<table>
<thead>
<tr>
<th></th>
<th><strong>Active Employees</strong></th>
<th><strong>Retirees</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indivduals Term Life Insurance Benefit Amount</strong></td>
<td>1.8X Current Annual Salary</td>
<td>1.8X Current (Reduced) Annual Pension*</td>
</tr>
<tr>
<td><strong>Premium Rate per $1,000 Coverage</strong></td>
<td>$0.75 payable bi-weekly</td>
<td>$0.81 payable semi-monthly</td>
</tr>
<tr>
<td><strong>Employer Cost Sharing</strong></td>
<td>50/50</td>
<td>50/50</td>
</tr>
<tr>
<td><strong>Minimum/Maximum Coverage Amount</strong></td>
<td>$5,000/$90,000</td>
<td>$5,000/$90,000</td>
</tr>
<tr>
<td><strong>AD&amp;D Rider Included</strong></td>
<td>Yes, up to age 70</td>
<td>No</td>
</tr>
<tr>
<td><strong>Living Benefit Rider Included</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Optional Dependent Coverage Available</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

* - Current (Reduced) Annual Pension equals 75% of the full annual pension amount regardless of retirement date.

NOTE: Premium refund requests must be submitted to INSURANCE COMPANY within 120 days of the effective date of individual participant termination. In any event, the maximum refund amount is 120 days of premium most recently remitted to insurance company for the terminating individual.

### Optional Dependent Coverage Schedule

<table>
<thead>
<tr>
<th></th>
<th><strong>Option 1</strong></th>
<th><strong>Option 2</strong></th>
<th><strong>Option 3</strong></th>
<th><strong>Option 4</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>$10,000</td>
<td>$25,000</td>
<td>$40,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>Children (14 days to under 1 year)</td>
<td>$6,000</td>
<td>$6,000</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Children (1 year through 18*)</td>
<td>$10,000</td>
<td>$15,000</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Parents/Parents-in-Law</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>$5,000</td>
</tr>
<tr>
<td>IAC Bi-Weekly Rate</td>
<td>$4.95</td>
<td>$7.95</td>
<td>$10.95</td>
<td>$36.95</td>
</tr>
</tbody>
</table>

* - Single and dependent on parent for support. Coverage is available for children through age 24 if full-time student. For complete provisions, see the Dependents Term Life Insurance rider.
CNMI GOVERNMENT GROUP LIFE INSURANCE ENROLLMENT FORM

[ ] Re-Enrollment  [ ] New Enrollee  [ ] Change  [ ] Termination

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Government Department</th>
<th>Employment Date</th>
<th>Social Security Number</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>☐ Married/Common-Law  ☐ Single</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>☐ Active; 20 or more hours per week  ☐ Retiree  Name of employer retired from:</th>
</tr>
</thead>
</table>

Are you presently on leave of absence from work due to sickness, injury, medical treatment, or unpaid leave of absence for personal reasons?  ☐ Yes  ☐ No  If yes, identify the leave and state the reason(s):

INDIVIDUAL’S TERM LIFE INSURANCE  Available to Active Employees and Retirees

[ ] I want Individual’s Term Life Insurance

OPTIONAL DEPENDENT’S TERM LIFE INSURANCE  Available to Active Employees Only

[ ] I elect Dependent’s Term Life Insurance  Option:  ☐ 1  ☐ 2  ☐ 3  ☐ 4

Option 4 only: Complete the following for each parent/parent in-law to be covered. Evidence of insurability is required.

Name (last, first, middle)  Relationship  Name (last, first, middle)  Relationship

Complete the following for all other non-parent Dependents to be covered.

Name (last, first, middle)  Date of Birth  Social Security Number  Relationship

The Employee is the beneficiary of Dependent Life Insurance benefits.

[ ] I WAIVE the optional Dependent’s Term Life Insurance coverage. I understand that I will have NO Dependent’s Term Life Insurance coverage, and if I apply at a later date, I will be required to furnish evidence of insurability.

BENEFICIARIES  The total of the Percentage column must equal 100%, or check here  ☐ for equal shares.

<table>
<thead>
<tr>
<th>Legal Name (last, first, middle)</th>
<th>Relationship</th>
<th>Age or Date of Birth</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>%</td>
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<td></td>
<td>%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>%</td>
</tr>
</tbody>
</table>

☐ Minor Beneficiary Form completed

INSURANCE AUTHORIZATION

By signing below, I declare that the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I apply for coverage more than 61 days from my Employment Date, I will be required to furnish evidence of insurability for all individuals for whom coverage is requested. I also understand that regardless of when enrollment occurs, the addition of new parent(s) always requires completion of evidence of insurability. Coverage is not effective until approved by Individual Assurance Company. I authorize my employer to deduct from my earnings the required cost of the coverage(s) I have elected above.

Signature:  Date:

FOR EMPLOYER USE ONLY

Annual Salary: $___________  Basic Life Coverage: $___________  Premium Deduction: $___________  Process Date: __________

Underwritten by Individual Assurance Company, Life, Health & Accident, 3200 E. Memorial Road, Suite 100, Edmond, OK 73013

IAC 1000ER(MP)(2014)
EVIDENCE OF INSURABILITY

GROUP DIVISION ________________ GROUP POLICY NUMBER ________________

Amount of Insurance Applied for $ ________________

S.S.# ________________ Married □ Divorced □ Single □ Legally Separated □

State of Birth ________________

Full Name ___________________________ Occupation ___________________________

Last First Middle

Residence Address __________________________________________________________________________

Street and Number __________________________________________________________________________

City ________________ State ________________ Zip Code ________________

Name of Employer ___________________________ Dept/Branch ___________________________

Date Employed _______________________

Employee □

Spouse □

1st Child □

2nd Child □

3rd Child □

4th Child □

Parent □

Parent In-Law □

Parent In-Law □

HEALTH STATEMENT OF EMPLOYEE AND DEPENDENT (if dependent coverage is desired)

Have you ever been treated for, or diagnosed as having, any of the following conditions:

1. any disease or disorder of the heart or circulatory system? □

2. cancer, diabetes, stroke, or lung disorder? □

3. liver or kidney disease? □

4. AIDS or tested positive for HIV? □

5. alcohol or drug abuse? □

Give details for any “yes” answer above (use reverse side if more room is required):

Name ___________________________ Condition (Diagnosis) ___________________________

Dates Treated ___________ Results of Treatment (Recovered?) ___________________________

Full Name & Address of Physicians Consulted __________________________________________________________________________

Witness Signature ___________________________ Proposed Insurer’s Signature ___________________________

Spouse’s Signature, if to be insured □ ___________________________ Date ___________________________

APPLICATION WILL BE RETURNED UNLESS ALL QUESTIONS ARE ANSWERED.
INSURANCE WILL NOT BE IN FORCE UNTIL THE APPLICATION IS APPROVED BY THE COMPANY.

IAC 1006EOI-01(2014)

CONSOMER PROTECTION NOTICES FOR THE APPLICANT

Investigative Consumer Report Notice – In connection with your application for insurance, an investigative consumer report may be prepared, in which information is obtained from public records and through personal interviews with your neighbors, friends, employers, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may make a written request to receive additional, detailed information about the nature and scope of this investigation. Either of these written requests should be directed to the Underwriting Department, Individual Assurance Company, 3200 E. Memorial Road, Suite 100, Edmond, OK 73013.

MIB, Inc. Notice – Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact the MIB at 866.692.6901 (TTY 866.346.3642 for hearing impaired). If you question the accuracy of the information in the MIB’s file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

IAC INC(2012)
### DISTRIBUTION OF PROCEEDS ELECTION FORM

**MINOR BENEFICIARY**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Owner (if other than insured)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NAMED MINOR BENEFICIARY(IES)

<table>
<thead>
<tr>
<th>Name (print in full)</th>
<th>Relationship</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### CONTINGENT

<table>
<thead>
<tr>
<th>Name (print in full)</th>
<th>Relationship</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Should I die while any of the beneficiaries named above is a minor, I desire the benefits to be held in an annuity fund with the Company and paid out in a lump sum payment upon the beneficiary’s ____________ (not less than 18th) birthday.

I direct that any amendment of the policy requested above take effect on the date this request is signed but without any liability to the Company on account of payment made or action taken by it before this request was acknowledged by the Company. I agree that the Company may waive any policy provision requiring presentation of the policy for endorsement but may require such presentation, if desired.

_________________________  ___________________________
Signature of Owner Date

The undersigned agrees to the above requests and changes.

_________________________  ___________________________
Signature of Owner’s Spouse Date
(If resident of community property state)

_________________________  ___________________________
Signature of Assignee Date
(Signature of Irrevocable Beneficiary)
(If any)