



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

**Nonmedical
Enrollment & Waiver
Form**

Company name	Group Number	Div/Loc	Class
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A. Employee Information							
Your name (Last, First, Middle initial)				Social Security Number		Effective Date	Hours per week
Address Street or PO Box			City	ST	Zip-code	Salary	Ann
Date of Birth	Gender		Marital Status		Date of Hire		
	Male	Female	Single	Married			

B. Complete for Life and/or Disability Check the box <input checked="" type="checkbox"/> if Electing Coverage							
Basic Life	Accidental Death & Dismemberment	Dependent Life	Short Term Disability	Long Term Disability			
Voluntary Life	Voluntary Long Term Disability	Supplemental Life Amt _____		Supplemental AD&D Amt _____			
	Voluntary Life	Voluntary AD&D		Voluntary Life	Voluntary AD&D		Voluntary Life
(Amount selected) Employee:	\$ _____	\$ _____	Spouse	\$ _____	\$ _____	Child(ren)	\$ _____
Spouse name		Last, First, MI		Birthdate (mm/dd/yy)		Social Security Number	
(Voluntary Life Only)							
Beneficiary for Employee Coverage/Relationship (<i>Employee is Beneficiary for spouse and child coverage</i>) Print as "Doe, Mary A.", not "Mrs. John Doe")							
Last Name		First Name		MI	Relationship to you		

C. Complete for Dental and/or Vision Check the box <input checked="" type="checkbox"/> if Electing Coverage				If Employer offers two Plans: Option 1 Option 2			
Coverage Requested		Dental Employee Only		Vision for Employee Only			
		Dental for Employee and Dependents		Vision for Employee and Dependents			
Dental and/or Vision coverage is for:							
Employee		Employee & Spouse		Employee & Child(ren)		Employee & Family	
*Reason for waiving coverage(s) Please read the Waiving Coverage in Section F. for information relating to consequences of refusing Initial coverage:							
		COBRA, USERRA or State Continuation		Spouse's Group		Other	

D. Complete for Dependent Coverage			Date of Birth	Gender		
Spouse Name (Last, First, MI)			mm/dd/yy	M F		
Dependents	1)					
	2)					
	3)					
	4)					

Note: If you have chosen Life coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete a Statement of Health form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date Nippon Life Benefits approves your Statement of Health form.

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 dental coverage later; however, such enrollment could affect my initial level of dental benefits. (d) I (and my dependents) may enroll for Life and/or Disability 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. 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 and will be used by Nippon Life Benefits to determine insurability. 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 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 two years 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.

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.

Employee signature required _____ **Date signed** _____

Requested date of change _____ **Signed at (City, State)** _____

Instructions

After this form has been completed and signed, send the original to Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, KS 66225-5951, and keep a copy for your records.