Term Life Eligibility

If you are a member and work at least 40 hours per month, you are eligible to apply for member Voluntary Term Life.

Dependents

Your Spouse

Your legal spouse is eligible to apply provided you are enrolled for coverage for yourself.

Your Domestic Partner

Your domestic partner is eligible to apply provided you are enrolled for coverage for yourself and your relationship meets the criteria found on the SEIU Local 503 Domestic Partner Affidavit (see page 16) or you have obtained a Certificate of Domestic Partnership from the State of Oregon.

Your Dependent Children

Your child under age 26, unmarried, not in a domestic partnership and who meets any of the following criteria:

1. You or your spouse's natural child, step child, adopted child or a child legally placed with you or your spouse for adoption; or
2. a child for whom you or your spouse have court appointed guardianship; or
3. a child for whom you or your spouse are required to provide coverage by a legal Qualified Medical Support Order.

If your spouse/partner or child cannot perform the normal activities of daily living a person of his or her age and gender on the date coverage would begin his or her coverage will not begin until he or she is so able.

Member Term Life Insurance

Member Voluntary Term Life Insurance is available in the following amounts: **$10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000, $100,000, $110,000, $120,000, $130,000, $140,000, $150,000**

New Member - If you enroll within 90 days of becoming a SEIU Local 503 member you are guaranteed enrollment for the following amounts: **$10,000, $20,000, $30,000** or **$40,000**

Open Enrollment - If you enrolled as a new member you may "Step-Up" up to a guaranteed maximum of **$40,000**. If you have never enrolled you are guaranteed enrollment for the following amounts: **$10,000** or **$20,000**

Enrollment any other time and enrollment for all other amounts requires satisfactory Evidence of Insurability and approval by LifeMap Assurance Company.

Spouse/Partner Term Life Insurance

Spouse /partner Voluntary Term Life Insurance is available in the following amounts: **$10,000, $20,000, $30,000, $40,000, $50,000, $60,000, $70,000, $80,000, $90,000, $100,000, $110,000, $120,000, $130,000, $140,000, $150,000**

New Member - If you enroll within 90 days of becoming a SEIU Local 503 member and you elect coverage for yourself your spouse/partner is guaranteed enrollment for the following life amounts: **$10,000** or **$20,000**

Open Enrollment - If you elect coverage for yourself your spouse/partner life is guaranteed enrollment for the following amount: **$10,000**

Spouse/partner Voluntary Term Life Insurance enrollment cannot exceed your member Voluntary Term Life Insurance amount.

Enrollment any other time and enrollment for all other amounts requires satisfactory Evidence of Insurability and approval by LifeMap Assurance Company.

Child Term Life Insurance

Your children are guaranteed coverage within 90 days of you becoming a member of SEIU Local 503, if you enroll for Voluntary Term Life Insurance.

New Member - If you enroll within 90 days of new SEIU Local 503 membership and you elect coverage for yourself your child(ren) are eligible for the following amounts: **$5,000** or **$10,000**

Open Enrollment - If you are enrolled your child(ren) are guaranteed enrollment for the following amounts: **$5,000** or **$10,000**

Enrollment any other time requires satisfactory Evidence of Insurability and approval by LifeMap Assurance Company.

Terminal Illness Benefit
If you are diagnosed by a physician as terminally ill with a life expectancy of 12 months or less, the accelerated payment benefit for terminal illness provides for 80% of the coverage amount in force or $120,000, whichever is less, to be paid to the insured.

Any benefit paid under an Terminal Illness Benefit will reduce the Voluntary Life Insurance death benefit and may be taxable. As with all tax matters, you should consult with a personal tax advisor to assess the impact of this benefit.

Exclusions
Voluntary Term life Insurance will not be paid for death resulting from suicide, intentionally self-inflicted injury, or any attempt to injure oneself, while sane or insane during the first two years of coverage.

Age Increase Adjustments
SEIU Local 503 adjusts the monthly premium amount for you and your dependent term life coverages according to your birth year. The adjustment occurs the first of the month following your advancement to the next age bracket.

Waiver of Premium
If you become totally disabled (as defined by the policy) premium will be waived and Voluntary Term life insurance benefits will continue until the member reaches age 65 provided you remain Totally Disabled.

Conversion Privilege
When you terminate employment, your term life insurance will be continued without cost for 31 days. Within that period, you may convert your Voluntary Term Life Insurance benefit to a guaranteed individual permanent insurance policy. Application for conversion of group coverage must be made within 31 days of employment termination.

Portability Privilege
If you terminate prior to age 65 Voluntary Term Life Insurance benefits can be ported. Spouse/partner and child life can be ported as well. You must apply within 31 days from the date your employment terminated. Coverage is guaranteed.

Short Term Disability Eligibility

If you are a member and work at least 80 hours per month, you are eligible to apply for member Short Term Disability.

Short Term Disability

A weekly benefit will be paid for a maximum of 26 weeks for a covered disability if you are unable to work because of a disabling off-the-job accidental bodily injury or illness. You do not have to be hospitalized or house-confined to be eligible for benefits. You need to be certified by a physician as being unable to work, and under a physician's care. ***You must be actively at work on the effective date of insurance for your coverage to go into effect.***

Disability Benefits
- For an off-the-job accident, coverage begins on the 15th day of continuous and total disability. Your disability must be verified by a treating physician who is licensed to practice medicine.
- For an off-the-job **illness**, coverage begins on the 15th day of continuous and total disability. Your disability must be verified by a treating physician who is licensed to practice medicine.

Definition of Disability
You will be considered Disabled if because of injury or sickness you are unable to perform all the material duties of your regular occupation.

New Member - You may enroll for Short Term Disability Insurance within 90 days of becoming a new member without having to supply evidence of insurability.

Open Enrollment - You may enroll for Short Term Disability Insurance during an annual Open Enrollment period.

You may enroll for Short Term Disability Insurance any time by answering the health questions on the Evidence of Insurability form. Coverage will be issued with the Insurance Company's approval. Coverage is effective when the Insurance Company has approved the coverage and premium payment begins.

Short Term Disability Insurance Benefit Amounts

Class 1: If your basic earnings are $999 or less per month and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is $175.

Class 2: If your basic earnings are $1,000-$2,999 per month and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is $225.

Class 3: If your basic earnings are $3,000-$3,999 per month and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is 66 2/3% of your salary, up to a maximum of $300.

Class 4: If your basic earnings are $4,000 or more and you work a minimum of 80 hours per month. Your weekly benefit for any week during your disability is 66 2/3% of your salary, up to a maximum of $500.

Exclusions

Short Term Disability benefits will not be paid if your disability results directly or indirectly from:

a) injuries intentionally inflicted while sane or insane; or
b) any act or hazard of a declared or undeclared war; or
c) active participation in a riot; or
d) commission of a felony; or
e) an injury or sickness for which you are entitled to benefits from Workers' Compensation or occupational disease law; or
f) an injury or sickness that is work related.

Short Term Disability benefits will not be paid for a period of disability when you are not under the appropriate care of a licensed physician practicing within the scope of his license.

Pre-existing Condition Limitation

Short Term Disability benefits are not payable for any disability caused by a pre-existing condition if the disability begins during the first 12 months of your coverage. A pre-existing condition is a sickness or injury for which you received any form of treatment, including prescription drugs, within 3 months prior to your effective date of Short Term Disability coverage.

This is a summary of plan provisions related to the policy issued by LifeMap to SEIU Local 503. In the event of a conflict between this summary and the policy or certificate, the policy and/or certificate shall dictate the insurance provisions, exclusions, all limitations and terms of coverage.

How to Enroll

New Member Enrollment

You must complete and submit a SEIU Local 503 Term Life and Disability enrollment form. If you are enrolling for coverage over the guaranteed amount you must complete and submit an Evidence of Insurability form. Please read the entire brochure for enrollment requirements. SEIU Local 503 Member Benefits Department must receive the completed form within 90 days of new Union membership.

Open Enrollment

You must complete and submit a SEIU Local 503 Term Life and Disability enrollment form. You may elect $20,000 of member Voluntary Term Life insurance, $10,000 Spouse/Partner Voluntary Term Life insurance and up to $10,000 Child Voluntary Term Life insurance. If you enrolled as a new member for Voluntary Term Life Insurance you may "Step-Up" to a guaranteed maximum of $40,000 during an open enrollment period without have to supply Evidence of Insurability. All other coverage requires satisfactory Evidence of Insurability.

Enrollment Change

Changes to your plan are allowed with a qualified status event and if the requested change is consistent with the qualifying event and within 31 days of the event. A qualified status event may include:

- Marriage or divorce
- Birth or adoption
- Last child loses coverage, for example, child reaches age 26 or marries
- Death of spouse or dependent

SCHEDULE OF MONTHLY PREMIUMS

Member and Spouse Life Monthly Premiums

(spouse premiums are calculated using member's age)

Member's Age	$ 10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$ 80,000
Under 25	0.81	1.62	2.43	3.24	4.05	4.86	5.67	6.48
25-29	0.76	1.52	2.28	3.04	3.80	4.56	5.32	6.08
30-34	0.88	1.76	2.64	3.52	4.40	5.28	6.16	7.04
35-39	1.18	2.36	3.54	4.72	5.90	7.08	8.26	9.44
40-44	1.73	3.46	5.19	6.92	8.65	10.38	12.11	13.84
45-49	2.68	5.36	8.04	10.72	13.40	16.08	18.76	21.44
50-54	4.25	8.50	12.75	17.00	21.25	25.50	29.75	34.00
55-59	6.65	13.30	19.95	26.60	33.25	39.90	46.55	53.20
60-64	9.34	18.68	28.02	37.36	46.70	56.04	65.38	74.72
65-69	16.63	33.26	49.89	66.52	83.15	99.78	116.41	133.04
70-74	32.99	65.98	98.97	131.96	164.95	197.94	230.93	263.92
75 and over	67.96	135.92	203.88	271.84	339.80	407.76	475.72	543.68

Member and Spouse Life Monthly Premiums continued

Member's Age	$ 90,000	$ 100,000	$ 110,000	$ 120,000	$ 130,000	$ 140,000	$ 150,000
Under 25	7.29	8.10	8.91	9.72	10.53	11.34	12.15
25-29	6.84	7.60	8.36	9.12	9.88	10.64	11.40
30-34	7.92	8.80	9.68	10.56	11.44	12.32	13.20
35-39	10.62	11.80	12.98	14.16	15.34	16.52	17.70
40-44	15.57	17.30	19.03	20.76	22.49	24.22	25.95
45-49	24.12	26.80	29.48	32.16	34.84	37.52	40.20
50-54	38.25	42.50	46.75	51.00	55.25	59.50	63.75
55-59	59.85	66.50	73.15	79.80	86.45	93.10	99.75
60-64	84.06	93.40	102.74	112.08	121.42	130.76	140.10
65-69	149.67	166.30	182.93	199.56	216.19	232.82	249.45
70-74	296.91	329.90	362.89	395.88	428.87	461.86	494.85
75 and over	611.64	679.60	747.56	815.52	883.48	951.44	1019.40

Member Short Term Disability Monthly Premiums

Salary Classification	Weekly Benefit	Premium
Class I (salary less than $999 per month)	$175	8.58
Class 2 (salary $1,000-$2,999 per month)	$225	11.03
Class 3 (salary $3,000-$3,999)	66 2/3% of salary up to $300	14.70
Class 4 (salary $4,000 and up)	66 2/3% of salary up to $500	24.50

Child Life Monthly Premiums

Child Rate	$5,000	$10,000
All ages	0.80	1.60

This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of the Term Life coverage are set forth on Group Policy Number OR 048692. Terms and conditions of the Short Term Disability coverage are set forth on Group Policy Number OR 048692. The availability of this offer may change. Please keep this material as a reference, and file it with your certificate, should you become insured.

The plan may be amended from time to time or terminated in its entirety at any time by SEIU Local 503.

underwritten by
LifeMap Assurance Company

LOCAL 503 SEIU
Stronger Together

Term Life, Disability & Beneficiary Enrollment Form

Important notice: This form replaces all other enrollment forms on file, and must be signed and dated for enrollment or beneficiary to be valid.

Section 1 Member Information

This enrollment is for: ❍ New Member ❍ Open Enrollment ❍ Beneficiary Designation Only ❍ Change Reason for change: _____ Date of change: _____

Name	Date of Birth	Gender ❍M ❍F	E-mail

Social Security Number	Agency Employed	Home Phone

Mailing Address	City/State	Zip	Work Phone

Marital Status ❍Single ❍Married ❍Domestic Partnership (per Certificate of Registered Domestic Partnership) ❍Widowed ❍Divorced ❍Domestic Partner (per Affidavit of Domestic Partnership)*

**If enrolling a domestic partner attach a completed SEIU Local 503 Affidavit of Domestic Partnership form.*

☑ **Free $2,500 Member Term Life**

How many hours per month do you work in your SEIU Local 503 represented position? _____

Section 2 Voluntary Term Life Insurance *(you must work at least 40 hours per month to enroll in life insurance)*

You must be enrolled in member term life to apply for spouse/partner or child term life. Spouse/partner term life amount cannot exceed member term life amount.

Member Term Life

(Member term life benefit levels are $10,000, $20,000, $30,000 $40,000, $50,000, $60,000, $70,000, $80,000, $90,000 , $100,000, $110,000, $120,000, $130,000, $140,000 or $150,000)

❍$10,000 ❍$20,000 ❍$30,000 ❍$40,000

❍Increase Member Life to $_____

Spouse/Partner Term Life

(Spouse term life benefit levels are $10,000, $20,000, $30,000 $40,000, $50,000, $60,000, $70,000, $80,000, $90,000 , $100,000, $110,000, $120,000, $130,000, $140,000 or $150,000)

❍$10,000 or ❍$20,000

❍Increase Spouse Life to $_____

Spouse/Partner Name Date of Birth Relationship

_____

Child Term Life

❍$5,000 or ❍$10,000

Child Name Date of Birth Relationship

_____

_____

_____

_____

_____

Section 3 Voluntary Short Term Disability Insurance *(you must work at least 80 hours per month to enroll in short term disability insurance)*

Short Term Disability Insurance: $ _____ *(current monthly salary)*

Monthly Salary: ❍Class 1 *up to $999* ❍Class 2 *$1,000-$2,999* ❍Class 3 *$3,000-$3,999* ❍Class 4 *$4,000 and up*

Section 4 Beneficiary Designation *(attach an additional sheet if more space is required. Additional sheet must be signed and dated to be valid)*

You may choose a beneficiary(s) to receive life benefits. If no beneficiary survives, payment will be made in accordance with the terms of the policy. Unless designated otherwise, beneficiary designations for all life coverage will be the same. For Spouse/Partner and Child Term Life, you are the beneficiary.

	Name of Beneficiary	Social Security #	Date of Birth	Address	Relationship
Primary					
Contingent					

Section 5 Signature for Enrollment , Beneficiary Designation and Authorization for Payroll Deduction

I hereby apply for benefits under SEIU Local 503 group insurance plan issued by LifeMap Assurance Company. I authorize my employer to deduct from my salary the amount necessary to cover my premium for the group coverage (if payroll deduction is available). The amount of such insurance and the premium thereon is subject to change as determined by the salary and age schedule as outlined in the benefit booklet and master policy issued by LifeMap Assurance Company.*

Signature _____ **Date** _____

**** Please read the information on the back of this form.***

FOR SEIU USE ONLY

MEMBER DATE	CODE A M S C D	DEDUCTION AMOUNT	AGENCY	EFFECTIVE DATE	GWNN

Please keep a photocopy for your records and mail this original to: **SEIU Local 503 at P.O. Box 12159, Salem, Oregon 97309, email to memberbenefits@seiu503.org or fax to (503) 581-1664**

Revised 9/2017

Insurance will become effective the 1st of the month for which payroll deduction is taken. If the deduction is taken on the last day of the month, the insurance will become effective the 1st of the following month. Payroll deduction may not be available through all employers. Contact your payroll department or the SEIU Local 503 benefits department if you have any questions. If payroll deduction is not available you will be required to self pay your premium.

Benefit Eligibility

To be eligible for coverage under this plan you must maintain your membership with SEIU Local 503. You must work at least 40 hours per month in your SEIU Local 503 represented position to purchase life insurance. You must work at least 80 hours per month in your SEIU Local 503 represented position to purchase short term disability insurance. You must be scheduled for the minimum required hours and actively working for your insurance to take effect.

Dependents eligible for coverage include spouse/partner and all unmarried dependent children under age 26. If enrolling a domestic partner attach a completed Affidavit of Domestic Partnership form or indicate on the front of this form that you have obtained a Certificate of Registered Domestic Partnership.

If a dependent cannot perform the normal activities of a person of his or her age and sex on the date of his or her coverage would begin his or her coverage will not begin until he or she is so able.

Enrollment Change

Elections can only be changed or canceled during an Open Enrollment period or with a qualified status event. You must notify SEIU Local 503 Member Benefits within 31 days of the qualified event to be eligible for the enrollment change.

Termination of Coverage

Coverage under the term life plan ends when the participant fails to make the required monthly premium payment, or fails to meet the eligibility requirements and/or is no longer a member of SEIU Local 503.

If a plan participant retires or terminates employment, life insurance will be continued without cost for 31 days. Within that period, you may convert your Voluntary Term Life Insurance to an individual guaranteed permanent policy. Application for conversion must be made within 31 days of retirement or employment termination. It is your responsibility to contact the SEIU Local 503 Benefits Department to request an application for conversion.

If a plan participant terminates employment prior to age 65 Voluntary Term Life Insurance benefits can be ported. You must apply within 31 days from the date your employment terminated. It is your responsibility to contact the SEIU Local 503 Benefits Department to request an application for portability.

Benefit eligibility and termination provisions are detailed in the LifeMap Assurance Company Benefit Booklet. The booklet is located on the SEIU Local 503 website member benefits page at seiu503.org. You can obtain a printed copy of the booklet by contacting the SEIU Local 503 Member Benefits Department at the number below.

The plan may be amended from time to time or terminated in its entirety at any time by SEIU Local 503.

LOCAL 503 SEIU Stronger Together

SEIU Local 503
PO Box 12159
Salem, Oregon 97309-0159

1.844.503.SEIU (7348)

LifeMap™ P.O. Box 1271 MS E8L
Portland, OR 97297-1271

Mail to:
SEIU Local 503
P.O. Box 12159
Salem, OR 97309

LOCAL 503 SEIU Stronger Together

Evidence of Insurability Form

Part I

This box for SEIU use only:

Existing Voluntary Coverage: Member $ _____ Spouse/Domestic Partner (DP) $ _____ Child(ren) $ _____ Verified _____

Applying for:
○ Supplemental Life ○ STD Class _____

Total Amount of Insurance requested (Show existing PLUS any increase)
Member $ _____ Spouse/DP $ _____ Child(ren) $ _____

Member Name | Phone Number

Residence Address Street | City | State | Zip Code

Social Security Number – – | Birthdate Mo Day Yr / / | Gender M F | Place of Birth | Annual Salary $

Name of organization providing insurance: **SEIU Local 503** | Policy Number: **OR 048692** | Occupation | Date of Employment

Spouse / DP Name (if applying for coverage) | Social Security Number – – | Birthdate Mo Day Yr / / | Gender M F | Place of Birth

Agreements

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and (c) I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health to give the LifeMap Assurance Company or its reinsurers any such information (including information about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases). This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received a copy of the Privacy Notice.

Insurance Fraud Warning:

Unless specific state language is provided below, the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If your answers on this application are incorrect or untrue, LifeMap Assurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

X _____ **Member Signature** | **Date Signed** | **X** _____ **Spouse / DP** (if applying for coverage) | **Date Signed**

(Please complete all three pages of this form.)

Part 2: Evidence of Insurability.

Employee's Name (Last, First, MI)

Answer the following questions for yourself, your Spouse and your Dependent Child(ren) if applicable.

Employee Height _____ Weight _____	Child Name (first/last) _____ Date of Birth_____ Gender ☐M ☐F Height _____ Weight _____	Child Name (first/last) _____ Date of Birth _____ Gender ☐M ☐F Height _____ Weight _____
Spouse Height _____ Weight _____		
If you have more than 4 eligible children, please complete another form for the remaining children and submit both forms together.	Child Name (first/last) _____ Date of Birth _____ Gender ☐M ☐F Height _____ Weight _____	Child Name (first/last) _____ Date of Birth _____ Gender ☐M ☐F Height _____ Weight _____

Please answer Yes or No to all questions for yourself, your Spouse and your Dependent Child(ren).

	Employee	Spouse	Child(ren)
1. Within the past 10 years has any person applying for coverage been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
2. Within the past 5 years has any person applying for coverage been diagnosed or treated for any of the following: a. a heart or circulatory disorder, stroke, transient ischemic attack (TIA); b. diabetes requiring treatment with insulin; c. kidney disease (except kidney stones); d. cancer or malignancy of any kind (other than basal cell or squamous cell carcinoma of the skin); e. liver disease (including Hepatitis B and C); f. major organ failure or transplant; g. a lung disease(other than mild asthma); h. Systemic Lupus Erythematosus; or i. a neurological disorder (except for a controlled seizure disorder without a seizure in the past 2 years)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
3. Within the past 10 years has any person applying for coverage sought treatment or counseling for excessive use of alcohol or drugs, used any controlled substances, been told by a medical practitioner that you had (or still have) a problem with substance abuse, been convicted of operating a vehicle while intoxicated, or had their drivers license suspended or revoked?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
4. Are you pregnant?	☐ Y ☐ N	N/A	N/A
5. Has any person applying for coverage been advised or recommended by a physician to have surgery which has not yet been performed?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
6. Is any person applying for coverage currently disabled or does any person applying for coverage have a condition which prevents or limits activities?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Please continue completing form on the following page.

Employee's Name (Last, First, MI)

	Employee	Spouse	Child(ren)
7. Has any person applying for coverage been diagnosed with, been treated, received medical advice, or taken medication for any disease or disorder of the following: a. the circulatory system including the heart and blood vessels, such as heart murmur, heart palpitations, chest pain, circulatory problems, high blood pressure or high cholesterol; b. the blood, such as anemia, leukemia, non-insulin dependent diabetes or albumin or blood or sugar in the urine; c. the glandular system, including the thyroid; d. the urinary system including the kidneys and bladder; e. the respiratory system, including the chest and lungs, such as asthma; f. the digestive system, including the stomach, pancreas or intestines; g. the muscular or skeletal system, including the back, spine and connective tissue, such as arthritis, fibromyalgia or fibromyositis; h. chronic fatigue syndrome; i. the central nervous system, such as dizziness, headaches, seizures, epilepsy, paralysis, Parkinson's, Alzheimer's, multiple sclerosis, motor neuron disease or ALS; j. the reproductive system; k. the mental nervous system, such as depression, anxiety, or stress; l. the immune system; or m. cancer or malignancy of any kind (more than 5 years ago) including carcinoma in situ, any other form of malignant disease, and any benign tumors of any kind.	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
8. Within the past 5 years has any person applying for coverage consulted with or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
9. Is any person applying for coverage currently receiving any treatment by a medical practitioner or taking any medication?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
10. During the past 5 years, has any person applying for coverage been absent from work more than five consecutive working days because of an illness or injury (excluding pregnancy)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
11. Is your spouse currently pregnant? If yes, give expected delivery date:_____ and describe any complications below.	N/A	☐ Y ☐ N	N/A

Name and address of **your** personal physician:	Name and address of your **Spouse's** personal physician:
_____ _____ _____ Date last seen and reason: _____	_____ _____ _____ Date last seen and reason: _____

IMPORTANT

Provide details of all 'YES' answers given to medical questions in 7 through 10.

If additional space is required, attach a separate signed and dated sheet.

Question Number & Individual	Illness/Reason for Checkup or Physician's Treatment/Consultation	Dates From	Dates To	Full Name & Complete Address of Attending Physician or Other Practitioner

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize any physician, pharmacy benefit manager, retail pharmacy, clearing house, health plan or insurance company to disclose prescription drug information about me within their possession to Milliman IntelliScript on behalf of LifeMap Assurance Company ("LifeMap"). The purpose of this disclosure is for Milliman to provide the information to LifeMap to evaluate my application for Life, Disability, and/or Critical Illness insurance products.

I understand that this prescription drug information may contain sensitive data, including data related to the treatment of sexually transmitted diseases, HIV/AIDS, mental health and reproduction or contraception (including prenatal care and abortion). I specifically authorize the disclosure of prescription drug information that is related to alcohol or substance abuse and I understand that my alcohol and substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described below.

I understand and acknowledge the following:

- Once any person(s) or entity(ies) discloses my information to an authorized recipient the privacy protections provided by law may no longer apply.
- I may cancel this authorization at any time by sending written notice to LifeMap Assurance Company, Attn: Individual Underwriting, PO Box 1271 M/S E8L, Portland, OR 97207. Cancellation of this authorization will not affect any actions taken by any entity disclosing information before receiving the cancellation notice.
- Completing this authorization is a condition to be eligible for and enrolled in LifeMap Life, Disability and/or Critical Illness insurance products.
- None of the authorized person(s) and entity(ies) above nor Milliman are responsible for any action taken by an authorized recipient of my protected health information.

This authorization will expire two years from the data signed unless a shorter time frame is requested here (mm/dd/yyyy): _____.

Applicant Full Name (please print clearly) | Date of Birth (MM/DD/YYYY)

Group Name | Group Number

Applicant Signature | Date

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individuals (e.g., Power of Attorney, Guardianship, Conservatorship, etc.)

Name of Personal Representative | Relationship Phone

Signature of Personal Representative | Date

SEIU LOCAL 503
AFFIDAVIT OF DOMESTIC PARTNERSHIP

SECTION ONE AFFIRMATION OF DOMESTIC PARTNERSHIP

(1) Are each eighteen (18) years of age or older.
(2) Share a close personal relationship and are responsible for each other's common welfare.

(3) Are each other's sole domestic partner.
(4) Are not married to anyone nor have had another domestic partner within the prior six months.

(5) Are not related by blood closer than would bar marriage in the State of Oregon.

(6) Have jointly shared the same regular and permanent residence for at least six (6) months immediately preceding the date of this affidavit with the intent to continue doing so indefinitely.

(7) Have signed a domestic partner declaration (applicable in jurisdictions, which provides for domestic partner declarations).

(8) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Domestic partners need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost. If requested I would be able to provide at least three of the following as verification of our joint responsibility.

(a) Joint mortgage or lease.
(b) Designation of the domestic partner as primary beneficiary for a life insurance or a retirement contract.
(c) Designation of the domestic partner as primary beneficiary in the employee's will.
(d) Durable power of attorney for health care or financial management.
(e) Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
(f) A relationship or cohabitation contract which obligates each of the parties to provide support for the other party.

SECTION TWO DECLARATION OF MEMBER

(1) I understand that my domestic partner is eligible for enrollment:

(a) Within 90 days of my becoming a new member of SEIU Local 503.
(b) During an open enrollment period.
(c) Within 31 days of meeting the criteria listed in Section One.

(2) I understand that children of my domestic partner are eligible if they meet the requirement for an eligible dependent as defined by LifeMap Assurance Company, and/or ARAG Group.

(3) I understand that this affidavit shall be terminated upon the death of my domestic partner or by a change in circumstance attested to in this Affidavit.

(4) I agree to file a Statement of Termination of Domestic Partnership with the SEIU Local 503 Benefits Department within 30 days of any change to circumstances attested to in this Affidavit.

(5) After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed with the SEIU Local 503 Benefits Department until such time as the conditions of Section One above have been met.

SECTION THREE DECLARATION OF PARTNERS

(1) We understand that the information contained in the Affidavit relates to eligibility for benefits under the SEIU Local 503 life and/or legal insurance program. Any other use of this information will be subject to disclosure only upon either of our written authorization or as required by law.

(2) We understand that a civil action may be brought against us for any losses, including reasonable attorney fees and court costs, because of willful falsification of information contained in this Affidavit of Domestic Partnership.

(3) We understand that in addition to the eligibility requirements of SEIU Local 503 member benefit program for domestic partner coverage, there are terms and conditions of coverage set forth in the Service Agreement of each insurance plan offered through SEIU Local 503, plans which we agree to be bound.

(4) We understand willful falsification of information contained in this Affidavit will result in termination of enrollment pursuant to this agreement by the SEIU Local 503 member benefit program.

We certify under penalty of perjury under the laws or the State of Oregon, that the foregoing is true and accurate to the best of our knowledge

Signature of Member	Print Name
Signature of Domestic Partner	Print Name
Member SSN	Date

This affidavit of domestic partnership is for SEIU Local 503 life and/or legal insurance enrollment only and must be received by the SEIU Local 503 Benefits Department to be valid.

Fax completed enrollment forms and domestic partner affidavit to (503) 581-1664 , mail to SEIU Local 503, PO Box 12159, Salem , OR 97309-0159 or email to memberbenefits@seiu503.org.

LifeMap Assurance Company
200 SW Market St
P.O. Box 1271, M/S E8L
Portland, OR 97207
(503) 721-7161 * (800) 794-5390

PRIVACY NOTICE

We, at LifeMap Assurance Company, know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. Because we endeavor to earn and keep your trust, we have long-standing privacy policies, robust training, and full-time staff dedicated to protecting privacy. We also maintain physical, administrative, and technical safeguards to protect your personal information from unauthorized access. Even if you are no longer a LifeMap member, we protect the confidentiality of your personal information as if you were.

Marketing

While other companies may sell or rent your contact information, LifeMap never sells or rents your personal information for marketing purposes. If you want LifeMap to share your personal information with a nonaffiliated third party so the third party can market to you, you must give us your express permission.

Your Personal Information

We collect personal information such as your name, contact information, health information, and financial information from you, your providers, and other insurers that provide coverage to you. We use this information to provide services to you and to conduct insurance transactions. You may receive a copy of your personal information by contacting us at the phone number or address below. We will not disclose your personal information unless we are permitted or required by law or you give your permission. As permitted or required by law, we may provide personal information to our affiliates and agents, reinsurers, insurance administrators, consultants, or regulatory and governmental authorities. We obligate entities receiving this information on our behalf to protect it in the same way that we protect it.

Changes to Our Practices

We may change our privacy practices in an effort to provide even better protection. If we change our privacy practices in a material way, we will notify current customers in writing.

Contact Us

If you have any questions about our privacy program, you may contact us at (800) 794-5390 or write to:

LifeMap Privacy Official
P.O. Box 1271, Mailstop E12P
Portland, OR 97207

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