Group Cancer and Specified Disease Insurance

Underwritten by MetLife

Plan Features

- Donor Benefits
- Wellness Benefits
- Many Benefits have No Lifetime Maximum
- Covers Certain Lodging and Transportation
- Portable (take it with You)
- In and Out of Hospital benefits
- Pays regardless of other coverage

Benefit	Amount
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemocult stool specimen, or prostate screen. No Lifetime Maximum	Up to $0 - $100 per calendar year *See Rate Quote for Benefit Amount*
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	$0 - $10,000 *See Rate Quote for Benefit Amount*
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Incurred Expenses
Non-Local Transportation. Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual billed charges by a common carrier or 50 cents per mile if a personal vehicle is used.
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual billed charge of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging. 50 cents per mile if a personal vehicle is used.
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum	Incurred Expenses
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	$1,500 - $9,000 *See Rate Quote for Benefit Amount*
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following benefit for the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual billed charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	(a) Two (2) times the elected Hospital Confinement benefit. *See Rate Quote for Benefit Amount* (b) Actual billed charges for round trip coach fare;or personal automobile expense of 50 cents per mile. (c) Actual billed charges up to $50 per day
Bone Marrow and Stem Cell Transplant. We will pay incurred expenses per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Incurred Expenses to a combined lifetime maximum of $15,000

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"Your solutions begin at the Bridge"®

Benefit	Amount
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery. No Lifetime Maximum	Up to 25% of surgical benefit paid.
For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma. No Lifetime Maximum	$100 maximum per Covered Person for skin Cancer
Ambulatory Surgical Center. We will pay the actual billed charges incurred at an Ambulatory Surgical Center. No Lifetime Maximum	$250 Per Day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to $250 per calendar year
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum	Incurred Expenses up to $200 - $1,000 per day OR $2,500 - $5,000 per month *See Rate Quote for Benefit Amount*
Miscellaneous Diagnostic Services. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving Radiation, Radioactive Isotopes Therapy, Chemotherapy or Immunotherapy, or within 30 days following a covered treatment.	Incurred Expenses up to a lifetime maximum of $10,000
Self-Administered Drugs. We will pay the incurred expenses for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum	Incurred Expenses up to $4,000 per month
Colony Stimulating Factors. We will pay incurred expenses for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum	Incurred Expenses up to $0 - $4,000 per month *See Rate Quote for Benefit Amount*
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Incurred Expenses up to $200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	Up to $35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	Up to $100 per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the actual billed charges if a Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging actual billed charges. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation Benefits of the policy.	Actual Billed Charges limited to a lifetime maximum up to $750 for evaluation. Actual Billed Charges limited to a lifetime maximum up to $350 for transportation and lodging.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Incurred Expenses
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	Up to $1,500 lifetime maximum per amputation.
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	Up to $35 per session
Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay three times the selected Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum	Three (3) times the elected Hospital Confinement benefit. *See Rate Quote for Benefit Amount*
Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum	Up to $50 per day
At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum	Up to $100 per day
New or Experimental Treatment. We will pay the actual billed charges incurred by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum	Up to $7,500 per calendar year
Hospice Care. If a Covered Person elects to receive hospice care, We will pay the actual billed charges for care received in a Free Standing Hospice Care Center. No Lifetime Maximum	Up to $50 per day
Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum	$200 per day
Hairpiece. We will pay the incurred expenses per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Incurred Expenses up to a lifetime maximum of $150

Benefit	Amount
Rental or Purchase of Durable Goods. We will pay the incurred expenses for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, Hospital bed, or wheelchair. No Lifetime Maximum	Incurred Expenses up to $1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	$100 - $600 per day *See Rate Quote for Benefit Amount*

Other Specified Diseases Covered:

- Addison's Disease
- Amyotrophic Lateral Sclerosis
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Epilepsy
- Hansen's Disease
- Legionnaire's Disease
- Lupus Erythematosus
- Lyme Disease
- Malaria
- Meningitis (epidemic cerebrospinal)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Niemann-Pick Disease
- Osteomyelitis
- Poliomyelitis
- Rabies
- Reye's Syndrome
- Rheumatic Fever
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Tay-Sachs Disease
- Tetanus
- Toxic Epidermal Necrolysis
- Tuberculosis
- Tularemia
- Typhoid Fever
- Undulant Fever
- Whipple's Disease

Payment of Benefits

Benefits are payable for a Covered Person's Positive Diagnosis of a Cancer or Specified Disease that begins after the Certificate Effective Date and while this Certificate has remained in force.

Pre-Existing Condition Limitation

During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. During the first 12 months following the date a Covered Person makes a change in coverage that increases his or her benefits, the increase will not be paid for Pre-Existing Conditions. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person.

Pre-Existing Condition means Cancer or a Specified Disease, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Certificate Effective Date of coverage for each Covered Person.

Exceptions and Other Limitations

The Policy pays benefits only for diagnoses resulting from Cancer or Specified Diseases, as defined in the Policy. It does not cover:

1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
   a. Specified Disease or Specified Disease treatment; or
   b. Cancer or Cancer treatment, or unless otherwise defined in the Policy
4. care and treatment received outside the United States or its territories;
5. treatment not approved by a Physician as medically necessary;
6. Experimental Treatment by any program that does not qualify as Experimental Treatment as defined in the Policy.

Termination of Coverage

A Covered Person's insurance under the Policy will automatically terminate on the earliest of the following dates:

1. the date that the Policy terminates.
2. the date of termination of any section or part of the Policy with respect to insurance under such section or part.
3. the date the Policy is amended to terminate the eligibility of the Employee class.
4. any premium due date, if premium remains unpaid by the end of the grace period.
5. the premium due date coinciding with or next following the date the Covered Person ceases to be a member of an eligible class.
6. the date the Policyholder no longer meets participation requirements.

Portability

On the date the Policy terminates or the date the Named Insured ceases to be a member of an eligible class, Named Insureds and their covered dependents will be eligible to exercise the portability privilege. Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Portability coverage will be effective on the day after insurance under the Policy terminates.

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated. The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.

Covered Persons

Covered Person means any of the following:

a. the Named Insured; or
b. any eligible Spouse or Child, as defined and as indicated on the Certificate Schedule whose coverage has become effective;
c. any eligible Spouse or Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or
d. a newborn child (as described in the Eligibility Section).

Child (Children)

means the Named Insured's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and
grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is not yet age 26.

Option to Add Additional Benefits Hospital Intensive Care Insurance Rider

In consideration of additional premium, this coverage will provide you with benefits if you go into a Hospital Intensive Care Unit (ICU).

Benefits

Your benefits start the first day you go into ICU. The benefit is payable for up to 45 days per ICU stay.

Hospital Intensive Care Confinement Benefit

You may choose a benefit ranging from $325 to $825 per day. It is reduced by one-half at age 75.

Double Benefits

We will double the daily benefits for each day you are in an ICU as a result of Cancer or a Specified Disease. We will also double the benefit for an injury that results from: being struck by an automobile, bus, truck, motorcycle, train, or airplane; or being involved in an accident in which the named insured was the operator or was a passenger in such vehicle. ICU confinement must occur within 48 hours of the accident.

Emergency Hospitalization and Subsequent Transfer to an ICU

We will pay the benefit selected by you for the highest level of care in a hospital that does not have an ICU, if you are admitted on an emergency basis, and you are transferred within 48 hours to the ICU of another Hospital.

Step Down Unit

We will pay a benefit equal to one half the chosen daily benefit for confinement in a Step Down Unit.

Exceptions and Other Limitations

Except as provided in Step Down Unit and Emergency Hospitalization and Subsequent Transfer to an ICU, coverage does not provide benefits for: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units; or other facilities which do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable: if you go into an ICU before the Certificate Effective Date; if you go into an ICU for intentionally self-inflicted injury or suicide attempts; if you go into an ICU due to being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law in the jurisdiction where the accident or cause of loss occurred.

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer's Guide available from the Company.
This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected.
Upon receipt of your policy, please review it and your application.
If any information is incorrect, please contact us.

Administered by:
Bay Bridge Administrators
P.O. Box 161690 | Austin, Texas 78716 | 1-800-845-7519

Mississippi Division of Medicaid

Group Cancer Rate Quote - Monthly Rates

Effective Date: 1/1/2019

Base Policy

Coverage Tier	Option I	Option II	Option III
Individual	$26.23	$30.23	$36.02
Individual + Spouse	$52.24	$60.19	$71.55
Individual + Child(ren)	$35.81	$40.75	$47.90
Family	$61.81	$70.70	$83.43

Variable Benefit Elections

Benefit	Option I	Option II	Option III
Hospital Confinement	$100 per day	$100 per day	$100 per day
Surgical	up to $3,000	up to $4,500	up to $4,500
Radiation/Chemotherapy	$5,000 per month	$5,000 per month	$5,000 per month
First Diagnosis	$2,500	$5,000	$10,000
Colony Stimulating Factors	$4,000 per month	$4,000 per month	$4,000 per month
Wellness	$100 per year	$100 per year	$100 per year

Optional Intensive Care Rider

Coverage Tier	$325 per day	$625 per day	$825 per day
Individual	$2.49	$4.80	$6.33
Individual + Spouse	$5.37	$10.32	$13.63
Individual + Child(ren)	$4.04	$7.78	$10.27
Family	$6.92	$13.30	$17.56

Underwritten by:
Metropolitan Life Insurance Company

Administered by:

BAY BRIDGE ADMINISTRATORS

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P.O. Box 161690 - Austin, Texas 78716 - (800) 845-7519

Insurance Provided By:
Metropolitan Life Insurance Company

Administered By:
Bay Bridge Administrators, LLC
P.O. Box 161690, Austin, TX 78716
800-845-7519

Enrollment Form for Group Cancer/Specified Disease Insurance

☐ **New Enrollment** ☐ **Change**

NAME OF GROUP	DIVISION / CLASS / LOCATION	DATE OF HIRE	AVERAGE WEEKLY HOURS
Mississippi Division of Medicaid		/ /	

EMPLOYEE/MEMBER *Last* *First* *Middle*	SEX	DATE OF BIRTH
		/ /

E-MAIL ADDRESS	SOCIAL SECURITY NUMBER / ID NUMBER

ADDRESS *City* *State* *Zip Code*	PHONE NUMBER
	( ) -

Complete for Spouse / Domestic Partner / Child Coverage

	FIRST	LAST	DOB	SEX
SPOUSE / DOMESTIC PARTNER			/ /	
CHILD			/ /	
CHILD			/ /	
CHILD			/ /	
CHILD			/ /	
CHILD			/ /	

☒ Yes, I want the Cancer/Specified Disease Insurance offered by the Policyholder.
☐ Option I ☐ Option II ☐ Option III

Optional Rider:
☐ Intensive Care Unit Benefit Rider:
☐ $325 per day ☐ $625 per day ☐ $825 per day

Total Premium: $_____
weekly, bi-weekly,
semi- monthly, monthly,
other:_____

Select level of Coverage:

☐ Employee/Member ☐ Employee/Member + Spouse/Domestic Partner
☐ Employee/Member + Child(ren) ☐ Employee/Member + Dependents

FRAUD WARNING

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DECLARATIONS

By signing below, I declare:

1. I have read this enrollment form and all information I have given is true and complete to the best of my knowledge and belief.
2. That I am actively at work on the date I am enrolling. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
4. I have read the applicable Fraud Warning(s).

Before signing this form, please read the fraud warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

_____ _____

Employee's / Member's Signature Date

James C. Thomas BB10488

Employee's / Member's Name and Number Enroller's Name and Number

Voluntary Group Life Insurance for Mississippi Division of Medicaid

Underwritten by Cigna (Rated A+ by A.M. Best)
Through the North American Insurance Trust (NAIT)
Administered by MWG Mestmaker & Associates

Highlights

- *This group term life insurance program provides up to $200,000 Guarantee Issue for employees, up to $30,000 for spouse, and up to $10,000 for dependents if you apply within your initial eligibility period.*
- *Up to $500,000 of coverage may be purchased under this program for employees (up to $250,000 for spouse).*
- *Portability-Conversion-Cigna will contact you with options to continue coverage in the event you are terminated, retire, and/or change employer.*

More Details

- Full time employees who work at least 40 hours per week for the employer on a regular basis are eligible to participate.
- All amounts of insurance will reduce 35% at age 65, 60% at age 70, 75% at age 75, and will terminate at age 80.
- Special living benefits up to 75% of the insurance may be paid if the attending physician indicates that the insured has a terminal illness with less than twelve months life expectancy. This means that money can be received from this program at a time when funds are needed most.
- AD&D - Benefit amount equal to the life amount elected by you. Cost included in the schedule.

Age	Monthly Rate Per $1,000
Up to age 29	$.06
30–34	$.07
35–39	$.09
40–44	$.14
45–49	$.22
50–54	$.41
55–59	$.69
60–64	$.82
65–69	$1.44
70-74	$3.42
75-79	$13.10
Child(ren):	
$10,000	$2.00/month

MWG MESTMAKER & ASSOC.
A division of Morgan White Group

1675 Chester Ave. Ste 400, Bakersfield, CA 93301
P.O. Box 2302, Bakersfield, CA 93303
Phone: 661-325-5999 | Fax: 661-325-6090

Application for
Employee Term Life Insurance

MESTMAKER & ASSOC.
A division of Morgan White Group

Cigna

Life Insurance Company of North America (LINA), Cigna Life Insurance Company of New York a Cigna Company (herein called the Insurance Company)

Enrollment	Change		
❑ Initial enrollment ❑ Late applicant	❑ Increase coverage ❑ Terminate coverage	❑ Add dependant ❑ Reduce coverage	❑ Address change ❑ Name change

Policy name	Policy #	Employer name
North American Insurance Trust (NAIT)	FLX969411	Mississippi Division of Medicaid

Employee Information

Prefix *(choose one)* ❑ Mr. ❑ Mrs. ❑ Ms.	Employee		
SSN	Age	Date of birth	Occupation
Address	City	State	Zip
Work phone	Home phone	Sex *(choose one)* ❑ M ❑ F	

Voluntary Life Insurance

❑ **Employee** *Amount of Coverage Applied for (multiples of $10,000 to a max of $500,000)*

Current voluntary life amount		Additional amount requested		Total amount requested
$	+	$	=	$

❑ **Spouse/Domestic Partner** *Amount of Coverage Applied for (multiples of $10,000 to a max of $250,000, not to exceed 50% of employee's amount)*

Current dependents voluntary life amount		Additional amount requested		Total amount requested
$	+	$	=	$

Spouse name	Marriage date	
Date of birth Use Employees DOB	SSN	Sex *(choose one)* ❑ M ❑ F

❑ **Dependent Children Voluntary Life** *(please select one)* ❑ $2,500 ❑ $5,000 ◉ $10,000

Beneficiary Name	Birthdate	SSN	Relationship	% of Benefit

Acceptance/Declination

I accept the insurance coverages elected above. If premium is to be paid by payroll, I authorize my employer to deduct the necessary amounts from my earnings. If I have not elected coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the insurance company's approval.

Signature X _____ Date _____ / _____ / _____
(Important: You must also sign and date the Agreements and Authorizations section) Month Day Year

Employer Use (Mandatory Data Needed): In order to process this application, the employer must complete all requested information.

Date of hire	Annual salary	Group insurance eligibility date	Verified by

Important: you must complete the medical questions in this application if, (1) as a newly enrolled member you apply for life insurance exceeding the guaranteed coverage amount, or life insurance more than 31 days after you are eligible to elect benefits; or (2) you are currently insured under the prior life insurance plan and elect to increase your current insurance amount(s); or (3) you were eligible but did not enroll for insurance under the prior life insurance plan.

Employee		*Spouse (if applicable)*	
Height *(ft/in)*	Weight *(lbs)*	Height *(ft/in)*	Weight *(lbs)*

Questions

Please indicate your answer for each question in this section by checking the yes or no box.		*Member*		*Spouse*	
		Yes	*No*	*Yes*	*No*
1. Within the last 5 years, has the proposed insured been (a) diagnosed with any of the conditions in items A through F, or (b) told by a medical professional that he/she has or may have any of the conditions in items A through F:					
A	A heart attack or stroke?	❑	❑	❑	❑
B	Cancer (other than nonmelanoma skin cancer), Hodgkin's disease, or leukemia?	❑	❑	❑	❑
C	Emphysema or chronic obstructive pulmonary disease (COPD)?	❑	❑	❑	❑
D	HIV infection or AIDS?	❑	❑	❑	❑
E	Diabetes, hepatitis C or cirrhosis of the liver?	❑	❑	❑	❑
F	Alcohol or drug abuse or dependency?	❑	❑	❑	❑
2. Within the last five years, has the proposed insured had a driving while intoxicated (DWI) or a driving under the influence (DUI) conviction?		❑	❑	❑	❑

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files for an insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of information concerning any fact material thereto, commits a fraudulent insurance act.

Agreements and Authorizations

To the best of my knowledge and belief, all written, telephonic, and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the insurance company is one of those conditions. I understand and agree that:

1. This request will be a part of the policy that provided the insurance.
2. I may need to provide more medical info.
3. I must report any change in my health that happens before the insurance is effective.
4. Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date the insurance is to be effective.

I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, The Medical Information Bureau (MIB) or any other person or organization having information about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me or my children to disclose to the insurance company or its authorized agent, any such information, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 30 months from the date below. I accept that a copy of this authorization is as valid as the original. I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request. I understand that the information will be used to assess my request for insurance. I may revoke this authorization at any time in writing. Any such revocation will not: 1) change any action taken in reliance on the authorization; and 2) change the insurance company's right to use the authorization for context of a claim or policy in accordance with applicable law.

I understand that information provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The insurance companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Member signature _____ Date _____ /_____ /_____
Month Day Year

Spouse signature (*if applying for insurance*) _____ Date _____ /_____ /_____
Month Day Year

Email, mail, or fax completed, signed form to:

MWG Mestmaker & Assoc. • P.O. Box 2303 • Bakersfield, CA 93303
Phone: 661-325-5999 • Fax: 661-325-6090

BENEFICIARY DESIGNATION FORM

Life Insurance Company of North America

CIGNA Group Insurance
Life • Accident • Disability

Employer Name _____

Employee Name_____ Employee Social Security #_____

Current Address_____ City_____State_____ Zip _____

Home Phone_____Work Phone_____ ***please enter all dates in mm//dd/yyyy format.***

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Basic Life Insurance, Life Insurance Company of North America - Policy No. _____				
Employee's Primary Beneficiary(ies):	**Relationship**	**SS #**	**Date of Birth**	**% (total must equal 100%)**
Contingent(s):	**Relationship**	**SS #**	**Date of Birth**	**% (total must equal 100%)**
Basic Accident Insurance, Life Insurance Company of North America - Policy No. _____				
Employee's Primary Beneficiary(ies):	**Relationship**	**SS #**	**Date of Birth**	**% (total must equal 100%)**
Contingent(s):	**Relationship**	**SS #**	**Date of Birth**	**% (total must equal 100%)**

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature_____Date____/____/____

Owner Signature_____Date____/____/____

Please refer to page 2 to review *Guidelines for Designation of Beneficiaries*. If you need additional space, using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn't provide for this situation.

Life Status Changes - We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Critical Illness and Cancer

Mississippi

Mississippi Division of Medicaid

Consider coverage that helps protect you, your family, and your assets in the event of a critical illness. It offers specialized benefits to supplement other health insurance when you and your family may be most vulnerable: during the working years. Benefit payments can assist in covering a variety of expenses associated with a critical illness: out-of-pocket medical care costs, home healthcare, travel to and from treatment facilities, rehabilitation, and other expenses.

Coverage type	Voluntary Critical Illness insurance is a group policy form that includes coverage for heart/stroke, cancer, and other critical illnesses.
Benefit amount	Benefit amounts are available at various levels. You can choose: • $5,000 to $50,000 for employees You can also add coverage for your dependents: • Spouse: $2,500 to $25,000. Spouse coverage benefit is equal to exactly half of the employee's coverage • Child: $2,500 to $5,000 for each eligible child
Coverage for vascular conditions	Percent of benefit amount paid at initial diagnosis: • Heart attack 100% • Transplant as a result of heart failure 100% • Stroke 100% • Coronary artery bypass surgery as a result of coronary artery disease 25%
Coverage for cancer conditions 30 day waiting period	Percent of benefit amount paid at initial diagnosis: • First diagnosis of internal cancer or malignant melanoma 100% • Carcinoma in situ 25%

This is not a complete disclosure of plan qualifications and limitations. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made.

Policy: 8011
Underwritten by ManhattanLife Assurance Company

ManhattanLife℠
Since 1850

Critical Illness and Cancer

Mississippi

Mississippi Division of Medicaid

Coverage for other critical illnesses

Percent of benefit amount paid at initial diagnosis:

- Transplant, other than heart 100%
- End-stage renal failure 100%
- Loss of sight, speech, or hearing 100%
- Coma 100%
- Severe burns 100%
- Permanent paralysis due to an accident 100%
- Occupational HIV 100%

Additional included benefits

Waiver of premium for disability: This waives an employee's premium if he or she becomes totally disabled for at least 180 days after the effective date of coverage. For employees ages 18-55.

☐ **Benefit recurrence:** This provides an additional benefit for the same condition if a covered participant is treatment-free for at least 12 months.

Portability

Portable after six months of continuous coverage if group master policy remains in force and the insured is less than age 70. Participants may continue coverage by paying premiums on a direct billing method.

- All ported certificates will be subject to any rate increases on the Employer's Master Policy.

This is not a complete disclosure of plan qualifications and limitations. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made.

Policy: 8011
Underwritten by ManhattanLife Assurance Company

ManhattanLife℠
Since 1850

ManhattanLife SM
Since 1850

Mississippi Division of Medicaid

Critical Illness and Cancer Rates
Mississippi

Employee rates (for Non-Tobacco Users)

Displaying Monthly payroll deductions including Benefit Recurrence

Age	Employee - NTU									
BENEFIT:	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$4.16	$7.81	$11.46	$15.11	$18.76	$22.41	$26.06	$29.71	$33.36	$37.02
30-39	$6.51	$12.51	$18.50	$24.50	$30.49	$36.49	$42.49	$48.48	$54.48	$60.48
40-49	$9.71	$18.91	$28.11	$37.32	$46.52	$55.72	$64.92	$74.12	$83.32	$92.52
50-55	$14.51	$28.51	$42.51	$56.51	$70.51	$84.50	$98.50	$112.50	$126.50	$140.51
56-59	$14.51	$28.51	$42.51	$56.51	$70.51	$84.50	$98.50	$112.50	$126.50	$140.51
60-64	$17.91	$35.31	$52.70	$70.11	$87.51	$104.91	$122.31	$139.70	$157.10	$174.51
65-69	$19.36	$38.21	$57.05	$75.90	$94.75	$113.60	$132.46	$151.30	$170.15	$189.00

Spouse Rates

Displaying Monthly payroll deductions including Benefit Recurrence

Age	Spouse - NTU									
BENEFIT:	$2,500	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$1.95	$3.90	$5.85	$7.80	$9.75	$11.70	$13.66	$15.61	$17.56	$19.51
30-39	$3.23	$6.45	$9.68	$12.90	$16.13	$19.35	$22.58	$25.80	$29.03	$32.25
40-49	$5.00	$10.00	$15.00	$20.00	$25.00	$30.00	$35.00	$40.00	$45.00	$50.00
50-55	$7.63	$15.25	$22.88	$30.50	$38.13	$45.75	$53.38	$61.00	$68.62	$76.24
56-59	$7.63	$15.25	$22.88	$30.50	$38.13	$45.75	$53.38	$61.00	$68.62	$76.24
60-64	$9.52	$19.05	$28.57	$38.10	$47.62	$57.14	$66.67	$76.19	$85.72	$95.24
65-69	$10.33	$20.65	$30.98	$41.30	$51.63	$61.95	$72.28	$82.60	$92.93	$103.25

NTU: Non-tobacco user; TU: Tobacco user

Children Rates

Displaying Monthly payroll deductions including Benefit Recurrence

Age	Children	
BENEFIT:	$2,500	$5,000
0-25	$1.87	$3.75

The proposed rates are for an effective date no later than 1/1/2019

Policy: 8011
Underwritten by ManhattanLife Assurance Company of America.

ManhattanLife SM
Since 1850

Mississippi Division of Medicaid

Critical Illness and Cancer Rates
Mississippi

Employee rates (for Tobacco Users)

Displaying Monthly payroll deductions including Benefit Recurrence

Age	Employee - TU									
BENEFIT:	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-29	$5.51	$10.51	$15.50	$20.50	$25.50	$30.50	$35.50	$40.49	$45.49	$50.49
30-39	$9.76	$19.01	$28.26	$37.51	$46.76	$55.99	$65.24	$74.49	$83.74	$92.99
40-49	$15.76	$31.01	$46.27	$61.53	$76.78	$92.03	$107.28	$122.54	$137.79	$153.04
50-55	$24.66	$48.81	$72.96	$97.13	$121.28	$145.43	$169.58	$193.73	$217.88	$242.04
56-59	$24.66	$48.81	$72.96	$97.13	$121.28	$145.43	$169.58	$193.73	$217.88	$242.04
60-64	$31.11	$61.71	$92.31	$122.92	$153.51	$184.11	$214.71	$245.31	$275.91	$306.51
65-69	$31.91	$63.31	$94.71	$126.10	$157.50	$188.90	$220.30	$251.70	$283.10	$314.51

Spouse Rates

Displaying Monthly payroll deductions including Benefit Recurrence

Age	Spouse - TU									
BENEFIT:	$2,500	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-29	$2.70	$5.40	$8.10	$10.80	$13.50	$16.21	$18.90	$21.61	$24.30	$27.01
30-39	$5.02	$10.05	$15.07	$20.10	$25.13	$30.16	$35.18	$40.21	$45.23	$50.26
40-49	$8.32	$16.65	$24.97	$33.30	$41.62	$49.95	$58.26	$66.59	$74.91	$83.23
50-55	$13.21	$26.40	$39.61	$52.80	$66.01	$79.20	$92.41	$105.60	$118.81	$132.01
56-59	$13.21	$26.40	$39.61	$52.80	$66.01	$79.20	$92.41	$105.60	$118.81	$132.01
60-64	$16.77	$33.55	$50.32	$67.10	$83.87	$100.65	$117.42	$134.20	$150.97	$167.74
65-69	$17.23	$34.45	$51.68	$68.90	$86.13	$103.35	$120.58	$137.80	$155.03	$172.25

NTU: Non-tobacco user; TU: Tobacco user

Children Rates

Displaying Monthly payroll deductions including Benefit Recurrence

Age	Children	
BENEFIT:	$2,500	$5,000
0-25	$1.87	$3.75

The proposed rates are for an effective date no later than 1/1/2019

Policy: 8011
Underwritten by ManhattanLife Assurance Company of America.

ManhattanLife Voluntary Benefits

Group	**Mississippi Division of Medicaid #897940, Renewal offer, Signature not required.**	Underwriter	**Shari Bennett**
Offer Date	**03/13/2019**	Valid Through	**04/13/2019**

PLAN PROVISIONS

Policy	**ManhattanLife Critical Illness/Cancer**	
Policy Form	**8011**	
Availability	**MS Situs**	
Underwriting	**Contingent Guarantee Issue**	**Simplified Issue**
Base Plan	**Vascular/Other Illness/Cancer**	**Vascular/Other Illness/Cancer**
Employee Benefit	**$10,000**	**$50,000**
Spouse Benefit	**Simplified Issue: 50% of employee benefit to a max of $25,000**	
Child Benefit	**Simplified Issue: 50% of employee benefit to a max of $5,000**	
Optional Benefit		
– Benefit Recurrence	**Must be included on all policies/certificates**	

Pre-existing Condition Limitation – Unless explicitly indicated in the product contingencies, all pre-existing exclusions apply. Please refer to your policy for specific pre-existing limitations.

Benefit Waiting Period – 30 calendar day waiting period on cancer benefit. 90 calendar day waiting period from the effective date on the Health Screening Benefit.

Eligibility	**20 hours per week**
Number of Eligible Employees	**900**
Participation Requirement	**20% (Additional 90 approved applications required for the Contingent Guarantee Issue offer)**
Employer's Service Waiting Period	**Will match the Employer's Service Waiting Period**
Issue Ages	**18-69 – Employee, 18-69 – Spouse, 14 days -24 years – Child**

PRODUCT QUALIFICATIONS AND CONTINGENCIES

- Total amount of Critical Illness in force with all carriers cannot exceed $100,000. Total amount of Critical Illness in force with ManhattanLife cannot exceed $100,000.
- Total amount of Cancer in force with all carriers cannot exceed $100,000. Total amount of Cancer in force with ManhattanLife cannot exceed $100,000.
- Minimum of 5 participants required to set up the product for the group.
- Late enrollees will be accepted on an SI basis only.

ManhattanLife℠ Since 1850

Enrollment Form for Voluntary Group Critical Illness

ManhattanLife Assurance Company of America

ManhattanLife SM Since 1850

Mississippi Division of Medicaid

PLEASE INDICATE: ⊗ ENROLLMENT FOR NEW COVERAGE ❍ CHANGE TO EXISTING COVERAGE

Proposed Insured (Please Print)

Person Proposed for Coverage (First Name, MI, Last Name) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ❍ Male ❍ Female

Address (Street or R.R.)

City | State | Zip Code | Home Telephone ( ) -

Employer Name or Group Number: MS Division of Medicaid | Date of Employment (MM/DD/YYYY) / /

How many hours per week do you work? | Employee Class (If Applicable) ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ❍ Male ❍ Female

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ❍ Male ❍ Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ❍ Male ❍ Female

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ❍ Male ❍ Female

Administrative Office: [10777 Northwest Freeway, Houston, TX 77092]
Toll Free Telephone Number: [(800) 669-9030] FAX: [(713) 821-6463]

CRITICAL ILLNESS INSURANCE ❍ Employee ❍ Spouse ❍ Child(ren)

	Employee	Spouse
Has any Proposed Insured used any form of tobacco in the last 12 months?	❍ Yes ❍ No	❍ Yes ❍ No

Base Plan ☒ Vascular ☒ Cancer ☒ Other Critical Illnesses

Base Benefit Benefit Amount $ ___,___ Total Modal Premium $ ___.__

Optional Benefits ☒ Health Screening ☒ Automatic Benefit Increase

Section I: Complete this Section if applying for Guarantee Issue.	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you Actively at work?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
2. Will this coverage replace a critical Illness policy or certificate of Insurance paid for, by, or through your employer?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Section II: Complete this Section and Section I if applying for Contingent Guarantee Issue.										
3. Has the Proposed Insured been performing their normal duties at work, home, or school on a full-time basis and not having missed more than 5 consecutive days In the last 12 months due to illness or Injury, except for normal pregnancy?	❍	❍								
4. Is any Proposed Insured now being treated, or ever been treated or diagnosed, by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for the antigens or antibodies to an AIDS virus?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
5. In the 6 months prior to the application date, has any Proposed Insured been hospitalized as an Inpatient or outpatient, or missed more than 5 consecutive days of work due to an illness or Injury, except for normal pregnancy?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Section III: Complete this Section, Section I and Section II if applying for Simplified Issue. In questions 6 and 7, complete items A, B, and/or C as appropriate.										
6. Within the past 5 years, has any Proposed Insured been diagnosed with or treated for:										
A) **Vascular:** Heart disease, including angina; heart attack; congestive heart failure; heart bypass; cerebrovascular disease, Including Transient Ischemic Attack (TIA); stroke (blockages or hemmorhage); diabetes; or blood pressure readings above the normal range which have not been controlled with medication?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
B) **Cancer:** Cancer, Including melanoma; leukemia; malignant tumors; or skin cancers?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
C) **Other:** Drug abuse or alcohol abuse; disease of the liver, kidney or digestive system; disease or disorder of the lung; diabetes; diseases of the nervous system, including Parkinson's, MS and cerebral palsy; or any disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing, or speech?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
7. To the best of your knowledge and belief, have any 2 of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:										
A) **Vascular:** Heart attack, heart disease or stroke?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
B) **Cancer:** Cancer?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
C) **Other:** Kidney disease or diabetes?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

8. A) Proposed Insured Height (Ft-In) - Weight B) Spouse Height (Ft-In) - Weight

C) Child One Height (Ft-In) - Weight D) Child Two Height (Ft-In) - Weight

E) Child Three Height (Ft-In) - Weight

EMPLOYEE'S REPRESENTATION AND AGREEMENT

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that the above statements are representations and not warranties.

Signed at _____ M S
City State

_____
Signature of Proposed Insured/Owner

/ / Date (MM/DD/YYYY)

INSURANCE PRODUCER'S USE

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Signature of Licensed Insurance Producer James C. Thomas

Date (MM/DD/YYYY)

Insurance Producer Number	% Credit	Insurance Producer Number	% Credit
1 3 1 3 4 7 2	1 0 0		

Lincoln Financial Group®

Accident

Accident Insurance

Protect yourself and your loved ones with cash benefits for accidental injuries.

Lincoln Financial Group®

Accident insurance can make mishaps a little less painful.

Accidents can hurt in more ways than one. Just as you are starting to recover, the bills start to come in. Bills that may not be completely covered by other insurance you have.

Accident insurance from Lincoln Financial Group can help. If you or a loved one is injured in an accident, you get a cash benefit. So even though you can't see an accident coming, you can still plan for one.

For example, if you are injured and admitted to the hospital, your accident insurance sends you a check that you can use however you like — to cover a copay or deductible, pay for everyday living expenses, or even make a purchase.

It pays to have accident insurance.

You receive a cash benefit if a covered injury results in any of the following:

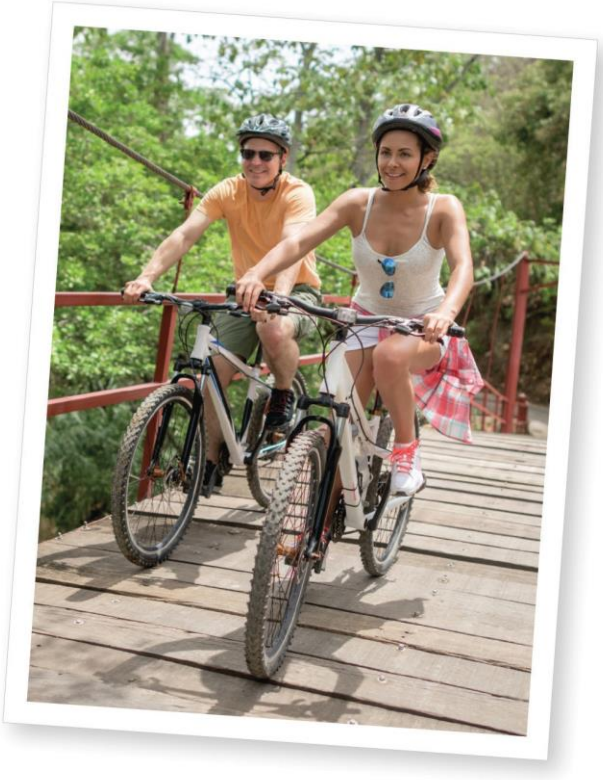
- Emergency room visits
- Ambulance transportation
- Hospital admission and confinement
- Intensive care
- Surgeries
- Fractures and dislocations
- Lacerations
- Concussions
- Accidental death and dismemberment

(See your Summary of Benefits for a complete list.)

And if you have multiple injuries from the same accident, you may receive a separate cash benefit for each of your injuries and covered treatments.

It's affordable, too, with group rates.

Group rates are typically more affordable than what you might pay for an insurance plan on your own. And with payroll deduction, no money is due now — your premium simply comes out of your paycheck.



Lincoln Financial Group®

Now Available to
Full-Time Employees of Mississippi Division of Medicaid:
Accident insurance with affordable group rates

Protect yourself.
And your loved ones.

Accidents happen, no matter how careful we try to be. And while you can't always prevent them, you can protect yourself and your loved ones.

The Lincoln Accident Insurance Choice Plan:

- Provides cash benefits if you or a covered family member is accidentally injured
- Features group rates for Mississippi Division of Medicaid employees
- Includes valuable support services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance
- Also includes *TravelConnect*® services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Here's how this important coverage works.

If you or a loved one is injured in a covered accident, you receive a cash benefit in addition to any other insurance you may have. For example, if one of you were to suffer a broken leg, you could receive:

- **$150 for an ambulance**
- **$150 for a trip to the ER**
- **$600 for a surgical fracture**
- **$1,000 for hospital admission**
- **$600 for a hospital stay $200 per day**
- **$25 for crutches**
- **$300 for follow-up doctor and physical therapy visits ($50 per visit)**

Total: $2,825 for a single accident!

As you can see, your cash benefits really add up. And you can use the money to help cover your medical costs or however you like.

A complete Summary of Benefits is included on the next few pages.

Here's how little you pay with group rates.

As a Mississippi Division of Medicaid employee, you can take advantage of this accident insurance plan for less than $0.56 a day. Plus, you can add loved ones to the plan for just a little more.

Coverage	Monthly Premium
Employee only	$16.94
Employee & spouse	$23.71
Employee & child/children	$28.69
Employee & family	$37.98

Plan benefit options are available for an additional cost.
See the Summary of Benefits for details.

Note: This coverage is guaranteed for as long as you continue to pay your premium, and will not change due to your age. The premium for employee & child/children and employee & family coverage includes all children.

No money is due at enrollment. Your premium simply comes out of your paycheck.

Lincoln Financial Group®

Accident Insurance | Choice Plan Summary of Benefits

Prepared for: Full-Time Employees of Mississippi Division of Medicaid

Group rates for Mississippi Division of Medicaid employees make accident insurance more affordable than ever. This coverage provides cash benefits if you or a covered family member is injured in an accident. The types of injuries covered and the cash benefits for each — along with additional plan benefits, options, and services — are outlined on the following pages.

Your premium comes out of your paycheck, so no money is due now.

Cash Benefit Amounts

Emergency Care	Your Cash Benefit
Ambulance/air ambulance	$150/$600
Initial physician office visit/ER visit	$50/$150
Major diagnostic exam	$100

Hospitalization & Follow-up Care	Your Cash Benefit
Hospital admission	$1,000
Hospital confinement daily benefit	$200
Intensive care daily benefit	$400
Alternate care and rehabilitative facility daily benefit	$100
Follow-up doctor/patient care (up to 6 sessions)	$50
Transportation for care (up to 3 times per accident)	$175
Companion lodging (up to 30 days per accident)	$100
Family care per child (up to 30 days)	$20

Fractures & Dislocations	Your Cash Benefit
Bone fracture treated surgically	$100-$2,400
Bone fracture treated without surgery	$50-$1,200
Chip fracture	25% of fracture benefit
Dislocation injury treated surgically	$300-$4,800
Dislocation injury treated without surgery	$150-$2,400

Other Injuries	Your Cash Benefit
Transfusion	$150
Burn	$100-$6,400
Skin graft	25% of burn benefit
Joint replacement (hip, knee, shoulder)	$1,500-$2,000
Coma	$2,000
Concussion	$100
Dental crown – once per accident	$150
Dental extraction – once per accident	$50
Eye (removal of foreign body) – once per eye/accident	$100
Eye (surgical repair) – once per eye/accident	$300
Laceration	$50-$400
Surgery	$250-$1,000
Surgical repair of ligaments/tendons, knee cartilage, rotator cuff, ruptured disc	$300-$400

Mobility Assistance	Your Cash Benefit
Crutches, wheelchair, walker, other	$25-$350
Prosthesis per limb/device	$500
Reasonable modifications to home or vehicle	$2,500

Accidental Death & Dismemberment (AD&D)	Your Cash Benefit
Employee accidental death	$30,000
Spouse accidental death	$10,000
Child accidental death	$5,000
Loss of or loss of use of one hand, foot, arm, leg, or eye	$7,000
Loss of or loss of use of any finger, thumb, or toe	$300
Common carrier enhanced death benefit	2x benefit amount
Transportation of remains	$5,000
Seat belt/helmet AD&D benefit	10% of AD&D
Common disaster enhanced death benefit	2x benefit amount
Catastrophic loss	$50,000

Additional Plan Benefits, Options, and Services

Health Assessment Benefit Option	Monthly Premium
Employee Only	$2.21
Employee & Spouse	$4.40
Employee & Child/children	$2.76
Employee & Family	$5.07

Health Assessment (Wellness) Benefit

- You receive a $50 cash benefit every year you have one or more covered screening tests. This is in addition to what your health insurance may cover.
- There are 24 covered screening tests, including mammograms and colonoscopies.
- This benefit is also available to family members.

Additional Plan Benefits	
Portability	Included

Portability

- You may be able to continue your coverage if you leave your job.
- To take advantage of this benefit, send your written application and first premium payment to Lincoln Financial Group within 31 days of the date your coverage would otherwise end.

Additional Plan Services	
Support Services | Accident Employee Assistance Program (EAP)	Included
Travel Assistance Services | *TravelConnect*®	Included

Support Services | Accident Employee Assistance Program (EAP)

- This employee assistance program provides you and your family confidential access to counselors and other helpful resources for personal, legal, and financial issues when injured in a covered accident.
- Program services include:
  - Unlimited, 24/7 access to information and referrals
  - One free consultation with a network attorney (with subsequent meetings at a reduced fee)
  - Online tools, tutorials, videos, and much more

Travel Assistance Services | *TravelConnect*®

- This travel assistance program provides a wealth of travel, medical, and safety-related services you can access while traveling more than 100 miles from home, for business or pleasure.
- These services include:
  - Evacuation services for medical emergencies, natural disasters, or political events
  - Travel Assistance services such as replacement of travel documentation, return of pets, and vehicle return
  - Medical, dental, and pharmacy referrals

Benefit Exclusions

This accident insurance policy covers many injuries that result from an accident. Like any insurance, though, the policy does have some exclusions. These include injuries that occur before the coverage begins, after the coverage ends, or while:

- Serving as a member of the military, including the Reserves and National Guard
- Flying in a non-commercial airplane
- Participating in a high-risk or extreme sport, such as bungee jumping, parachuting, base jumping, and mountaineering
- Undergoing cosmetic or elective surgery
- Committing or attempting to commit a felony
- Being held in a prison or detention facility
- Under the influence with a blood alcohol level of .08 grams or more per 100 milliliters of blood
- Deliberately using poison, gas, fumes, or drugs other than those prescribed by a physician and administered as prescribed
- Committing or attempting to commit suicide or inflict injury to one's self
- Participating in, practicing for, or officiating a semi-professional or professional sport
- Riding in or driving a vehicle for race, stunt show, or speed test
- Participating in a riot, insurrection, or rebellion or as a result of war or act of war
- Residing outside the U.S., U.S. territories, Canada, or Mexico for more than 12 months

This accident insurance policy also does not cover sickness or disease. A complete list of benefit exclusions is included in the policy. State variations apply.

Questions? Call 800-423-2765 and mention ID: DEPTMEDMS.

This is not intended as a complete description of the insurance coverage offered. While benefit amounts stated in this summary are specific to your coverage, other items may summarize our standard product features and not the specific features of your coverage. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A policy will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the policy, the policy will govern.

Employee Assistance Program services are provided by ComPsych® Corporation, Chicago, IL. *TravelConnect*® travel assistance services are provided by On Call International, Salem, NH. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. ComPsych® and On Call International are not Lincoln Financial Group companies and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations. ComPsych® and GuidanceResources® are registered trademarks of CompPsych Corporation.

Coverage is subject to contract language that contains specific terms, conditions, and limitations.

In Minnesota and New York, this product is offered as an individual insurance policy. In all other states, this product is offered as a group insurance policy. This plan design is not offered in New York.

Benefits may vary by state, have limits on the number of services provided, or limit the time frame in which the services must be rendered. See your certificate booklet or policy for more information. This insurance product does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Insurance products (policy series GL41, GL41SG, WIND) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. In New York, insurance products (policy series WIND) are issued by Lincoln Life & Annuity Company of New York (Syracuse, NY). Both are Lincoln Financial Group® companies. Product availability and/or features may vary by state. Limitations and exclusions apply.

Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: 800-423-2765 Fax: 877-573-6177

Here is your Enrollment Form.

Follow these steps to complete the form.
Print clearly in ink.
Step 1: Fill in or confirm your personal information.
Step 2: Fill in dependent information, if any.
Step 3: Select your benefits.
Step 4: Assign beneficiaries.
Step 5: Confirm enrollment.
Step 6: Sign, date & return the form.

Group ID: DEPTMEDMS

1. Your Personal Information

Group/Employer/Participating Organization Name: Mississippi Division of Medicaid
County _____ Zip _____ State _____

Your First Name _____ Middle Name/MI _____ Last Name _____
Social Security No. ___-___-____ Employee ID No. _____ Date of Birth ___/___/____

Street Address (Include Apt. or Suite No.) _____
City _____ State _____ Zip _____

Home Phone (___) ___-____ Cell Phone (___) ___-____ Work Phone (___) ___-____ Email Address _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

2. Personal Information on Dependents — Complete if you are enrolling dependents.

☐ **Spouse**

First Name _____ Middle Name/MI _____ Last Name _____
Social Security No. ___-___-____ Date of Birth ___/___/____

Provide contact information if different than Your information above.

Home Phone (___) ___-____ Cell Phone (___) ___-____ Work Phone (___) ___-____ Email Address _____

Dependent Children – List all children you are enrolling (attach a separate sheet, if needed).

First Name	Middle Name/MI	Last Name	SSN (Optional)	Gender	DOB	Full-time Student
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No
			___-___-____	☐ Male ☐ Female	___/___/___	☐ Yes ☐ No

Employer Completes this Section.

Billing Division or Location: _____
Sort Group/Code: _____ Payroll Cycle: _____
Policy #(s): _____
Average Hours Worked Per Week: _____ ☐ Full-time ☐ Part-time Occupation: _____
Earnings: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly $_____ Date of Employment: ___/___/____
Actively at Work? ☐ Yes ☐ No Date of Rehire: ___/___/____

Continue on Next Page. . .

3. Benefit Selection — Choose your benefits.

Voluntary/Optional Group Insurance				
Mark the box or boxes for each type of group insurance you are applying for. All insurance amounts are subject to the limitations and exclusions as stated in the policy and certificate.				
Employer Completes this section.		**Type of Insurance**	**Amount of Insurance**	**Total Premium (Monthly)**
Class	**Effective Date**			
_____	_____/_____/_____	Accident ☐ **Yes** ☐ **No**	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____
_____	_____/_____/_____	Accident – Health Assessment Benefit ☐ **Yes** ☐ **No**	☐ Employee ☐ Employee/ Spouse ☐ Employee/ Children ☐ Employee/ Spouse/Children	$_____

*By selecting "No," enrolling for insurance at a later date may require further medical information and/or a physical exam, which will be at your own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

Continue on Next Page. . .

4. Confirm Enrollment

This group insurance has been offered to me and after careful consideration of the benefits, I have decided to:

☐ **ENROLL FOR INSURANCE for which I am or may become eligible** under the group policies issued by The Lincoln National Life Insurance Company, or its insurance partners. If contributions are required, I authorize my Employer to deduct premium from my pay.

☐ **NOT ENROLL myself in the group insurance offered.** I understand if I enroll for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

☐ **NOT ENROLL my dependents in the group insurance offered.** I understand if I enroll my dependents for insurance at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

Fraud Warning/State Disclosure(s)

A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

5. Sign and Return

I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand that the vision insurance I have elected provides reimbursement for certain vision costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my provider or me for vision care expenses that I have incurred may not be covered by my vision care insurance benefit plan.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

The information provided is complete, true, and accurate to the best of my knowledge.

Your Full Name (Print): _____

Your Signature: X_____ **Date** _____/_____/_____

Complete and return this form.

(Be sure to sign and date the form to start your insurance.)

Questions? Call 800-423-2765