Relationship _____

Contingent _____ Relationship _____

If you name a contingent beneficiary, the contingent beneficiary will receive the death benefit if your primary beneficiary is not living when you die. If you name more than one person as a primary beneficiary or a contingent beneficiary, specify the percentage of benefit payable to each beneficiary. The insured member will be the beneficiary of all dependent coverage.

10. Applicant Contact Information:

Street _____

City _____ State _____ Zip Code _____

Office Phone _____ Home Phone _____ E-mail _____

Cell Phone _____

*Domestic Partner Coverage is not available in Virginia.

Tear here

Underwritten by the following CIGNA companies: Life Insurance Company of North America (LINA), Connecticut General Life Insurance Company (CG), CIGNA Companies (herein called the Insurance Company)

APPLICANT INFORMATION						
LIST BELOW ONLY INDIVIDUALS APPLYING FOR COVERAGE	ALIAS/ MAIDEN NAME	RELATIONSHIP (TO APPLICANT)	BIRTH DATE (MM/DD/YY)	AGE	HEIGHT (FT. IN.)	WEIGHT (LBS.)
APPLICANT (Full Name)						
ELIGIBLE DEPENDENTS (Full Names)						

HEALTH QUESTIONS SECTION A

By applying for this coverage, do you intend to replace, discontinue or exchange existing life insurance coverage? Yes **or** No

Within the last five years, have you or your eligible dependents been:

- diagnosed with any of the conditions shown in items A through J below,
- told by a medical professional he/she has, or may have, any of the conditions shown in items A through J below,
- or been treated by a medical professional for any of the conditions shown in items A through J below?

- A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation, or any other condition affecting the heart or circulatory system? Yes **or** No
- B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver, or pancreas? Yes **or** No
- C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract? Yes **or** No
- D. Any condition affecting the kidneys, urinary tract, prostate gland, or reproductive system? Yes **or** No
- E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes? Yes **or** No
- F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system? Yes **or** No
- G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity, or loss of limb? Yes **or** No
- H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition? Yes **or** No
- I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps, or Moles? Yes **or** No
- J. Alcohol or drug abuse or dependency? Yes **or** No

HEALTH QUESTIONS SECTION B

Within the last five years, have you or your eligible dependents:

- A. Used any controlled or illegal drug or other substance? Yes **or** No
- B. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams? Yes **or** No
- C. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture? Yes **or** No
- D. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above? Yes **or** No

USE THE SPACE BELOW TO EXPLAIN "YES" ANSWERS. IF MORE SPACE IS NEEDED, USE A NEW PAGE, SIGN AND DATE IT AND ATTACH TO THIS FORM.

Name of Person	Condition	Date Occurred	Duration/Treatment Received	Current Status

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 fact material thereto, commits a fraudulent insurance act.

PHYSICIAN SECTION			
	Name	Contact Information	Street Address (City, State, & Zip)
Applicant Physician		Tel# Fax#	
Spouse/Domestic Partner Physician		Tel# Fax#	
Child(ren) Physician		Tel# Fax#	

AGREEMENTS AND AUTHORIZATION

To the best of my knowledge and belief, all written, telephonic, and electronic information I gave is true and complete. I also understand that coverage for each of my dependents will not go into effect if a dependent is confined in a hospital or institution. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

- (1) This request will be a part of the policy that provides the insurance.
- (2) I may need to provide more medical information.
- (3) I may need to take medical tests and report the results to the Insurance Company.
- (4) My dependent(s) may need to take medical tests. The results of those tests must be reported to the Insurance Company.
- (5) I must report any change in my health, or of a dependent for whom coverage is requested, that happens before the insurance is effective.
- (6) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

AUTHORIZATION

I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, or any other person or organization having information about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me or my children to disclose to the Insurance Company or its authorized agent, any such information, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the information will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with the applicable law.

I understand that the information provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

X _____
Applicant's Signature Date

X _____
Signature of Spouse/Domestic Partner (if applying) Date

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

Better Insurance.

Better Prices.

Better Value.[®]

Increase Your WAEPA Life Insurance....Now!

- Apply Now - No Open Season required
- Enjoy coverage levels of up to \$750,000
- Get more coverage for your spouse and dependent children



**Protect your Family with
More Coverage ... See Inside!**

WAEPA Members:

www.WAEPA.org
433 Park Avenue
Falls Church, VA 22046

Better Insurance. Better Prices. Better Value.SM

