

Dependent Information: Please list your spouse, domestic partner and all eligible children. (continued)**

Dependents must meet eligibility requirements. Foster child and stepchild eligibility is subject to approval by Nippon Life Insurance Company of America (Nippon Life Benefits). Complete a Foster Child or Stepchild Questionnaire. A domestic partner must elect coverage for the domestic partner's children to be eligible for coverage. If you have developmentally disabled/physically handicapped children over age 19 (or any other age as required by state law) complete an Application to Continue Handicapped Child. Contact your employer for assistance with any questions.

Employee Signature (please read and sign)

I request to be covered. If the group plan provides that contributions be made by me, I authorize my employer to deduct from my pay.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

Date signed _____ Signature of member _____
|X

Employer to Complete

Date employed	Occupation	Earnings				Location
		\$	yr	wk	mo	
Employer _____						

Waiver of Group Coverage Applicable only to Coverages for which you Contribute

I hereby certify that I have been given the opportunity to apply for group coverage. I understand that benefits available and I DECLINE to enroll myself my spouse and/or my child(ren)

for: _____ coverage(s)

because: _____

I understand

- a) if I waive any coverage for myself, my dependent(s) are not eligible for that coverage.
- b) if I waive any coverage for myself or for my dependent(s), I (and/or my dependents) will not be able to enroll in the plan without proof of good health. Medical information will be provided at my own expense. Coverage will not become effective until approved by Nippon Life Insurance Company of America, subject also to actively-at-work and period of limited activity provisions.
- c) that health conditions which may be present now or develop later may prevent me (and/or my dependents) from ever being approved for coverage.
- d) I can not, under any conditions, re-enter the plan as a retired person.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form 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. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

The information given on this waiver is correctly recorded, completed and true to the best of my knowledge and belief.

_____ Date signed _____ Signature of member _____ Group number _____

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.