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SUPPLEMENTAL GROUP TERM LIFE INSURANCE APPLICATION

EMPLOYEE NAME: _____ DESERET MUTUAL ID NO: _____
First Middle Last

ADDRESS: _____ BIRTH DATE: _____

HOME PHONE: _____ WORK PHONE: _____

I would like to enroll in the Supplemental Group Term Life Insurance Program. I agree to pay the entire premium and understand that my coverage and premium may change each year as my age and salary change. I understand that to be eligible for Supplemental Group Term Life insurance coverage, I must be enrolled in the Basic Employee Benefit Program for Group Term Life insurance.

EMPLOYEE OPTION DESIRED:

- No coverage
- 1 X Salary Level
- 2 X Salary Level
- 3 X Salary Level
- 4 X Salary Level
- 5 X Salary Level
- 6 X Salary Level

The maximum benefit is \$1,000,000. Coverage reduces for employees age 60 or older. For more information, see your Benefits Handbook.

SPOUSE OPTION DESIRED:

- No coverage
- \$ 3,000*
- \$ 20,000 \$ 120,000
- \$ 40,000 \$ 140,000
- \$ 60,000 \$ 160,000
- \$ 80,000 \$ 180,000
- \$100,000 \$ 200,000

CHILDREN OPTION DESIRED:

- No coverage
- \$ 3,000* 6 months and older (\$ 1,000* Birth to 6 months)
- \$ 5,000 6 months and older
- \$ 10,000 6 months and older

Children six months of age and older must meet health standards before they can be eligible for additional coverage.

***Applicant does not need to meet health standards for this level of coverage if application is made within 30 days of the eligibility date.**

IT IS MUTUALLY AGREED THAT:

- (a) salary level is equal to the previous year's annual salary rounded up to the next \$10,000 (current salary is used for newly hired employees);
- (b) the representations in this application are correctly recorded, complete, and true to the best knowledge and belief of the undersigned;
- (c) voluntary change in the insurance coverage requires agreement between the employee and Deseret Mutual. **Employees who choose to increase their salary level multiple must meet health standards;**
- (d) no representative of any Deseret Mutual Participating Employer is authorized to accept risks, pass upon insurability, or waive any of Deseret Mutual's requirements;
- (e) 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;
- (f) the insurance applied for herein, if approved, shall terminate upon failure to pay the premiums or as provided for in the policy; and
- (g) once the salary level has been reduced, the applicant must meet health standards to increase the salary level in the future.

I AUTHORIZE MY EMPLOYER, UNTIL THIS AUTHORIZATION IS REVOKED BY ME IN WRITING, TO DEDUCT FROM ANY EARNINGS DUE ME THE AMOUNT NECESSARY FOR PREMIUMS DUE DESERET MUTUAL FOR INSURANCE PROTECTION INDICATED ON THIS APPLICATION.

Signed: _____ Date: _____

BENEFICIARY INFORMATION

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

WAIVER OF SUPPLEMENTAL GROUP TERM LIFE INSURANCE

- I do not wish to enroll at this time.
- I wish to discontinue my Supplemental Group Term Life insurance.

I hereby acknowledge that I have been given an opportunity to apply for Supplemental Group Term Life insurance as offered by my employer, and after careful consideration, I have decided not to take advantage of this offer. I understand that if I want such insurance in the future, I will be required to meet Deseret Mutual's health standards, and that Deseret Mutual reserves the right to refuse to grant such insurance.

Signed: _____ Date: _____
(Sign only if benefits are rejected)

FOR EMPLOYER'S USE ONLY

- New hire Hire Date: Month _____ Day _____ Year _____
- Discontinuing coverage Company Code: _____
- Change Payroll Number: _____

Employee's Salary Factor _____ X Salary Multiple _____

= Employee's Coverage _____ X Rate / \$1,000 _____

= Employee's Monthly Premium _____

Spouse's Coverage _____ X Rate / \$1,000 _____

= Spouse's Monthly Premium _____

Children's Monthly Premium = _____

Company Employer Authorization Date Signed

FOR DESERET MUTUAL USE ONLY

- APPROVED
- DECLINED: _____

UNDERWRITER'S INITIALS: _____

DATE: _____ EFFECTIVE DATE: _____

SUPPLEMENTAL GROUP TERM LIFE INSURANCE HEALTH QUESTIONNAIRE

RELATIONSHIP TO EMPLOYEE	NAME	BIRTH DATE	SEX	AGE	HEIGHT	WEIGHT (LBS.)	WEIGHT ONE YEAR AGO
	(FIRST, MIDDLE INITIAL, LAST)	(MO, DAY, YR)			(FT., IN.)		
E - Employee	E	EMPLOYEE	M F				
S - Legal Spouse			M F				
N - Natural or Adopted Child			M F				
SC - Stepchild			M F				
GC - Grandchild			M F				
O - Other (Specify In Section I)			M F				
			M F				
			M F				
			M F				

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 (list below name of drug, illness being treated, and duration)			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 /any treatment for depression			16. Cancer of any type, tumors, unexplained growths		
6. Malaria, typhoid fevers, tuberculosis, spinal meningitis, venereal disease			17. Alcohol use (list below amount and duration of use)		
7. Stomach ulcers, disorders of the stomach or intestines, colon, rectal diseases			18. Head or internal injuries		
8. Liver, kidney, ureter, gallbladder, pancreas, thyroid disorders, hepatitis			19. Physical disabilities, paralysis, congenital abnormalities, amputation, muscular disorders		
9. AIDS, AIDS-related complex, HIV positive, other immune deficiency disorders			20. Respiratory or lung disease, asthma, shortness of breath, pneumonia		
10. Smoke or use (have used) tobacco products (list below type, amount, and duration)			21. High or low cholesterol / triglycerides		
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 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.

Date: _____ Employee Signature: _____