RETIREE SUPPLEMENTAL GROUP TERM LIFE APPLICATION

APPLICATION FOR BENEFITS

Retiree name: _____ DMBA ID number: _____

Address: _____

Home phone: _____ Birth date (MM/DD/YYYY): _____

I wish to enroll in Retiree Supplemental Group Term Life. I understand 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* ☐ $ 7,500* ☐ $ 15,000*

You must meet health standards to be eligible for the Retiree Supplemental Group Term Life benefit.

** If Group Term Life (or Supplemental Group Term Life for for spouse and children) was in effect immediately before your retirement, you do not need to meet health standards for this benefit level.*

IT IS MUTUALLY AGREED THAT:

- The representations in this application are correctly recorded, complete, and true to the best knowledge and belief of the undersigned.
- Voluntary change to this benefit requires agreement between the retiree and DMBA.
- No representative of any participating employer (except DMBA) is authorized to accept risks, pass upon eligibility, or waive any plan rights or requirements.
- The benefit applied for herein shall not go into force or take effect unless and until the application has been approved and the first premium has been collected during the good health of the person(s) to be enrolled.
- The benefit applied for herein, if approved, shall end upon failure to pay the premiums or as provided for in the plan.

Signature: _____ Date: _____

BENEFICIARY INFORMATION

To designate your beneficiaries, complete a Beneficiary Form or log onto www.dmba.com.

HEALTH QUESTIONNAIRE

Applicant Name (First, Middle, Last)	Relationship to Retiree	Birth Date (MM/DD/YYYY)	Age	Height (Ft., In.)	Weight (Lbs.)	Weight One Year Ago	Occupation	In Good Health Now? Yes or No
RETIREE	SELF							
	SPOUSE							

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 on the next page.	Yes	No
1. Current prescription medication		
2. Surgical operations, hospitalization, serious accidents		
3. High or low blood pressure, artery or vein disorder, blood disorder		
4. Heart disorder, enlarged heart, murmur, irregular heartbeats, chest pain		
5. Hospitalization for depression, mental illness, psychiatric care, any treatment for depression		
6. Malaria, typhoid fevers, tuberculosis, spinal meningitis, venereal disease		
7. Stomach ulcers, disorders of the stomach or intestines, colon, rectal diseases		
8. Liver, kidney, ureter, gallbladder, pancreas, thyroid disorders, hepatitis		
9. AIDS, AIDS-related complex, HIV positive, other immune deficiency disorders		
10. Smoke or use (have used) tobacco products (list below type, amount, and duration)		
11. Ever used LSD, heroin, cocaine, marijuana or other such drugs		
12. Diabetes, blood-sugar problem		
13. Arthritis (state type), lupus, bone disease or infection		

14. Stroke, epilepsy, seizures		
15. Eye disease, hearing problem		
16. Cancer of any type, tumors, unexplained growths		
17. Alcohol use (list below amount and duration of use)		
18. Head or internal injuries		
19. Physical disabilities, paralysis, congenital abnormalities, amputation, muscular disorders		
20. Respiratory or lung disease, asthma, shortness of breath, pneumonia		
21. High or low cholesterol/triglycerides		
22. Disease or disorder not already identified		

(Attach a separate sheet of paper if necessary.)

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

AUTHORIZATION

I have carefully read all of the above questions, statements, and answers, and agree all such statements and answers are correct and true. I authorize the use of this questionnaire in connection with any benefit applied for in this application and I understand any misstatement or omission in this application may void such benefit. I understand and agree that there will be no additional

Retiree Supplemental Group Term Life (RSGTL) in effect until DMBA approves the applicant(s) for such benefit. Coverage will be effective the first of the month following the month the applicant is approved. I authorize any licensed physician, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, or other organization, institution, or person who has any records or knowledge of me or my health (or of any persons proposed for RSGTL) to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to DMBA for the purpose of evaluating my application for RSGTL. A photocopy of this authorization and request form shall be as valid as the original. In all circumstances, my authorized agent or representative or I may request a copy of this authorization. This authorization may be used for a period of six months from the date signed, unless sooner revoked. On behalf of me and my dependents, I waive any action for such disclosure.

Retiree Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

SIGN ONLY IF SPOUSE BENEFIT IS REQUESTED

Dependent Signature: _____ Date: _____

SIGN ONLY IF DEPENDENT CHILD BENEFIT IS REQUESTED AND CHILD IS AGE 18 OR OLDER

WAIVER OF BENEFIT

Retiree name: _____ DMBA ID number: _____

- ☐ I do not wish to enroll.
- ☐ I wish to discontinue participation in Retiree Supplemental Group Term Life. I understand I may not apply for this benefit in the future.

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

Retiree Signature: _____ Date: _____

SIGN ONLY IF BENEFITS ARE REJECTED

Please return this completed form to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530. You may also email it to enrollmenthelp@dmba.com or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or toll free at 800-777-3622.