Nippon Life Benefits®

Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951

Enrollment & Waiver Form - CA

Company name _____ Group number _____

A. Employee Information

Your name (last, first, middle initial) _____ Social security number _____

Address (street or P.O. box) _____ City _____ State _____ ZIP code _____

Date of birth _____ ☐ male ☐ female ☐ single ☐ married Phone number _____ County _____

B. Benefit Election: Ask your employer what coverages the group policy has. Check your election option(s) below.

	Medical	Dental	Vision	Basic Life	Dependent Life	Short Term Disability	Long Term Disability
Myself	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect
	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*	☐ Waive*
Spouse	☐ Elect	☐ Elect	☐ Elect	Amount	☐ Elect	☐ Elect	☐ Elect
	☐ Waive*	☐ Waive*	☐ Waive*	$ _____	☐ Waive*	☐ Waive*	☐ Waive*
Children	☐ Elect	☐ Elect	☐ Elect	or Multiple	☐ Elect	☐ Elect	☐ Elect
	☐ Waive*	☐ Waive*	☐ Waive*	_____ X	☐ Waive*	☐ Waive*	☐ Waive*

	Supplemental Life	Supp Life Amount	Supplemental AD&D	Supp AD&D Amount
Myself	☐ Elect	$ _____	☐ Elect	$ _____
	☐ Waive*	or _____ X	☐ Waive*	or _____ X
Spouse	☐ Elect	$ _____	☐ Elect	$ _____
	☐ Waive*	or _____ X	☐ Waive*	or _____ X
Children	☐ Elect	$ _____	☐ Elect	$ _____
	☐ Waive*	or _____ X	☐ Waive*	or _____ X

Medical options (if applicable to your group policy): Deductible choice _____ PPO network choice _____

If your employer offers a high option and a low option plan, please select the medical plan option which you are electing. _____

* Reason for waiving coverages(s): (Please read the Waiving Coverage in Section E for information relating to consequences of refusing initial coverage.)

☐ individual coverage ☐ COBRA, USERRA or state continuation ☐ government coverage
☐ spouse's group ☐ my employer's HMO ☐ I am retiring from firm
☐ other _____

C. Beneficiary Designation: Complete if your coverages include group term life insurance.

Beneficiary for employee group term life insurance (Print as "Doe, Mary A.", not "Mrs. John Doe")

last name first name middle initial relationship to you

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

D. Dependent Information: Please list your spouse and all eligible children that are applying for coverage.

Spouse's name (last, first, middle initial)	Social Security Number	Date of Birth	☐ Male ☐ Female

Do you and your spouse work for the same employer? ☐ Yes ☐ No

NOTE: The Full-time student information below is not applicable to dependent children less than 26 years of age who are applying for Medical, Dental or Vision coverage.

Full name of dependent child(ren)	Date of Birth (mm/dd/yyyy)	Social Security Number	Full-time student (If yes, please complete questions a. through h. below)	Foster child	Handicapped child*	Male	Female
1.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
2.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
3.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
4.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
5.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐

If you need additional space please attach a separate piece of paper.

To Be Completed By Member	Dependent 1	Dependent 2	Dependent 3	Dependent 4	Dependent 5
a. Does this child reside in the United States?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Does this child live with you when not attending school?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Was the child placed with you by an authorized state placement agency or by order of a court?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. Does this child reside in your home permanently?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Do you provide more than one-half of this child's financial support?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Is this child claimed as a dependent by you for federal income taxes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Please provide the date legal guardianship began (mm/dd/yyyy).					
h. Under what circumstances did you receive legal guardianship of this child?					

Is there any other pertinent information not covered above? (If so, please provide on a separate sheet of paper.)

Dependents must meet eligibility requirements. Foster child eligibility may be subject to approval by Nippon Life Insurance Company of America (Nippon Life Benefits). A domestic partner must elect coverage in order for the domestic partner's children to be eligible for coverage.

***With respect to Medical, Dental or Vision coverage:** If you have developmentally disabled/physically handicapped children over age 26 or any other age as required by state law, complete an Application to Continue Handicapped Child.

Contact your employer for assistance with any questions.

***With respect to Medical, Dental or Vision coverage: Dependent coverage may be extended beyond the group policy limiting age if your child qualifies as a full-time student.** We consider a full-time student to be a child who is attending an accredited school that has a regular teaching staff, curriculum, student body, and who attends school on a full-time basis as his or her main focus, carries a minimum load of 12 credit hours, and is dependent on you for principal support.

NOTE: Future verification of full-time student status will be required at the time of claim submission. (If more than one student, please provide this information on a separate sheet of paper.)

Full-Time Student Name	Name & Address of School, College or University	
Beginning Date of Attendance	**Anticipated Graduation Date**	**No. of Current Credit Hours**

E. Waiving or Electing Coverage

Waiving Coverage – Important information, please read if you are waiving any coverage:

I declare that I have been given an opportunity to apply for coverage. I understand if I refuse coverage:

(a) My dependents are not eligible for any coverage for which I am not covered.

(b) I cannot under any conditions reenter as a retired person.

(c) I (and my dependents) may enroll for medical coverage later; however, unless eligible for the special enrollment rights described in the Notice to Enrollees, I (and my dependents) will be subject to the late enrollee provisions.

(d) If I am enrolled in a health maintenance organization (HMO) sponsored by my employer, and if there is an open enrollment period under the policyholder or employer plan or the Nippon Life Benefits medical policy, I may transfer to the Nippon Life Benefits medical policy during that time.

(e) I (and my dependents) may enroll for dental coverage later; however, such enrollment could affect my initial level of dental benefits.

(f) I (and my dependents) may enroll for nonmedical coverage later; however, necessary proof of good health must be provided at my own expense and coverage will not become effective until approved by Nippon Life Benefits, subject to actively at work and period of limited activity provisions. Health conditions which may be present now or develop later may prevent me (or my dependents) from ever being approved for coverage.

Electing Coverage – Please read if you are electing any coverage:

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If the group policy requires my contributions, I authorize my employer to deduct from my pay.
- Applicable if medical coverage is an option under the group policy: I have been given a Notice to Enrollees regarding the special enrollment rights, and I understand these provisions.
- I represent all information on this form and attachments are complete and true to the best of my knowledge and belief. They are part of this request for coverage. I agree Nippon Life Benefits is not liable for a claim before the effective date of coverage and all group policy provisions apply. I have read, or had read to me, the information and my answers on this form. My coverage can be cancelled at any time if I commit an act or practice that constitutes fraud or make an intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage. I also understand that I am entitled to receive a completed copy of this form.
- I authorize Nippon Life Benefits to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid for 30 months from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Nippon Life Benefits for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by Nippon Life Benefits only as allowed by law.

Applicable to all enrollees:

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Nippon Life Benefits.

E. Waiving or Electing Coverage (continued)

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Employee signature required _____ Date signed _____

Requested date of change _____

Employer to Complete this Section		Nippon Life Benefits to Complete	
Company name as it appears on your billing		Employee effective date	Dependent effective date
Date employed	Job/class		Hours worked per week
Location	Earnings $ ☐ yr ☐ wk ☐ mo ☐ hr		

Employer Instructions

After this form is completed and signed, make two copies and send the original to Nippon Life Insurance Company of America, keep one copy for your records and give one copy to the employee.

Print

Federal Regulations require an employee to receive the following notices for medical coverage.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- Loss of eligibility

  Loss of eligibility includes:

  - death, divorce, legal separation, or cessation of dependent status
  - reduction in work hours or termination of employment
  - if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
  - if the other health coverage no longer offers any benefits to a class of similarly situated individuals
- Employer contributions have terminated
- COBRA or state continuation has exhausted

  Exhaustion of COBRA or state continuation includes:

  - failure of the employer or other responsible entity to remit premiums timely
  - if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
  - completion of the maximum continuation period

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the late enrollee provisions. An eligible dependent cannot be covered for medical benefits if the eligible employee is not enrolled as a member.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverage, your spouse and dependent child(ren) may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Special Enrollment Rights Regarding Children's Health Insurance Program (CHIP)

If you or your dependent are eligible, but not enrolled for coverage, you may enroll for coverage if:

- you or your dependent are covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility of Medicaid or CHIP coverage; or
- you or your dependent become eligible for premium assistance to purchase coverage under the group health plan.

You must enroll no later than 60 days after the date eligibility is lost or the date you or your dependent are determined to be eligible for premium assistance.

If you or your dependent do not enroll within 60 days, you will be considered a late enrollee.

Additional Information

To obtain additional information or assistance, contact:

Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, KS 66225-5951
Telephone: 1-800-374-1835

Please keep this notice for your records.