Application Instructions

1. Complete all information on the application. (Do not forget beneficiary information – section 1).
2. Sign and date section 4. Spouse signature is required for $7,500 spousal benefit.
3. Mail completed application to:

Pacific Financial Designs, Inc.
11230 Sorrento Valley Road #105
San Diego, CA 92121
Attn: Web Enrollment

4. Coverage will begin after 2 deductions have been withheld from your paycheck.
5. If you have any questions, please call (800) 733-4487 x 300.

SUPPLEMENTAL APPLICATION

ADMIN USE ONLY

KLEA MEMBERSHIP DATE:_____

Sponsored by the:

Kern Law Enforcement Association (KLEA)

Employer- County of Kern

Use this form if you are an active member of the KLEA and you are applying for Supplemental Life Insurance.

Check To Elect Coverage.

Active Member: ☐ $100,000, Spouse $7,500, Each Dependent Child $5,000

NOTE: You must elect to participate in the plan while you are an actively employed by the County of Kern and six months prior to a change in employment status from active status to retired status.

SIMPLIFIED ACCEPTANCE

Does any person to be insured now have a known sign of any physical or mental disorder, disease or defect, or within the past year been admitted to a hospital or other facility, been advised to be admitted, or had surgery performed or recommended? ☐ **YES** ☐ **NO**

If you cannot answer "no" to the above question, you can still apply for insurance. Refer to Section 3 below and complete the additional questions.

1. Complete this section for your insurance.

Name _____ Date of Birth ____/____/____

Address _____ Social Security Number ____/____/____

City _____ Telephone Number (____) _____

State _____ Zip_____ Height ____ ft. ____ in. Weight ____ lbs. Sex ____

Employer-COUNTY OF KERN

Beneficiary_____Age _____ Date of Birth mo. day yr. Relationship _____

2. Complete this section for your spouse or children.

(Unless you specify otherwise, you will be designated as your spouses' and dependents' beneficiary.)

Spouse's First Name

_____

Occupation _____

Age _____ Date of Birth mo. day yr.

Place of Birth _____

Height ____ ft. ____ in. Weight ____ lbs. Sex ____

Children's First Names Date of Birth mo./ day/ yr.

_____ / /

_____ / /

_____ / /

_____ / /

_____ / /

(Please use a separate sheet, if necessary, for additional children.)

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3. Answer these questions to the best of your knowledge and belief.

1. Has any person to be insured, ever had or been told such person had, consulted with or been treated by a doctor for any of the following: cancer; high blood pressure; ulcers; diabetes or gland disorder; heart attack; chest pain or heart trouble; or any disorder of the kidneys, lungs, blood, liver or drug/alcohol abuse? ☐ Yes ☐ No
2. Within the past five years has any person to be insured, been confined in any hospital, sanatorium or extended care facility for any illness or injury, seen a doctor for treatment, special tests or consultation for any reason, presently have any physical impairment or illness of any kind? ☐ Yes ☐ No
3. Has any person to be insured, ever had life or health insurance declined, postponed, modified, or rated up? ☐ Yes ☐ No If yes, give reason and year: _____
4. Have you been regularly performing the duties of your occupation or profession on a full-time basis (30 or more hours per week) for the past consecutive working days at your usual place of business or practice? ☐ Yes ☐ No (If "no, explain on a separate piece of paper, sign and date.)
5. Will the insurance which you have applied for under this group policy replace, change or modify any other life insurance in force on the lives of the persons to be insured? ☐ Yes ☐ No (If "yes", list individual insured, company name, address, type of plan and policy number to be replaced on a separate sheet of paper, sign and date.)
6. Name, address, and phone number of family physician.

_____

Give full details for any "Yes answers to 1 and 2. For more space use a separate sheet (please sign and date.)

Name	Question No	Details or Reasons	Dates	Onset	Results	Names & Addresses of all Physicians & Hospitals

_____

_____

A Paramedical and additional medical information may be required by Beneficial Life.

4. Read this section; sign, date and mail the application to Beneficial Life.

I represent that the statements on this application are true and complete to the best of my knowledge and belief.
I agree that this application shall be a part of the contract under which I am applying for insurance.
I understand that the insurance applied for shall become effective on the date specified by the Company only if each person to be insured is still engaged in their normal activities on the stated effective date and this application is accepted by the Company and the first premium is paid during my lifetime.

The undersigned applicant certifies that the applicant has read or has had read to him or her the completed application and that the applicant realizes that any false statements or misrepresentation in the application may result in loss of coverage under the policy.

I AUTHORIZE any physician, medical professional, hospital, clinic, Veterans Administration or other medically related facility, insurance company, agent, administrator, insurance support organization (e.g., Medical Information Bureau), or other person, organization or institution having information which is needed to determine eligibility for insurance of the persons to be insured to release this information to Beneficial Life Insurance Company or its authorized representatives, Medical Director, reinsures, or insurance support organizations. This information may relate to such items as employment or diagnosis, treatment and prognosis with respect to any physical or mental condition. This authorization will be valid for a period of 2 years from the date signed. I am aware I have the right to receive a photocopy of this authorization, and that any photocopy will be as valid as the original. I have received and read the Notice of Insurance Information Practices.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Signature x_____ Spouse's Signature (if applying)_____

Date mo._____ day_____ yr._____ (premium rates are subject to change and policy is renewable at the option of the Company.)