THE CALIFORNIA STATE UNIVERSITY
Office of the Chancellor
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Date: January 9, 1998
Code: TECHNICAL LETTER
       HR/Benefits 6600
       98-02

To: Benefits Officers
From: Cathy Robinson, Senior Director
       Human Resources Administration

Subject: REVISED GROUP UNIVERSAL LIFE ENROLLMENT/WAIVER FORM

CIGNA, the CSU’s Group Universal Life (GUL) Insurance carrier, has revised their enrollment/waiver form. Campuses will now be required to verify an employee’s annual salary by initialling, signing and dating the form.

Employees who elect to enroll in the GUL program must complete the enrollment/waiver form and return it to their campus Human Resources or Payroll department. Campuses must verify the annual salary provided by the employee in Section 2 and forward it to CIGNA for further processing. Because of enrollment time constraints, it is important that campuses turn the forms around as soon as possible.

A supply of the revised enrollment/waiver form is enclosed for your use. Please discard all copies of the old form. If you need additional copies of the form or program brochure, please contact John Swedock, CIGNA Account Manager, at (860) 726-7056. If you have any questions regarding the GUL program, please contact systemwide Benefits Administration at (562) 985-2669.

CR/nle
Enclosure

Distribution (without enclosure):

Presidents
Interim Senior Director, Human Resources
Human Resources Directors
Payroll Supervisors
**California State University**

<table>
<thead>
<tr>
<th>Billing Location:</th>
<th>01-0430</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Code:</td>
<td>CSU Campus:</td>
</tr>
<tr>
<td>Benefits Officer Name:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

### 1. Employee Information

- **Employee Name:** Last | First | M.I. | Sex: [ ] Male [ ] Female
- **Social Security Number:**
- **Date of Birth (MM/DD/YYYY):**
- **Address:** Street | City | State of Residence | Zip Code | Date of Hire (MM/DD/YYYY):
- **Home Telephone Number:** ( )
- **Work Telephone Number:** ( )

### 2. Complete if Electing Employee Coverage

Indicate Insurance Amount:
- [ ] 1x
- [ ] 2x
- [ ] 3x
- [ ] 4x
- [ ] 5x Annual Earnings

Please provide Annual Salary: $________

I elect to contribute $__________ monthly to my Cash Accumulation Fund. (example: $5, $10, $25, etc.)

[ ] I want my coverage increased automatically as my salary increases.

### 3. Complete if Electing Spouse Coverage

I am currently married and my date of marriage is (MM/DD/YYYY): ________________

Indicate Insurance Amount (in $10,000 increments): $________

I elect to contribute $__________ monthly to my spouse’s Cash Accumulation Fund. (example: $5, $10, $25, etc.)

- **Spouse Name:** Last | First | M.I.
- **Spouse Social Security Number:**
- **Spouse Date of Birth (MM/DD/YYYY):**

### 4. Complete if Electing Dependent Children Coverage

(Employee and/or spouse must enroll to elect child(ren) coverage)

I currently have eligible dependent children and elect the following Insurance Amount: [ ] $10,000
5. Enrollment Questions

Complete the following questions for Employee and Spouse if selection exceeds the guaranteed issue amount indicated in the enrollment material.


Have you or your spouse been told that you have, or been treated during the past five years for:

1) Cancer, leukemia, Hodgkin’s disease, tumor or other associated malignancies?
2) Heart disease, stroke, elevated blood pressure, chest pain, or other related cardiovascular disease?
3) Diabetes, disease, or disorder of the thyroid, nervous system, lungs, kidneys, or liver?
4) Any alcohol or drug addiction/abuse?
5) Chronic pneumonia, enlarged lymph nodes, unexplained weight loss, Immune System Disorder, venereal disease, or AIDS (Acquired Immune Deficiency Syndrome), or ARC (Aids Related Complex)?
6) Any other condition for which you have been tested, treated, or told to get treatment, and/or to change or curtail your usual activities (do not include colds or normal pregnancy)?

Employee  Yes  No  Spouse  Yes  No

Please provide details below for those questions which you answered yes.

<table>
<thead>
<tr>
<th>Name of Employee/Spouse</th>
<th>Condition</th>
<th>Date Occurred</th>
<th>Duration</th>
<th>Current Status</th>
</tr>
</thead>
</table>

☐ Check here if additional space is required. Complete and attach a separate sheet of paper. Please sign and date attachment.

6. Beneficiary Designation

Please provide full name and relationship. If designating more than one beneficiary per insured, please indicate by percentage how you want your benefit divided.

For Employee Coverage:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship(s)</th>
<th>%</th>
</tr>
</thead>
</table>

*For Spouse Coverage:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship(s)</th>
<th>%</th>
</tr>
</thead>
</table>

*For Child(ren) Coverage:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship(s)</th>
<th>%</th>
</tr>
</thead>
</table>

*The beneficiary for the Spouse and Child(ren) is the Employee unless otherwise designated.

7. Certification

I understand that my statements and answers above are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage in an amount that exceeds the Guaranteed Issue Amount is subject to approval by the Insurance company. Additional medical information will be required to approve certain amounts of coverage. I also understand that I am responsible to report to the Insurance Company any change in my health prior to the effective date of my coverage and that no coverage will be effective unless I am insurable on the effective date. I certify that I have read the Medical Underwriting Certification and Disclosure Statement and to the best of my knowledge, all the information on this enrollment form is true and complete and that I am actively at work/not disabled.

Employee Signature  Date  Spouse Signature  Date