

Health Care Enrollment

COMPLETE ALL SECTIONS:

SECTION I - ENROLLMENT DATE

EFFECTIVE DATE (DATE OF HIRE)

SECTION II - PERSONAL INFORMATION

YOUR FULL NAME (LAST, FIRST, MIDDLE)

MAILING ADDRESS (STREET, APT. NO.)

CITY

STATE

ZIP CODE

HOME TELEPHONE NUMBER

()

SOCIAL SECURITY NUMBER

MARITAL STATUS

JOB TITLE

IN CASE OF EMERGENCY, CONTACT

RELATIONSHIP

EMERGENCY TELEPHONE NUMBER

()

SECTION III - MEDICAL PLAN ELECTION. SELECT ONE MEDICAL PLAN BELOW (INCLUDES DENTAL, VSP, CHEMICAL DEPENDENCY & EAP):

PLAN & LOCATION	GROUP #	PLAN & LOCATION	GROUP #	PLAN & LOCATION	GROUP #
<input type="radio"/> Anthem Blue Cross HRA (PPO) California	1793UR	<input type="radio"/> Kaiser Georgia HMO Georgia	2857-00-28	<input type="radio"/> Keystone Pennsylvania	514936
<input type="radio"/> Anthem Blue Cross HRA (PPO) Outside California	1793UT				
<input type="radio"/> Kaiser California HMO California	472	<input type="radio"/> Kaiser Oregon HMO Oregon	7885-AA-10	<input type="radio"/> Preferred Plus of Kansas HMO Kansas	500259

SECTION IV - COVERED INDIVIDUALS

LIST YOURSELF AND ALL PERSONS COVERED BY THIS ENROLLMENT. ONLY YOUR SPOUSE, CERTIFIED DOMESTIC PARTNER AND/OR DOMESTIC PARTNER CHILD(REN), AND UNMARRIED DEPENDENT CHILDREN MAY BE INCLUDED.

ADD/ DELETE	RELATION- SHIP	LAST NAME/FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY #	SEX	COVERED UNDER ANOTHER HEALTH PLAN?	PRIMARY CARE PHYSICIAN	FOR OFFICE ONLY
<input type="radio"/> ADD <input type="radio"/> DELETE	SELF		/ /	- -	OM OF	<input type="radio"/> YES <input type="radio"/> NO		
<input type="radio"/> ADD <input type="radio"/> DELETE	SPOUSE/DP		/ /	- -	OM OF	<input type="radio"/> YES <input type="radio"/> NO		
<input type="radio"/> ADD <input type="radio"/> DELETE	CHILD		/ /	- -	OM OF	<input type="radio"/> YES <input type="radio"/> NO		
<input type="radio"/> ADD <input type="radio"/> DELETE	CHILD		/ /	- -	OM OF	<input type="radio"/> YES <input type="radio"/> NO		
<input type="radio"/> ADD <input type="radio"/> DELETE	CHILD		/ /	- -	OM OF	<input type="radio"/> YES <input type="radio"/> NO		
<input type="radio"/> ADD <input type="radio"/> DELETE	CHILD		/ /	- -	OM OF	<input type="radio"/> YES <input type="radio"/> NO		
<input type="radio"/> ADD <input type="radio"/> DELETE	CHILD		/ /	- -	OM OF	<input type="radio"/> YES <input type="radio"/> NO		

SECTION V - EMPLOYEE'S SIGNATURE

I authorize LSI to withhold any necessary health premiums on a pretax basis through payroll deductions.

SIGNATURE

DATE

Employee Pretax Health Care Contributions

Pretax Group Health Plan Contributions

Payroll deductions occur every paycheck effective January 1, 2009.

The medical plans listed below included dental, vision, EAP and chemical dependency.

Location	Medical Plan	Employee Only	Plus 1 Dependent	Plus 2 Dependents	Plus 3 or More
California	Anthem Blue Cross HRA (PPO)	\$25	\$80	\$95	\$105
California	Kaiser	\$40	\$120	\$155	\$165
Georgia	Anthem Blue Cross HRA (PPO)	\$25	\$80	\$95	\$105
Georgia	Kaiser	\$35	\$105	\$135	\$145
Kansas	Anthem Blue Cross HRA (PPO)	\$25	\$80	\$95	\$105
Kansas	Preferred Plus of Kansas	\$35	\$105	\$135	\$145
Oregon	Anthem Blue Cross HRA (PPO)	\$25	\$80	\$95	\$105
Oregon	Kaiser	\$40	\$120	\$155	\$165
Pennsylvania	Anthem Blue Cross HRA (PPO)	\$25	\$80	\$95	\$105
Pennsylvania	Keystone	\$50	\$145	\$175	\$210
All Locations	Anthem Blue Cross HRA (PPO)	\$25	\$80	\$95	\$105
International Assignment Only					
	Cigna International	\$40	\$120	\$155	\$165

Please note: Actual costs for Domestic Partner coverage will vary due to IRS tax treatment of this benefit.

Instructions for Waiver of the LSI Group Health Coverage

You have the opportunity to waive participation in LSI's group medical-dental-vision coverage for your dependents and, in some instances, for yourself. If you waive LSI's coverage, you can enroll in the plan at a later date, but only in two situations:

1. During LSI's annual Benefits Open Enrollment, or
2. Within 31 days of a "Change in Family Status"

If you decide to enroll your dependents (or yourself) during an open enrollment period, the coverage will become effective on the date specified. However, pre-existing medical conditions will apply under the Anthem Blue Cross Health Reimbursement Account (HRA) PPO plan and if newly enrolled individuals had no medical coverage for the 6-month period immediately before enrolling. In addition, coverage under the LSI Dental Plan for orthodontic coverage becomes effective 12 months after the enrollment date.

If you decide to enroll your dependents (or yourself) within 31 days of a Change in Family Status, your coverage is effective on the date of the status change. The Anthem Blue Cross HRA (PPO) pre-existing condition limitation will also apply with enrollments under Change in Family Status if newly enrolled individuals had no medical coverage immediately before enrolling. In addition, the LSI Dental Plan has a provision for which orthodontic coverage becomes effective 12 months after the enrollment date. A Change in the Family Status is defined as one of the following:

- ✓ Your Marriage or Divorce
- ✓ Your spouse's new employment or termination of employment
- ✓ Birth or Adoption of a Child
- ✓ Death of a Dependent

Once you waive coverage for your dependents or yourself, the above are the circumstances under which you can enroll at a later date without incurring the pre-existing limitation even if you can provide evidence of good health.

If you do not want to cover your dependents under LSI's group health plan, complete Section I on the Application for Waiver of the LSI Group Health Coverage form and sign/date at the bottom.

You may waive the LSI group health coverage on yourself in the following circumstances:

- ✓ If you and your spouse are both LSI employees, one of you can waive employee coverage and be covered as the other's dependent. You must do so for LSI's entire medical-dental-vision package. Employees covered as dependents will be treated as employees for LSI's life, AD&D, BTA and long term disability coverages.
- ✓ You can waive LSI health coverage if you are covered for medical by your spouse's employer's plan. You must waive participation in the LSI medical-dental-vision package.
- ✓ Other reasons for waiving LSI employee-only health coverage will be considered on a case-by-case basis.

If you wish to waive LSI's group health coverage for yourself, complete Section II of the Application for Waiver of the LSI Group Health Coverage, then sign and date at the bottom.

Application for Waiver of the LSI Group Health Coverage

I have read the waiver of group health coverage instructions and understand the consequences of opting out of LSI group health coverage. I waive my right to enroll as follows:

SECTION I

☐ I elect not to cover my eligible dependents for Group Health Coverage.

Date Effective: _____

SECTION II

☐ I elect not to cover myself for Group Health Coverage for the following reason:

Date Effective: _____

☐ My spouse and I are both employees of LSI and I elect to be covered as a dependent under my spouse's health coverage.

My spouse's name is _____

☐ I am covered under my spouse's employer's medical plan as a dependent.

My spouse's name is _____

My spouse's employer is _____

The insurance company I am covered by is _____

☐ Other reasons are subject to approval. Attach a written explanation if you need more room.

PRINT NAME:

SOC. SEC. #:

SIGNATURE:

DATE:

LSI APPROVAL:

PRINT NAME:

TITLE:

SIGNATURE:

DATE:

LSI HR Information Center • Mail Stop AL100 • Fax 719-533-7668

Definition and Eligibility for Employee Domestic Partners

Definition of Domestic Partner

LSI Corporation defines Domestic Partner as the partner of a benefit eligible employee who is of the same or opposite sex, sharing a long-term committed relationship of indefinite duration with the following characteristics:

- Living together for at least 6 months in the same household
- Having an exclusive mutual commitment similar to that of marriage
- Financially responsible for each other's well-being and debts to third parties. This means that you have entered into a contractual commitment for that financial responsibility or have joint ownership of significant assets (such as home, car, bank accounts) and joint liability for debts (such as mortgages and major credit cards)
- Neither partner is married to anyone else nor has another Domestic Partner
- Partners are not related by blood closer than would bar marriage in the state of their residence

Eligibility Requirements for your Partner's Child(ren)

Eligible children include:

- Your Partner's unmarried children, from birth to age 19, including legally adopted children and foster children who depend on you or your Partner for support and maintenance, or who are the subject of a qualified court order relating to health coverage:
- Your Partner's unmarried dependent children ages 19 through the end of the month of their 25th birthday who are full-time students at least eight months a year
- Your Partner's unmarried child who is totally disabled and incapable of earning a living on the date coverage would otherwise end by reason of age. The child must be dependent on you or your Partner for support and live with you. The child's coverage will remain in effect as long as the disability continues and the child continues to qualify for coverage in all other aspects.

The carrier or the plan administrator may require evidence of dependency and/or disability.

Plans available for enrollment include:

<u>Plan & Location</u>	<u>Group #</u>
Anthem Blue Cross Lumenos HRA (PPO)	
California	1793UR
Outside California	1793UT
California Kaiser	472
Keystone	
Pennsylvania	514936

Domestic Partnership Certification

Employee:

Last Name	First Name	MI	Social Security Number	Date of Birth
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Domestic Partner:

Last Name	First Name	MI	Date of Birth
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Partner's Dependent Children:

Last Name	First Name	MI	Date of Birth
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Last Name	First Name	MI	Date of Birth
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Last Name	First Name	MI	Date of Birth
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For your Partner, complete section A below. For your Partner's child(ren) complete section B below.

A. Partner Certification

I hereby certify that the above named person and I meet all of the eligibility requirements as "Domestic Partners" under LSI's health care policy as set forth above, including acknowledgement of financial responsibility for each other. I understand that (1) falsely certifying eligibility or failing to inform LSI if we cease to meet eligibility requirements in any respect could result in disciplinary action, including termination of employment and loss of health, dental and vision coverage for my non-qualified Partner, (2) that LSI's health care providers may ask me to provide evidence that the eligibility requirements are being met, (3) that LSI's health care cost of providing these benefits to my domestic partner will be included on my W2 as taxable income, and (4) that it is possible that this Certification could be used as evidence by creditors of my Domestic Partner.

Signature of Employee: _____ Date: _____

Signature of Domestic Partner: _____ Date: _____

B. Dependent Child(ren) Certification

I hereby certify that the above-named child(ren) of my Partner meet all of the eligibility requirements. I understand that falsely certifying as to a dependent's eligibility or failure to inform LSI when a dependent no longer meets applicable eligibility requirements could result in disciplinary action, including termination of employment and loss of health, dental and vision coverage for my non-qualified Partner and/or Partner's child(ren).

Signature of Employee: _____ Date: _____

STATE OF _____	
County of _____	
On _____ DATE	before me, _____ NAME, TITLE OF OFFICER – e.g. "JANE DOE, NOTARY"
Personally appeared _____ NAME(S) OF SIGNER(S)	
<input type="checkbox"/> personally known to me - OR - <input type="checkbox"/> proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.	
WITNESS my hand and official seal.	
SIGNATURE OF NOTARY	

Basic Life, AD&D, and Business Travel Accident Insurance

COMPLETE ALL SECTIONS - Please Print

SECTION I - PERSONAL INFORMATION (NEW EMPLOYEES' "EFFECTIVE DATE" IS DATE OF HIRE.) EFFECTIVE DATE: _____ NAME (Last, First _____)	FOR OFFICE USE ONLY: Date HR Received _____ HR Initials _____
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SECTION II - BASIC LIFE

LSI pays for your Life Insurance premiums. Under federal tax laws, if your employer-paid life insurance amount is more than \$50,000, the premiums for coverage above \$50,000 will be added to the earnings reported on your annual W-2. This is called imputed income. You will pay applicable taxes on this amount.

SELECT ONE OF THE FOLLOWING LSI CORPORATION BASIC LIFE INSURANCE COVERAGE OPTIONS.

Employee (35+ hours per week)	Employee (30-34 hours per week)	Employee (20-29 hours per week)
____ 2X annual base salary	____ 1.5X annual base salary	____ 1X annual base salary
____ 1.5X annual base salary	____ 1X annual base salary	
____ 1X annual base salary	____ 2X annual base salary to a max. of \$50K	
____ 2X annual base salary to a max. of \$50K		

All coverage is to a maximum of \$1,500,000, unless otherwise noted.

Your spouse's signature is required if you choose a coverage amount that is less than the maximum available to you.

SPOUSAL ACKNOWLEDGEMENT:

It is with my knowledge that my spouse has elected the above basic life insurance policy as provided by LSI Corporation.

SPOUSAL SIGNATURE _____ DATE _____

SECTION III - BENEFICIARY DESIGNATION

Primary Beneficiary(ies): I hereby designate the following beneficiary(ies), hereby revoking all prior designations for the LSI Corporation Life Insurance policies:

Name	Relationship	Address (Street, City, State, Zip Code)	% of Total
1. _____	_____	_____	_____
2. _____	_____	_____	_____

Secondary Beneficiary(ies): I hereby designate the following beneficiary(ies), hereby revoking all prior designations for the LSI Corporation Life Insurance policies:

Name	Relationship	Address (Street, City, State, Zip Code)	% of Total
1. _____	_____	_____	_____
2. _____	_____	_____	_____

SECTION IV - SIGNATURE

Unless otherwise provided herein, if two or more primary beneficiaries are named for the LSI Basic, AD&D and Business Travel Accident Insurance policies, the proceeds shall be paid in equal shares to the named primary beneficiaries if surviving the insured, or to the survivor or survivors. If no primary beneficiary survives, payment shall be made to the named secondary beneficiaries if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. Subject to revocation by me by written notice to my employer, I request the coverage provided from time to time by my employer's group plan(s) and authorize the required payroll deduction (if any) from my wages.

SIGNATURE _____ DATE _____

LSI Voluntary or Short Term Disability Plans Election Form

Please designate your election for coverage in the LSI Voluntary or Short Term Disability Plan by completing the form below.

ELECTION TO PARTICIPATE - CALIFORNIA EMPLOYEES ONLY

I elect to participate in the LSI Voluntary Disability Plan as follows and authorize deductions from my wages in each calendar year during which I am a participant in the Plan:

- ☐ Voluntary Disability Basic Plan Only (2009 maximum benefit of \$959/week).
- ☐ Voluntary Disability Basic Plan and Supplemental Disability Plan (2009 maximum benefit of \$2,400/week).

ELECTION TO PARTICIPATE - NON-CALIFORNIA EMPLOYEES

- ☐ I elect to participate in the LSI Short Term Disability Plan and authorize deductions from my wages in each calendar year during which I am a participant in the Plan.

Once enrolled in either the California Supplemental Short Term Disability Plan or the Non-California Short Term Disability Plan, your benefit coverage will not change upon relocation to a different site in the United States.

REJECTION OF COVERAGE

- ☐ I reject participation in the LSI Voluntary Disability Basic Plan, the Supplemental Disability Plan, or the Short Term Disability Plan. I understand that if I should later wish to enroll in the Plan that I will be required to provide satisfactory evidence of my good health and that my participation will be subject to the approval of the Plan Administrator.

California Employees: If you reject the Voluntary Disability Plan, you will be covered by the California State Disability Insurance Plan. Premiums for the California State Disability Insurance Plan are higher than the LSI Voluntary Disability Basic Plan.

PERSONAL INFORMATION	
NAME (PLEASE PRINT)	STATE OF RESIDENCE
SIGNATURE	DATE
SOCIAL SECURITY NUMBER	
FOR HR USE ONLY	
EFFECTIVE DATE	RECEIVED BY

Flexible Spending Accounts

ELECTION FORM

LSI Corporation _____ Employee Name _____

Plan Year _____ Social Security # _____

Pay Periods in Plan Year _____ Address _____

Date of Hire _____

DEPENDENT CARE REIMBURSEMENT ACCOUNT ELECTION

The Dependent Care Reimbursement Account allows you to use pre-tax dollars to pay for eligible dependent care expenses which enable you and your spouse, if applicable, to work.

FOR PAYROLL USE ONLY

Total Contribution for the remainder of current year (\$5,000 annual max) \$ _____ ÷ _____ = \$ _____
No. of Pay Periods within Plan Year Your Pay Period Pre-Tax Salary Reduction

HEALTH CARE EXPENSE ACCOUNT ELECTION

The Health Care Expense Account allows you to use pre-tax dollars to pay for expenses which are not 100% covered or are ineligible for payment through any group health care plan(s) under which you or your spouse are covered.

FOR PAYROLL USE ONLY

Total Contribution for the remainder of current year (\$5,000 annual max) \$ _____ ÷ _____ = \$ _____
No. of Pay Periods within Plan Year Your Pay Period Pre-Tax Salary Reduction

I authorize the above selections and the subsequent adjustments to my base annual salary, I am aware that I have a grace period (see "Program Highlights") in which to submit reimbursement requests for expenses incurred during the plan year. Upon expiration of the grace period, any unused funds will be forfeited. I understand that my elections are binding for the entire plan year and cannot be altered unless I experience a family status change.

Signature _____

Date _____

LSI HR Information Center • Mail Stop AL100 • Fax 719-533-7668

Includes Dependent and Healthcare Accounts

Company: LSI Corporation

I (we) hereby authorize TRI-AD to initiate credit entries and to initiate if necessary debit entries and adjustments for any credit entries in error to my (our) checking/savings account indicated below.

SECTION I – BANK INFORMATION		
BANK NAME	BRANCH	TYPE OF ACCOUNT (CIRCLE) CHECKING SAVINGS
ADDRESS (STREET)	CITY/STATE	ZIP CODE

[illegible]

TRI-AD WILL PROVIDE ME WITH A NOTIFICATION OF DEPOSITOR STATEMENT which will include amount deposited to my checking/savings account and date of the transfer deposit. This authority is to remain in full force and effect until Bank has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Bank a reasonable opportunity to act on it, or until BANK has sent me (or either of us) ten (10) days written notice of BANK'S termination of this arrangement.

SECTION III - EMPLOYEE INFORMATION	
YOUR FULL NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY # / /
DAY TIME PHONE	HOME PHONE

SECTION IV – SIGNATURE	
EMPLOYEE SIGNATURE	DATE

SECTION V – OTHER SIGNATURE (IF JOINT ACCOUNT)	
SPOUSE SIGNATURE	DATE

Please mail or fax this completed form and voided check (if applicable) to:

**TRI-AD
FSA Administration Unit
221 W. Crest Street, Suite 300
Escondido, CA 92025**

Voluntary Term Life Insurance Application

SECTION I - EMPLOYEE INFORMATION

YOUR FULL NAME (LAST, FIRST, MIDDLE)		HIRE DATE
ADDRESS (STREET)	CITY/STATE	ZIP CODE

SECTION II - COVERAGE ELECTION AMOUNTS

Applicant	Name	Male	Female	Birth Date	Amount	Guaranteed Issue Limit	Maximum Issue Limit
Employee	_____	<input type="radio"/>	<input type="radio"/>	_____	No. of \$10,000 units _____	\$400,000*	\$750,000**
Spouse	_____	<input type="radio"/>	<input type="radio"/>	_____	No. of \$10,000 units _____	\$50,000	\$250,000**
Child	_____	<input type="radio"/>	<input type="radio"/>	_____	No. of \$2,000 units _____	N/A	\$10,000
Child	_____	<input type="radio"/>	<input type="radio"/>	_____	(Included in above child policy)		
Child	_____	<input type="radio"/>	<input type="radio"/>	_____	(Included in above child policy)		

* \$200,000 guaranteed issue limit age 65 and over.

** Subject to reduction starting at age 65.

SECTION III - BENEFICIARY DESIGNATIONS

NOTE: BENEFICIARY FOR SPOUSE OR CHILDREN WILL BE THE EMPLOYEE UNLESS OTHERWISE ON FILE

Employee's beneficiary must be designated below. Please use beneficiary's legal name

PRIMARY BENEFICIARY(IES) - I hereby designate the following beneficiary(ies) for my LSI Corporation Voluntary Term Life Insurance Plan:

NAME	RELATIONSHIP	CITY, STATE	SOCIAL SECURITY #	% OF TOTAL
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1. _____

2. _____

Beneficiary(ies) must survive me; otherwise, his or her share will be paid to the beneficiary who does survive me.

SECONDARY BENEFICIARY(IES) - In the event that the primary beneficiary(ies) is/are not living, I designate the following person(s) as my beneficiary(ies):

NAME	RELATIONSHIP	CITY, STATE	SOCIAL SECURITY #	% OF TOTAL
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1. _____

2. _____

A beneficiary for employee life insurance may be changed at any time. Contact the HR Information Center at 1-877-574-5463, or internally at 8003-7655, for details on how to submit a Beneficiary Designation Form.

SECTION IV - Any person who knowingly and with intent to defraud submits an application or files a statement of claim containing any materially false or misleading information, may be guilty of insurance fraud.

SECTION V - EMPLOYEE'S SIGNATURE

I hereby request coverage under my employer's Group Voluntary Term Life Insurance plan and authorize my employer to make the appropriate payroll deductions for the coverage(s) which I have specified above. I represent that the statements above are true and complete to the best of my knowledge and belief and are binding on any person claiming an interest in the coverage issued.

SIGNATURE _____ DATE _____

SIGNATURE OF SPOUSE _____ DATE _____

ReliaStar Life Insurance Company Insurance Information Practices Notice

We are pleased to provide you with information regarding this Evidence Form. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Evidence Form, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your Evidence Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Evidence of Insurability

ReliaStar Life Insurance Company

P.O. Box 20, Route 7812, Minneapolis, Minnesota 55440

ALL INFORMATION IN THE BOLD BOXES **MUST** BE COMPLETED. FOR QUESTIONS REGARDING PROPER AMOUNT TO BE UNDERWRITTEN, CONTACT YOUR HR BENEFITS PERSON. Please type or print in ball point pen.

Employee's Social Security Number _____	Employee's Name (Please Print) Last First Middle _____	Employee's Date of Birth ____/____/____	Employee's Sex M or F
--------------------------------------------	--------------------------------------------------------------	--------------------------------------------	--------------------------

Group Number 63358-5	Acct. No.	Name of Employer LSI Corporation	Hire Date (Full-time) ____/____/____	Employee's Job Title	Annual Salary
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For life coverages: Enter the dollar amount of current coverage (including any guaranteed amount, if applicable), the total dollar amount desired and the dollar amount of the difference between the total amount desired and the current amount which requires proof of good health at this time (i.e. needs to be medically underwritten).

Employee: <input type="checkbox"/> Supplemental Life	Current Amount \$ _____	Total Amount Desired \$ _____	Amount to be Underwritten \$ _____
Spouse: <input type="checkbox"/> Supplemental Life	\$ _____	\$ _____	\$ _____
Child(ren): <input type="checkbox"/> Life	\$ _____	\$ _____	\$ _____

This EOI submitted due to: ☐ Initial Enrollment ☐ New Hire ☐ Late Entrant ☐ Increase ☐ Other – Explain: _____

Employee's Home Address (Please Print) _____ Complete Street Address (Include Apt. #, PO Box #, RR#, etc.)	_____ City	_____ State	_____ Zip Code
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Employee Home Phone #: () _____	Employee Work Phone #: () _____ Ext. _____	Contact the HR Information Center at 1-877-574-5463, or internally at 8003-7655
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Now, complete all of the following information:

List below only the names of persons who must show proof of good health for coverage that needs to be underwritten as indicated above. NOTE: If you are requesting coverage for a step-child or a child over age 18, please check with your Benefits person to make sure the child would qualify as an eligible Dependent under the contract terms of this plan.

Names of persons to be underwritten at this time. Please print full name. (Last) (First)	Relationship to employee	Birthdate (mo., dy., yr.)	Present Height (ft.) (in.)	Present Weight (pounds)	Regular physician(s) - provide name and complete mailing address
Employee	SELF				
Spouse					
Child					
Child					
Child					

IMPORTANT! Please carefully read the next section. Then sign and date below.

I request the coverage indicated above on this Evidence Form under the Group Plan(s) sponsored by my Employer and authorize the required deduction, if any, from my wages. I declare that **all** of the statements and answers on **both** sides of this Evidence Form are **complete and true** to the best of my knowledge and belief. I agree that they shall be the basis for issuance of coverage under my Employer's Group Plan(s). I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested during the 2 year contestable period. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid. I certify that I have a copy of **both pages of this Evidence Form to keep for my records.**

Date	Employee's Signature (required)
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COMPLETE ALL MEDICAL INFORMATION ON BACKSIDE

NOTE: Answer Questions #1-7 below only as they pertain to the person(s) requesting coverage **AT THIS TIME**.

For each "yes" answer, state information below. (Please attach a separate sheet if additional space is needed.)

1. ☐ Yes ☐ No Has any person requesting coverage ever had or been treated for any of the following? Lung disorder; asthma; high blood pressure; heart trouble; nervous disorder; liver or stomach disorder; kidney or urinary disorder; diabetes; arthritis; cancer; high triglycerides/cholesterol; alcohol/chemical abuse; depression; or any physical/mental impairment.
2. ☐ Yes ☐ No In the last three years, has any person requesting coverage had or been treated for any of the following? Ulcer; back/neck trouble; eye or ear impairment; ear infections; any disorder or disease of the breasts, reproductive system or prostate; carpal tunnel syndrome; knee disorder, infertility or memory/concentration problems.
3. ☐ Yes ☐ No Has any person requesting coverage consulted a physician, received surgical or medical care or taken prescribed medication for any condition during the past 12 months (including current treatment)?
4. ☐ Yes ☐ No Is any person requesting coverage scheduled to be under a doctor's care for any condition within the next 6 months?
5. ☐ Yes ☐ No Has any person requesting coverage had or been told they had, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or AIDS related conditions or tested positive for the antibodies to the HIV virus?
6. ☐ Yes ☐ No Has any person requesting coverage been previously declined by ReliaStar Life or any other insurance company?
7. ☐ Yes ☐ No Is any person requesting coverage currently pregnant? Expected due date: _____

Q #	Name of family member	Condition/illness/injury-type of treatment	Date of Treatment	Physician's name and complete mailing address (include your medical or clinic ID number if any)

Authorization and Acknowledgment -- Please read and sign below.

For underwriting and claims purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, Medical Information Bureau (MIB), Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information as they apply to me, my spouse or any of my children who are to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42CFR Part 2. I may revoke this authorization as it applies to any information protected by this Federal Regulation at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB, Inc. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Insurance Information Practices Notice and Notice Regarding MIB, Inc. (on back of the Evidence of Insurability Instructions).

Date	Employee's Signature (required)	
Date	Spouse's Signature (if applying)	Spouse's Soc. Sec. # (if applying)