COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202

ENROLLMENT FORM / EVIDENCE OF INSURABILITY
GROUP TERM LIFE INSURANCE

Application Type: ☐ Initial Request ☐ Late Applicant ☐ Rehire
☐ Annual Enrollment ☐ Change in Status ☐ Increase

SECTION 1: EMPLOYEE (APPLICANT) INFORMATION – Always complete

Proposed Insured Name (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street City State Zip Code			Employee ID/Payroll No.
Email Address	State of Birth	Home Phone No. Business Phone No.	
Date Employed / Occupation/Job Title	Annual Base Salary	Hrs. Worked/ Week	Employee Class
Employer Name	Employer Address (Street-City-State-Zip)		Section/Dept. No.

SECTION 2: COVERAGE INFORMATION – Always complete

Coverage Elections	**Plan Code**	**Face Amount**	**Monthly Premium**
☐ **Employee** If multiple of salary, indicate multiple selected _____			
☐ **Spouse**			
☐ **Dependent Children**			
Is a suite being applied for? ☐ Yes ☐ No Rider Plan Code: _____			
		Total Premium	

SECTION 3: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage. Height and weight is required for spouse only.

Name (First, MI, Last)	Gender	HT	WT	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐					
	M ☐ F ☐					
	M ☐ F ☐					
	M ☐ F ☐					
	M ☐ F ☐					

SECTION 4: BENEFICIARY INFORMATION – Employee only

Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

SECTION 5: ELIGIBILITY INFORMATION – Required for Guaranteed Issue and all levels of underwriting		
	Proposed Insured	**Spouse**
1. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	Yes ☐ No ☐	
2. Are you actively working? If "No", are you disabled or unable to work?	Yes ☐ No ☐ Yes ☐ No ☐	
3. Is your spouse (if applying for coverage) disabled or unable to work?		Yes ☐ No ☐

SECTION 6: EVIDENCE OF INSURABILITY (complete if required)		
If you answer yes to any question please provide details on the following page.	**Proposed Insured**	**Spouse**
4. (Employee only) Indicate Your Current: Height_____ Weight_____		
5. Has any proposed insured tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐
6. Within the past 7 years has any proposed insured ever received medical advice or sought treatment by a member of the medical profession (including medication) for any condition listed below? If yes, provide details. Circulatory, Heart, Blood Vessel Disease or Disorder Cancer or Tumor, including leukemia or melanoma Blood Disease or Lymph Node Disorder Skin, Bone, Muscle or Joint Disorder Asthma, Emphysema, Lung or Respiratory Disorder Gastrointestinal or Digestive Disease or Disorder Kidney or Genitourinary Disease or Disorder Stroke Epilepsy Heart Murmur Heart Attack (MI) Diabetes Chest Pain / Angina High Blood Pressure Liver Disease or Disorder Nervous or Mental Disorder Paralysis Thyroid Disorder	Yes ☐ No ☐	Yes ☐ No ☐
7. Within the past 24 months, has any proposed insured engaged in hang gliding, mountain climbing, flying ultralights, parachuting, sky diving, ballooning, flown as a student or private pilot, engaged in auto, motorcycle or boat racing, scuba diving to depths greater than 75 feet; or participated in any other similar sport or avocation? If yes, provide details.	Yes ☐ No ☐	Yes ☐ No ☐
8. Within the past 5 years**,** has any proposed insured had their driver's license revoked or suspended for any reason; been convicted of operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to or been convicted of 3 or more speeding or other moving violations? If yes, provide details, including person's name, type of violation(s), date(s), driver's license number and state.	Yes ☐ No ☐	Yes ☐ No ☐
9. Has any proposed insured ever used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, with the exception of those prescribed by a member of the medical profession; received medical advice or sought treatment by a member of the medical profession for drug and/or alcohol abuse; or been advised by a member of the medical profession to reduce the consumption of drugs or alcohol? If yes, provide details including the frequency of use and the date last used, list condition(s), medication(s), date(s) of treatment, treatment received and recovery, physician's / hospital / facility name, address and phone number.	Yes ☐ No ☐	Yes ☐ No ☐
10. Has any proposed insured ever pled guilty to, pled no contest to, have a charge pending or been convicted of a felony or misdemeanor? If yes, list the person's name, reason for arrest, date and indicate if the person is on probation, parole or incarcerated.	Yes ☐ No ☐	Yes ☐ No ☐
11. Within the past 5 years, has any proposed insured been confined to a hospital or medical facility, seen a member of the medical profession for any reason other than stated on this application, or are currently taking medication or receiving medical advice by a member of the medical profession? If yes, provide details.	Yes ☐ No ☐	Yes ☐ No ☐

SECTION 7: DETAILS FOR ANY "YES" ANSWERS IN SECTION 6

Name	Detailed Description	Date	Duration	Treatment Received	Name & Address of Physician / Hospital

ADDITIONAL DATA SECTION

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

For the purpose of evaluating my application(s) for insurance submitted during the current enrollment and eligibility for benefits under any insurance issued including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application(s), I hereby authorize the disclosure of the following information about me and, if applicable, my dependents, from the sources listed below to Colonial Life & Accident Insurance Company (Colonial Life) and its duly authorized representatives.

Health information may be disclosed by any health care provider or institution, health plan or health care clearinghouse that has any records or knowledge about me including prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company, Medicare or Medicaid agencies or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Non-health information including earnings or employment history deemed appropriate by Colonial Life to evaluate my application may be disclosed by any person or organization that has these records about me, including my employer, employer representative and compensation sources, insurance company, financial institution or governmental entities including departments of public safety and motor vehicle departments.

Any information Colonial Life obtains pursuant to this authorization will be used for the purpose of evaluating my application(s) for insurance or eligibility for benefits. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. Colonial Life will not disclose the information unless permitted or required by those laws.

This authorization is valid for two (2) years from its execution and a copy is as valid as the original. A copy will be included with my contract(s) and I or my authorized representative may request access to this information. This authorization may be revoked by me or my authorized representative at any time except to the extent Colonial Life has relied on the authorization prior to notice of revocation or has a legal right to contest coverage under the contract(s) or the contract itself. If revoked, Colonial Life may not be able to evaluate my application(s) for insurance or eligibility for benefits as necessary to issue my contract(s). I may revoke this authorization by sending written notice to: Colonial Life & Accident Insurance Company, Underwriting Department, P.O. Box 1365, Columbia, SC 29202.

You may refuse to sign this form; however, Colonial Life may not be able to issue your coverage. I am the individual to whom this authorization applies or that person's legal Guardian, Power of Attorney Designee, or Conservator.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I confirm I have read and understand the Fraud Statement attached. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this application will not be binding upon Colonial Life & Accident Insurance Company until both: 1) the policy or certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy or certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the application.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices (which includes MIB, Inc. Disclosure Notice). I hereby authorize Colonial Life & Accident Insurance Company to release information to the MIB.
I elect to be interviewed if any investigative consumer report is prepared in connection with this application. Yes ☐ No ☐

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City_____ State _____ Date _____
mm/dd/yyyy

(x)_____ (x)_____
Signature of Proposed Insured Signature of Spouse

AGENT SECTION

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I have truthfully and accurately recorded on this application the information supplied by the Proposed Insured. I further certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

Date _____ (x)_____

mm/dd/yyyy Signature of Licensed Agent (if applicable)

Agent Name_____ License No._____ Code No._____

Fraud Warning Notice

For all states except those listed below:	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana and West Virginia	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 is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
Florida	**All statements and information found in the application are deemed representations and not warranties. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree**.
Kentucky, Kansas and North Carolina	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.
Maine and Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
Oklahoma	WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon and Texas	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. If coverage is contested, the company's only obligation will be to refund all premiums paid.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
Virginia	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.