Life Insurance Company of North America (LINA)

GROUP TERM LIFE INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any requested information below. Don't forget to include your Social Security Number, herein shown as SSN, Birthdate, sign your name and enter today's date.

Return completed form to: The Insurance Department

EMPLOYER: Capistrano Unified School District

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ SSN _____ Date of birth _____

Home Address _____ City _____ State _____ Zip _____

Email _____ Home/Cell Phone _____ Employee ID # _____ Gender: _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER**

To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer.

❑ I am currently married and my date of marriage is _____

❑ I am currently in a Domestic Partnership and the date of formation of my Domestic Partnership is _____

Spouse or Domestic Partner Name _____ SSN _____ Date of birth _____ Gender_____

YOUR COVERAGE ELECTIONS

View the Summary of Benefits for costs and instructions for how to calculate premium.

Employee-Paid Term Life Insurance – Policy # FLX0971055 Underwritten by LINA		
Choose your desired coverage amount below and who you would like to cover. See the Summary of Benefits for costs.		
Who You Want to Cover	**Coverage Amount**	**Accept your desired coverage amount or decline coverage below.**
❑ Employee	Units of $10,000 up to $500,000 Guaranteed Issue Amount***: $200,000	❑ $10,000 ❑ $200,000*** ❑ $500,000**** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
❑ Spouse or Domestic Partner	Units of $10,000 up to $500,000, not to exceed 100% of the employee's benefit Guaranteed Issue Amount***: $50,000	❑ $10,000 ❑ $50,000*** ❑ $500,000**** ❑ Other _____ *Amount must be a multiple of $10,000. The amount cannot exceed 100% of the employee's coverage.* ❑ Decline Coverage
❑ Children	Units of $1,000 up to $10,000 Guaranteed Issue Amount***: All amounts	❑ $1,000 ❑ $10,000**** ❑ Other _____ *Amount must be a multiple of $1,000.* ❑ Decline Coverage

If Children are elected, all eligible dependent children will be covered.

*** Guaranteed Issue Amount is only available if enrolling within the first 31 days of eligibility. For any coverage that is not Guarantee Issue, you must complete the Evidence of Insurability Form. Amounts of insurance may be limited by state law.

****This is the maximum coverage amount that you can choose under this plan. Coverage elected during this enrollment period will take effect on the later of 05/01/2026, the date your election form is received by your Employer, or if applicable the date your Evidence of Insurability Form is approved by the Insurance Company.

**Domestic Partner is defined in the Group Policy. For purposes of this form, wherever the term Spouse appears, it shall also include Domestic Partner and Domestic Partners registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your employer. Spouse includes Partners in Civil Union relationships for residents of Vermont and State registered Domestic Partners for residents of Oregon.

SIGN TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. I understand that coverage is subject to the insurance company's approval and 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 go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Caution: For your protection California law requires the following statement 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.

Please Sign Here Signature _____ Date _____

Created on 03/2026.