APPLICATION/ENROLLMENT FORM

NIPPON LIFE INSURANCE COMPANY OF AMERICA

521 Fifth Avenue
New York, New York 10175

Enrollment Instruction:
Please read carefully and provide complete information as requested on this Employee Enrollment Form. It is extremely important that any present and/or past medical history relating to you, your spouse, and/or your other dependents be accurately and completely explained. The "Waiver of Group Coverage" section on the reverse side must be completed in order to waive coverage. Please print legibly.

CHECK ONE			FOR OFFICE USE ONLY		
New Enrollee	Adding Dependents	Other	Eff. Date	Group #	Plan

EMPLOYEE DATA					
Employee's Name (First, Middle, Last)	Marital Status	Occupation(Be specific)		Date Employed (Full-time)	Hours Worked Per Week
Address	Apt. No.	City	State	Zipcode	County
Home Phone ( )	Work Phone ( )	Employer's Name	Dept.		Annual Salary

COVERAGE SELECTION AND ENROLLMENT

I am selecting coverage for: Employee Employee and Spouse Employee and Children Employee, Spouse and Child(ren)

Please complete all information on self and family, whether applying for coverage or not

Name (First MI Last)	Relationship	Date of Birth	Social Security Number	Sex	Height	Weight	Other Coverage	Student
	Employee						Yes No	
	Spouse						Yes No	
	Child						Yes No	Yes No
	Child						Yes No	Yes No

List additional children on a separate sheet and staple to this form.

MEDICAL INFORMATION

Employee must answer the following questions on self and dependents, whether applying for coverage or not: **YES** **NO**

1. Within the past 5 years, have you or any dependent had or been treated for heart disorder(s), high blood pressure, stroke, cancer, tumor, diabetes, kidney or liver disease, an immune deficiency disorder, AIDS, AIDS-Related Complex (ARC), respiratory disorder(s), or any mental or nervous disorder?
2. Have you or any dependent ever had an application for insurance declined, postponed, rated or otherwise modified?
3. Have you or any dependent, within the last 12 months, incurred more than $5,000 in medical expense?
4. Are you or any family member currently pregnant? If "Yes", give approximate due date: _____
5. Within the past 5 years, have you or any dependent had or been treated for any of the following:
   a. arthritis, back bone or joint disorder?
   b. seizures, convulsions, fainting spells or epilepsy?
   c. digestive system disorder, ulcer, liver, colon or rectal disorder?
6. Within the past 3 years, have you or any dependent:
   a. been confined to a hospital or similar institution?
   b. consulted or been treated by a physician, psychiatrist, psychologist, or other practitioner?
   c. taken any medication?
   d. had any symptoms not previously indicated?
7. Have you or any dependent ever used marijuana, cocaine, heroin or any other drugs not prescribed by a physician?

Details to "Yes" answers from questions 1-7, above

Question Number	Family Member	Nature of illness or injury (If operation performed, state type)	Date of Onset	Date last Seen by Dr.	Still under Doctor's care
					Yes No
					Yes No
					Yes No

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The Health Insurance Portability & Accountability Act of 1996 (H.R. 3103) provides for federal penalties of up to 5 years imprisonment for intentional misrepresentation of information in any application for healthcare benefits.