Colonial Life & Accident Insurance Company | GROUP ENROLLMENT FORM

Proposed Named Insured: _____ **Gender:** ___ **Date of Birth:** _____ **SSN:** _____

Home Address: _____ **Phone:** _____

Occupation/Job Title: _____ **Employee Class:** _____ **Hire Date:** _____

Annual Salary: $ _____ **Hrs/Wk:** ___ **Employee ID:** _____ **Section/Dept #:** _____

Employer: _____ **FICA:** Full ☐ Exempt ☐ Medicare only ☐

Employer Address: _____ **Business Phone Number:** _____

Are any eligible dependent children applying for coverage? If yes, provide identifying information below.	Yes ☐ No ☐
Is your spouse applying for coverage? If yes, provide identifying information below.	Yes ☐ No ☐

Spouse/Dependent Name	Relationship to Proposed Named Insured	Date of Birth	SSN

Type of Coverage	Base Plan Code	Total Premium	Rider Plan Code	Unit and/or Rider Amount	**P** = Pre-Tax **A** = After-Tax	Monthly Premium
Cancer						
☐ Named Insured ☐ Named Insured & Family					P ☐ A ☐	
Critical Illness						
☐ Named Insured ☐ Named Insured & Dependents ☐ Named Insured, Spouse & Dependents		[Units x Rate = Total Premium]			P ☐ A ☐	
Other Coverages						
					P ☐ A ☐	
					P ☐ A ☐	
					Total Monthly Premium $	

Are you or any person to be covered Medicare eligible? If yes, the Important Notice to Persons on Medicare will be provided.	Yes ☐ No ☐

Critical Illness	
Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery systems?	Yes ☐ No ☐

Critical Illness: Evidence of Insurability, if required				
Indicate Proposed Named Insured's Current: Height _____ Weight _____ Indicate Spouse's Current: Height _____ Weight _____				
Within the past 10 years, have you received medical advice or sought treatment (including medication) for:		Proposed Named Insured	Spouse	Dependent
Heart Attack (MI) Heart Surgery Heart Disease Emphysema Organ Transplant Congestive Heart Failure Diabetes Stroke Angina Macular Degeneration Glaucoma	Hepatitis B, C Blood Pressure Reading of 160/100 or Above Kidney Disease except Stones Chronic Obstructive Pulmonary Disease Cirrhosis or Liver Disease Transient Ischemic Attack Cancer Other than Skin Cancer Abnormal Heart Catherization Cardiomyopathy Retinitis Pigmentosa	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Cancer: Evidence of Insurability, if required				
Within the past 10 years have you ever been diagnosed with or treated for Cancer, other than skin cancer?		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Within the past 5 years, have you received medical advice or sought treatment for Skin Cancer, including basal cell carcinoma, squamous cell carcinoma, or melanoma of Clark's level I or II?		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Have you tested positive for the HIV virus or its antibodies, or been diagnosed with or received medical treatment from a member of the medical profession for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)?		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

I understand that the coverage applied for will not pay benefits for any loss incurred during the first 12 months after the issue date for a disease or physical condition that I now have or have had in the past. Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. By applying for the coverage indicated above, I am requesting cancellation of existing similar Colonial coverage (base plan and all applicable riders) if the coverage applied for is issued. If, for any reason the coverage applied for is not issued, this request for cancellation shall be null and void.

Signed at: City _____ **State** _____ **Agent Name** (if present) _____

_____ _____ _____

Date **Signature of Proposed Named Insured** (if applicable) **Signature of Licensed Agent** (if applicable) **Code #**