

Now is the Time...

... to convert your group accidental death insurance to an individual policy.

This document outlines the conditions under which a person no longer eligible for insurance under a Life Insurance Company of North America (LINA) Group Policy may convert to an individual policy affording Accidental Death and Dismemberment (AD&D) benefits . . . including Family coverage.

Northrop Grumman Corporation

Take advantage of the opportunity NOW!



CIGNA Group Insurance
Life • Accident • Disability

Now is the Time!

Because...

YOU UNDERSTAND the value of Accident Insurance. You've been enrolled in a Plan of LINA Group Accident Insurance, secure in the knowledge that your family will have the advantage of financial assistance in the event an accident results in death or dismemberment.

Because...

WE UNDERSTAND your interest in continuing Your Accident Insurance Protection without interruption. If you are under age 70, LINA is providing this opportunity to convert all or part of your current AD&D benefit, when your group coverage terminates because you ceased to be eligible or you have terminated employment with the policyholder.

Because...

IT'S EASY TO CONVERT TO INDIVIDUAL COVERAGE. You can secure a new, individual LINA accident insurance policy without medical certification, for yourself—and for your eligible family members.

You simply apply within 90 days after your coverage under the group insurance policy ends and pay the premium for a new LINA policy at the rate in effect for your attained age and occupation. Just forward the completed application, along with your check. You can provide continued peace of mind to yourself and your family. You can easily convert your group accident insurance to individual accident coverage. **Now is the time!**

Your Converted Policy

Will be effective on the day following the date coverage ended under your group insurance policy. The insurance pays for loss caused by, and occurring within one year after, a covered accident:

Loss of

Life	Principal Sum
Two or more members*	Principal Sum
One member	One-Half Principal Sum
Thumb and index finger of same hand	One-Quarter Principal Sum

*"Member" means hand, foot or eyesight.

Only one amount, the largest to which you are entitled, is payable for all losses resulting from one accident.

General Information

The policy is renewable with Company consent until you reach age 70. The Company may change renewal premium rates only on a class basis, not on an individual basis.

You may cancel at any time after the policy's original term.

If you are insured under more than one LINA group contract with your present employer, you may convert each but a separate application should be completed for each conversion.

Note: This individual insurance is not available if the Company has already issued you an individual AD&D policy converted from this employer's plan.

Family Plan

Under the Family Plan, you may insure your family members that were covered under your group insurance policy as follows:

Your spouse under age 70, and your dependent child/ren (including step, foster and legally adopted children—and children whose adoption procedures are pending)—under 19 years of age ...or until age 25, if they are full-time students, dependent on you for support and maintenance. Coverage will be extended for any dependent child who, upon reaching the stated maximum age, is mentally or physically incapable of self-sustaining support and who is dependent upon you for support and maintenance.

Northrop Grumman Basic and Voluntary AD&D Plans

Selection of Your Principal Sum

You may apply for an amount of coverage that is:

- a. in \$1,000 increments;
- b. not less than \$25,000, regardless of the amount of insurance under the group accident policy; and
- c. not more than the amount of insurance you had under the group accident policy, except as provided above, up to a maximum amount of \$250,000.

If you insure your spouse and/or dependent child/ren under the Family Plan, the amount of insurance applicable to members of the family is based on the composition of the family at the time of loss, and is expressed as a percentage of your Principal Sum, as follows:

- 1) At time of loss the family consists of You, Your Spouse and Dependent Children
Employee 100%
Spouse 40%
Each Child 10%
- 2) At time of loss the family consists of You and Your Spouse but NO Dependent Child/ren
Employee 100%
Spouse 50%
- 3) At time of loss the family consists of You and Your Dependent Child/ren but NO Spouse
Employee 100%
Each Child 15%

Example: Under the Family Plan, your benefit is \$100,000.
The family consists of you, your spouse, and three children.

Your Amount \$100,000.00
Your Spouse's Amount 40,000.00
Each Child's Amount 10,000.00

Limitations and Exclusions

The policy does not pay for loss resulting from intentionally self-inflicted injuries; suicide (in Missouri, while sane); declared or undeclared war or act of war; accident occurring while serving on full-time duty in the Armed Forces for more than 30 days (premiums will be prorated and returned for such period); commission of a felony by an insured; sickness, disease, bodily or mental infirmity, or medical or surgical treatment thereof or bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseen result of an external cut or wound, or accidental food poisoning.

Air travel is included while the insured person is traveling as a passenger only, in any plane, including AMC (Air Mobility Command) or similar service of another country – but excluding travel in experimental or testing aircraft, or aircraft designed for use beyond the earth's atmosphere; hang gliding; parachuting (except for self-preservation); and while serving as a pilot, crewmember, or student taking a flying lesson, in any aircraft.

Your Costs

The rates shown below are for persons in Class I Occupational Classifications—i.e., individuals who are engaged in the less hazardous occupations such as executives, managers, salesmen, accountants, lawyers, physicians, surgeons. If your occupation falls into a more hazardous classification, LINA, upon receipt of your application, will inform you of the rates that apply.

Accidental Death and Dismemberment Annual Premium Schedule

UNDER AGE 65		
PRINCIPAL SUM*	INSURED ONLY	INSURED & FAMILY
\$ 10,000	\$ 12.50	\$ 18.00
25,000	31.25	45.00
50,000	62.50	90.00
100,000	125.00	180.00
150,000	187.50	270.00
200,000	250.00	360.00
250,000	312.50	450.00
AGE 65 UNTIL AGE 70		
PRINCIPAL SUM*	INSURED ONLY	INSURED & FAMILY
\$ 10,000	\$ 18.50	\$ 27.00
25,000	46.25	67.50
50,000	92.50	135.00
100,000	185.00	270.00
150,000	277.50	405.00
200,000	370.00	540.00
250,000	462.50	675.00

* See the section labeled “**Selection of Your Principal Sum**” to determine the Principal Sum you are eligible to apply for.

If your terminating Principal Sum is not shown in the schedule above you can calculate your premium as follows:

To Calculate Your Premium

Example: If the Principal Sum on your terminating LINA group accident policy is \$75,000,

Under Age 65

Insured Only: \$75 (\$75,000 divided by 1,000) multiplied by **\$1.25 per year**** equals \$93.75 of annual premium.

Insured & Family: \$75 (\$75,000 divided by 1,000) multiplied by **\$1.80 per year**** equals \$135.00 of annual premium.

Age 65 Until Age 70

Insured Only: \$75 (\$75,000 divided by 1,000) multiplied by **\$1.85 per year**** equals \$138.75 of annual premium.

Insured & Family: \$75 (\$75,000 divided by 1,000) multiplied by **\$2.70 per year**** equals \$202.50 of annual premium.

**Rate per \$1,000 per year.

If you wish to pay the premium semiannually or quarterly, please note:

For a Principal Sum of \$50,000 or more, you may pay the premium semiannually by dividing the annual premium by 2.

For a Principal Sum of \$100,000 or more, you may pay the premium quarterly by dividing the annual premium by 4.

Example: If your Principal Sum is \$100,000, you have family coverage and your attained age is 55, Total Quarterly Premium for *You and Your Family* = \$45.00.

If you have any questions or need assistance in completing the application, please call our toll-free number 1-800-441-1832 (TDD 1-800-552-5744), Monday through Friday, 8:00 a.m. to 6:00 p.m. (EST).

APPLICATION

for conversion of accidental loss of life, limb or sight coverage to an individual policy.

This Part of Application to be Completed by Proposed Insured

Full Name _____ Social Security Number _____

Address _____

Date of Birth _____ Former Occupation _____ Present Occupation _____

Describe Present Duties _____

Converted Amount*: \$ _____ Coverage: Accidental Death and Dismemberment Family Coverage: Yes No

I wish to pay premiums: Annually Semiannually Quarterly

My check (made out to "LINA") in the amount of \$ _____ is enclosed.

Insured's Beneficiary: Loss of life benefits will be paid to:

(Print full name of beneficiary and relationship to you) _____

Spouse's Beneficiary: Loss of life benefits will be paid to the insured. All other benefits will be paid to the spouse.

Child's Beneficiary: Loss of life and all other benefits will be paid to the insured.

I have read the above statements and agree they are accurate and complete to the best of my knowledge and belief. I understand that this insurance will be issued on reliance upon such statements.

Signature of Proposed Insured _____ Date _____

* **Converted amount is dependent upon the reasons the current LINA group insurance policy or any portion of it ended. Find the reason that applies to you and the amount you are eligible for below.**

If your insurance or any portion of it ends due to; a.) Employment or membership ends, or b.) Eligibility ends. You may apply for an amount of coverage that is:

- a. in \$1,000 increments;
- b. not less than \$25,000, regardless of the amount of insurance under the group accident policy; and
- c. not more than the amount of insurance you had under the group accident policy, except as provided above, up to a maximum amount of \$250,000.

**Complete this application and mail it along with your check (made payable to LINA) to:
Life Insurance Company of North America, Individual Conversion Unit, P.O. Box 20187, Lehigh Valley, PA 18002-0187**

This Part of Application to be Completed by Employer

GROUP POLICY NO. _____

(Name of insured employee and/or of employee's insured dependent)

on _____ **became ineligible for coverage under the group or blanket policy.**

Prior to that date, the above individual was insured for: \$ _____ **Family Plan** Yes No

Signed _____ Title _____

for _____ (organization) Subsidiary of _____

Telephone # _____ Date _____

IF THE PROPOSED INSURED HAS PREVIOUSLY ASSIGNED OWNERSHIP OF HIS/HER POLICY TO ANOTHER PERSON FOR ESTATE TAX PURPOSES—OR NOW WISHES TO DO SO—BOTH THE PROPOSED INSURED AND THE OWNER MUST SIGN THIS PART OF THE APPLICATION.

The answers to the questions contained in the application have been made by the proposed insured at the request and on the behalf of the proposed Owner, and insurable interest in the proposed insured exists on the part of not only the proposed Owner but also the beneficiary or beneficiaries designated in the application, which designation is that of the proposed Owner.

The proposed Owner adopts as a part of the application all of the statements and answers of the proposed Insured.

The proposed Insured agrees and understands that the proposed Owner, as assignee of all the proposed insured's rights, privileges and interests under a group, blanket or individual policy, inclusive of a Conversion Privilege thereunder, is hereby exercising said Conversion Privilege and that all right, title and interest under the converted policy for which this application is submitted will become vested in the person named herein as proposed Owner.

If any interest or payment shall not vest in the proposed Owner, or in the beneficiary or beneficiaries designated hereunder, such interest or payments shall not revert to the proposed Insured or his/her estate but shall become payable in such shares and to such persons as may be entitled to take from him/her under the intestate law of the state of the Insured's residence at the time of death.

Name of Proposed Owner _____

Address _____

City & State _____

Relationship to Proposed Insured _____

Dated at _____ this day of _____
(month) (date) (year)

Signature of Proposed Owner _____

Signature of Proposed Insured _____