COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202
STATE OF ARKANSAS GROUP TERM LIFE with AD&D INSURANCE EVIDENCE OF INSURABILITY FORM

SECTION 1: EMPLOYEE/RETIREE INFORMATION – Always complete					
Proposed Insured Name (First, MI, Last)	☐ Active Employee ☐ Retiree	Gender M ☐ F☐	Birthdate (mm/dd/yyyy)	Social Security No.	
Home Address – Street City State Zip Code				Member ID No.	
Email Address				Primary Phone No. Secondary Phone No.	
Date Employed	Actively Employed by: ☐ AR State ☐ AR Public Schools	Annual Salary	Date Retired	Agency/District No.	

SECTION 2: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage				
Spouse Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			
Are there any eligible dependent children applying for coverage?				☐Yes ☐ No

SECTION 3: COVERAGE INFORMATION – Always complete for amount over Guaranteed Issue Amounts					
*Administrative use only		**Tax Status**	***Plan Code**	**Coverage Amount**	**Monthly Premium**
Employee	☐ Basic Life and AD&D $10,000 (state paid benefit)				
	☐ Expanded Basic Life and AD&D ($1,000 increments, up to $40,000)	Pre ☐ Post ☐			
	☐ Supplemental Life and AD&D ($1,000 increments, up to $250,000)	Post Tax			
Spouse Supplemental Life and AD&D					
Dependent Children Supplemental Life and AD&D					
☐ I do not wish to participate/continue the State Employee's Group Life Plan. I understand that if I enroll later, I must provide evidence of insurability				**Total Premium**	

SECTION 4: BENEFICIARY INFORMATION – Always complete for Employee only					
Beneficiary's Name (First, MI, Last) Sally Doe	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.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

SECTION 5: HEALTH QUESTIONS	**Proposed Insured**	**Spouse**
1. Is the proposed insured actively working? If "No", is the proposed insured disabled or unable to work?	Yes ☐ No ☐ Yes ☐ No ☐	
2. Is your spouse (if applying for coverage) disabled or unable to work?		Yes ☐ No ☐
3. Proposed Insured Current: Height_____ Weight_____ Spouse Current: Height_____ Weight_____		
4.Has the proposed insured or spouse, if applying for spouse coverage, 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 ☐
5.Within the past 7 years has the proposed insured or spouse, if applying for spouse coverage, been diagnosed with, received medical advice or treatment by a member of the medical profession (including medication) for any condition listed below? If yes, provide details in Section 6. 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 ☐
6. Does the proposed insured participate in any of the following hazardous sports or avocations: aeronautics, aviation related sports, mountain climbing, motorsports including racing or scuba diving greater than 75 feet in depth? If yes, provide details in Section 6.	Yes ☐ No ☐	Yes ☐ No ☐

HEALTH QUESTIONS - continued	Proposed Insured	Spouse
7. Within the past 5 years, has the proposed insured or spouse, if applying for spouse coverage, 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 in Section 6.	Yes ☐ No ☐	Yes ☐ No ☐
8. Has the proposed insured or spouse, if applying for spouse coverage, ever used marijuana, narcotics, barbiturates, amphetamines, hallucinogens, cocaine, heroin, or any other habit forming 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 in Section 6.	Yes ☐ No ☐	Yes ☐ No ☐
9. Has the proposed insured or spouse, if applying for spouse coverage, 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 in Section 6.	Yes ☐ No ☐	Yes ☐ No ☐
10. Within the past 5 years, has the proposed insured or spouse, if applying for spouse coverage, 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 in Section 6.	Yes ☐ No ☐	Yes ☐ No ☐

SECTION 6: DETAILS FOR ANY "YES" ANSWERS IN SECTION 5

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

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

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. I have read this form and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this form will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the 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. 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 form are the basis for any 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 form.

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

If I have elected to pay my premiums for Colonial Life & Accident Insurance Company's Group Term Life insurance with pre-tax dollars, I am aware of the tax savings I receive through a flexible benefits plan. While the Internal Revenue Service (IRS) allows me to receive tax savings on my premiums, the IRS also may require me to pay taxes on insurance benefits I receive from coverage purchased through a flexible benefits plan.

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)_____
Signature of Proposed Insured

AGENT SECTION

Agent's Name (If Present) _____
Please Print

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this form. I further certify that I am a licensed agent in the state where this form 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 (full name as it appears on license)

License No._____ Code No._____