2017 Employee Group Life Insurance Summary of Benefits
Commonwealth of the Northern Mariana Islands
February 1, 2017 through January 31, 2018

	Active Employees	Retirees
Individuals Term Life Insurance Benefit Amount	1.8X Current Annual Salary	1.8X Current (Reduced) Annual Pension*
Premium Rate per $1,000 Coverage	$0.75 payable bi-weekly	$0.81 payable semi-monthly
Employer Cost Sharing	50/50	50/50
Minimum/Maximum Coverage Amount	$5,000/$90,000	$5,000/$90,000
AD&D Rider Included	Yes, up to age 70	No
Living Benefit Rider Included	Yes	Yes
Optional Dependent Coverage Available	Yes	No

* - Current (Reduced) Annual Pension equals 75% of the full annual pension amount regardless of retirement date.

NOTE: Premium refund requests must be submitted to INSURANCE COMPANY within 120 days of the effective date of Individual participant termination. In any event, the maximum refund amount is 120 days of premium most recently remitted to insurance company for the terminating individual.

ACTIVE EMPLOYEES ONLY	**Optional Dependent Coverage Schedule**			
	Option 1	**Option 2**	**Option 3**	**Option 4**
Spouse	$10,000	$25,000	$40,000	$40,000
Children (14 days to under 1 year)	$6,000	$6,000	$6,000	$6,000
Children (1 year through 18*)	$10,000	$15,000	$15,000	$15,000
Parents/Parents-in-Law	None	None	None	$5,000
IAC Bi-Weekly Rate	$4.95	$7.95	$10.95	$36.95

* - Single and dependent on parent for support. Coverage is available for children through age 24 if full-time student. For complete provisions, see the Dependents Term Life Insurance rider.

CNMI GOVERNMENT GROUP LIFE INSURANCE ENROLLMENT FORM

☐ Re-Enrollment ☐ New Enrollee ☐ Change ☐ Termination

Last Name	First Name		Middle Name
Mailing Address			Date of Birth
			Marital Status ☐ Married/Common-Law ☐ Single
Government Department	Employment Date	Social Security Number	Phone Number

Employment Status

☐ Active; 20 or more hours per week ☐ Retiree Name of employer retired from:

_____

Are you presently on leave of absence from work due to sickness, injury, medical treatment, or unpaid leave of absence for personal reasons?

☐ Yes ☐ No If yes, identify the leave and state the reason(s):

INDIVIUDAL'S TERM LIFE INSURANCE Available to Active Employees and Retirees

☐ I want Individual's Term Life Insurance

OPTIONAL DEPENDENT'S TERM LIFE INSURANCE Available to Active Employees Only

☐ I elect Dependent's Term Life Insurance Option: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Option 4 only: Complete the following for each parent/parent in-law to be covered. Evidence of insurability is required.

Name (last, first, middle)	Relationship	Name (last, first, middle)	Relationship

Complete the following for all other non-parent Dependents to be covered.

Name (last, first, middle)	Date of Birth	Social Security Number	Relationship

The Employee is the beneficiary of Dependent Life Insurance benefits.

☐ I **WAIVE** the optional Dependent's Term Life Insurance coverage. I understand that I will have **NO** Dependent's Term Life Insurance coverage, and if I apply at a later date, I will be required to furnish evidence of insurability.

BENEFICIARIES The total of the Percentage column must equal 100%, or check here ☐ for equal shares.

Legal Name (last, first, middle)	Relationship	Age or Date of Birth	Percentage
			%
			%
			%
			%
			%
			%

☐Minor Beneficiary Form completed

INSURANCE AUTHORIZATION

By signing below, I declare that the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I apply for coverage more than 61 days from my Employment Date, I will be required to furnish evidence of insurability for all individuals for whom coverage is requested. I also understand that regardless of when enrollment occurs, the addition of new parent(s) always requires completion of evidence of insurability. Coverage is not effective until approved by Individual Assurance Company. I authorize my employer to deduct from my earnings the required cost of the coverage(s) I have elected above.

Signature: Date:

FOR EMPLOYER USE ONLY

Annual Salary: $_____ Basic Life Coverage: $_____ Premium Deduction: $_____ Process Date: _____

Underwritten by Individual Assurance Company, Life, Health & Accident, 3200 E. Memorial Road, Suite 100, Edmond, OK 73013

IAC 1000EF(MP)(2014)

INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT
3200 E. Memorial Road, Suite 100, Edmond, Oklahoma 73013 ♦ 1-800-821-5434

EVIDENCE OF INSURABILITY

GROUP DIVISION_____ GROUP POLICY NUMBER _____

Amount of Insurance Applied for $ _____

S.S.# _____ ☐ Married ☐ Divorced ☐ Single ☐ Legally Separated State of Birth _____

Full Name _____ Occupation _____
Last First Middle

Residence Address _____
Street and Number City State Zip Code

Name of Employer_____ Dept/Branch _____ Date Employed _____

	Name	Date of Birth	Age	Height	Weight	Sex
Employee						
Spouse						
1st Child						
2nd Child						
3rd Child						
4th Child						
Parent						
Parent						
Parent In-Law						
Parent In-Law						

HEALTH STATEMENT OF EMPLOYEE AND DEPENDENT (if dependent coverage is desired)

Have you ever been treated for, or diagnosed as having, any of the following conditions:	Employee Yes	Employee No	Spouse Yes	Spouse No	Child Yes	Child No	Parent/In-Law Yes	Parent/In-Law No
1. any disease or disorder of the heart or circulatory system?	☐	☐	☐	☐	☐	☐	☐	☐
2. cancer, diabetes, stroke, or lung disorder?	☐	☐	☐	☐	☐	☐	☐	☐
3. liver or kidney disease?	☐	☐	☐	☐	☐	☐	☐	☐
4. AIDS or tested positive for HIV?	☐	☐	☐	☐	☐	☐	☐	☐
5. alcohol or drug abuse?	☐	☐	☐	☐	☐	☐	☐	☐

Give details for any "yes" answer above (use reverse side if more room is required):

Name	Condition (Diagnosis)	Dates Treated	Results of Treatment (Recovered?)	Full Name & Address of Physicians Consulted

It is understood and agreed that all statements in this application are true to the best of my/our knowledge and belief and are offered as a consideration for and shall become a part of any policy issued hereon. I/we understand and agree that the insurance is not in force until I am notified by Individual Assurance Company, Life, Health & Accident (IAC) that I have been approved and accepted by IAC. I/we acknowledge receipt of the Consumer Protection Notices for the Applicant. To determine my/our insurability, I/we hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me/us or my/our health, to give to the underwriters of IAC or its reinsurers' underwriters any such information. This authorization is valid for 24 months from the date signed. I/we may revoke this authorization at any time by providing written notice to IAC. Upon request, I/we, or any person authorized to act on my/our behalf, are entitled to receive a copy of this authorization. A photographic copy of this authorization shall be as valid as the original.

_____ _____ _____ _____
Witness Signature Proposed Insured's Signature Spouse's Signature, if to be insured Date

APPLICATION WILL BE RETURNED UNLESS ALL QUESTIONS ARE ANSWERED.
INSURANCE WILL NOT BE IN FORCE UNTIL THE APPLICATION IS APPROVED BY THE COMPANY.

IAC 1000EOI-01(2014)

(Detach and leave with Applicant.)

CONSUMER PROTECTION NOTICES FOR THE APPLICANT

Investigative Consumer Report Notice – In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may make a written request to be interviewed in connection with the preparation of this report. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. Either of these written requests should be directed to the Underwriting Department, Individual Assurance Company, 3200 E. Memorial Road, Suite 100, Edmond, OK 73013.

MIB, Inc. Notice – Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact the MIB at 866.692.6901 (TTY 866.346.3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

IAC PNC(2012)

INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT (herein called the Company)
3200 E. Memorial Road, Suite 100, Edmond, Oklahoma 73013 ♦ 1-800-821-5434

DISTRIBUTION OF PROCEEDS ELECTION FORM
MINOR BENEFICIARY

Name	Date of Birth	Owner (if other than insured)

NAMED MINOR BENEFICIARY(IES)		
Name (print in full)	Relationship	Date of Birth

CONTINGENT		
Name (print in full)	Relationship	Date of Birth

Should I die while any of the beneficiaries named above is a minor, I desire the benefits to be held in an annuity fund with the Company and paid out in a lump sum payment upon the beneficiary's _____ (not less than 18th) birthday.

I direct that any amendment of the policy requested above take effect on the date this request is signed but without any liability to the Company on account of payment made or action taken by it before this request was acknowledged by the Company. I agree that the Company may waive any policy provision requiring presentation of the policy for endorsement but may require such presentation, if desired.

_____ _____
Signature of Owner Date

The undersigned agrees to the above requests and changes.

_____ _____ _____
Signature of Owner's Spouse (if resident of community property state) Signature of Assignee (if any) Signature of Irrevocable Beneficiary (if any)