



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 | 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 or Domestic Partner | 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 or Domestic Partner | 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 or domestic partner'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 or domestic partner and all eligible children that are applying for coverage.

| | | | | |
|---|------------------------|---------------|------|--------|
| Spouse's or Domestic Partner's name (last, first, middle initial) | Social Security Number | Date of Birth | Male | Female |
|---|------------------------|---------------|------|--------|

Do you and your spouse or domestic partner 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 | | Foster child | | Handicapped child* | Male | Female |
|-----------------------------------|----------------------------|------------------------|---|----|--------------|----|--------------------|------|--------|
| | | | (If yes, please complete questions a. through h. below) | | | | | | |
| 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 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 nonmedical 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 rescinded at any time within the first twenty-four months of coverage 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 short term and long term 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 information to obtain or amend insurance coverage or to make a 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.

BINDING ARBITRATION DISCLOSURE

Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, will be determined by final and binding arbitration administered by the American Arbitration Association ("AAA") under its Commercial Arbitration Rules and Mediation Procedures ("Commercial Rules"). Binding arbitration will be used to settle all disputes, including claims of medical malpractice. The award rendered by the arbitrator[s] will be final and binding on the parties and may be entered and enforced in any court having jurisdiction, and any court where a party or its Consolidation, joinder.

For those cases or disputes for which the total amount of damages claimed is greater than fifty thousand dollars, there will be three arbitrators. The parties agree that one arbitrator will be appointed by each party within twenty (20) days of receipt by respondent[s] of the Request for Arbitration or in default thereof appointed by the AAA in accordance with its Commercial Rules, and the third presiding arbitrator will be appointed by agreement of the two party-appointed arbitrators within fourteen (14) days of the appointment of the second arbitrator or, in default of such agreement, by the AAA. For those cases or disputes for which the total amount of damages claimed is fifty thousand dollars or less, a single neutral arbitrator will be selected by the parties with no jurisdiction or authority to award more than fifty thousand dollars. If the parties are unable to agree on the selection of a single neutral arbitrator, the arbitrator will be selected in accordance with the method provided in California Code of Civil Procedure § 1281.6.

If more than one arbitration is commenced under this Agreement and any party contends that two or more arbitrations are substantially related and that the issues should be heard in one proceeding, the arbitrators selected in the first-filed proceeding will determine whether, in the interests of justice and efficiency, the proceedings should be consolidated before those arbitrators. The Parties to this Agreement are bound to each other by this arbitration clause, provided that they have signed this Agreement. Each related party may be joined as an additional party to an arbitration involving other parties under this Agreement.

The seat or place of arbitration will be San Diego, California. The arbitration will be conducted and the award will be rendered in the English language. Except as may be required by law, neither a party nor the arbitrators may disclose the existence, content or results of any arbitration without the prior written consent of both parties, unless to protect or pursue a legal right. The arbitrators will have no authority to award punitive damages, consequential damages, or liquidated damages. The parties also agree that the AAA Optional Rules for Emergency Measures of Protection will apply to the proceedings.

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.

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 or domestic partner 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.