Application to: Colonial Life & Accident Insurance Company **PO Box 1365 Columbia, SC 29202**

Applicant Section

Applicant's Name (First, MI, Last)	Employee ☐ Spouse ☐ Dependent ☐	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.

Home Address – Street	City	State	Zip Code	State of Birth	Employee ID/Payroll No.

Date Employed	Occupation/ Job Title	Hrs. Worked/ Week	Annual Base Salary	Home Phone No. Business Phone No.

Billing Section

Payroll Deduction Employer Name	Employer Address (Street-City-State-Zip)	Section/Dept. No.	Employee Class

Payer or Owner if other than Applicant (Name, Address, Social Security No.)	☐Payer ☐Owner ☐Both

Spouse and Dependent Section

Name of Spouse (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
Employer's Name for Spouse	Date Employed	Occupation / Job Title	Hours Worked/ Week	Annual Base Salary
1. Are there any eligible dependent children applying for coverage?			Yes ☐ No ☐	Number Deps:

Complete Question 2 for all Products	Applicant	Spouse
2.A. Are you actively working?	Yes ☐ No ☐	Yes ☐ No ☐
2.B. If "No", is your spouse disabled or unable to work?		Yes ☐ No ☐

Plan Section

Indicate Type of Change (N) New **(T)** Transfer or **(R)** Rider Addition. **Indicate Tax Status (P)** for pre-tax or **(A)** for after tax

Product	Type Coverage	Type of Change	Policy Plan Code	Units/ Amount	Rider Plan/ Units	Rider Plan/ Units	Rider Plan Code	Rider Plan Code	Tax Status	Monthly Premium
☐Accident									P ☐ A ☐	
☐Hospital Confinement									P ☐ A ☐	
☐Cancer									P ☐ A ☐	
☐Int. Care									P ☐ A ☐	
☐Critical Illness									P ☐ A ☐	
☐Disability	Elim/Benefit period ____/____								P ☐ A ☐	
									Total Monthly Premium $	

Replacement Section – Complete for all Products

3. Will any health insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued? Yes ☐ No ☐

Insured's Name	Insurance Company	Type of Coverage	Policy Number

AIDS Section – Complete for all Products	Applicant	Spouse	Dependent
4. Have you tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue Section – Disability and Hospital Confinement	Applicant	Spouse
5. Have you previously purchased disability coverage that will remain in force which, when combined with the coverage you are applying for, will exceed 70% of your gross annual income? This does not include employer paid group disability coverage.	Yes ☐ No ☐	Yes ☐ No ☐
6. Within the past 12 months, other than colds, flu or normal pregnancy, have you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle?	Yes ☐ No ☐	Yes ☐ No ☐
7. Within the past 12 months, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI) · Heart Surgery · Congestive Heart Failure · Stroke · Transient Ischemic Attack Blood Pressure Reading of 160/100 or Above · Kidney Disease except Stones · Insulin Dependent Diabetes · Diabetes Diagnosed Prior to age 40 · Cancer Other than Skin Cancer Hepatitis B, C · Cirrhosis · Hodgkin's Disease · Leukemia	Yes ☐ No ☐	Yes ☐ No ☐

Dependent Health Section - Hospital Confinement				
8. Within the past 12 months, has any dependent been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer) or seizures? **Any dependent listed will not be covered under the Hospital Confinement policy to which a copy of the application is attached.**				Yes ☐ No ☐
Name (First, MI, Last)	Relationship	Birthdate (mm/dd/yyyy)	Social Security No.	

Simplified Issue Section - Critical Illness and Intensive Care	Applicant	Spouse	Dependent
9. Within the past 10 years, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI) · Heart Surgery · Heart Disease · Emphysema · Organ Transplant · Congestive Heart Failure · Diabetes · Stroke 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 Catherization	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Any dependent listed will not be covered under the Intensive Care or Critical Illness policy to which a copy of the application is attached.			
Name (First, MI, Last) / Relationship / Birthdate (mm/dd/yyyy) / Social Security No.			
10. 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 ☐		

Cancer Section	Applicant	Spouse	Dependent
11. In the past 10 years, have you ever been diagnosed with, or treated for, Cancer of any type or form?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
12. In the past 5 years, have you received medical advice or sought treatment for cancer, other than skin cancer; or, in the past 12 months have you received preventive Hormonal Therapy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Any dependent listed will not be covered under the Cancer policy to which a copy of the application is attached.			
Name (First, MI, Last) / Relationship(s) / Birthdate (mm/dd/yyyy) / Social Security No.			
13. 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 ☐

Other Section – Complete for all Products except Disability	
14. Are you Medicare eligible?	Yes ☐ No ☐
15. Has the Important Notice to Persons on Medicare been provided?	Yes ☐ No ☐

Applicant's Beneficiary Information – Complete for all Products					
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Applicant	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Applicant	Social Security No.

Height and Weight Section – Complete for all products at Simplified Issue Level 1 amounts

Indicate Applicant's Current: Height_____ **Weight**_____
Indicate Spouse's Current: Height_____ **Weight**_____

Medication Section - Complete for all products at Simplified Issue Level 1 amounts	Applicant	Spouse
M1. Are you currently prescribed any medication?	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue Level 1 Section – Disability	Applicant
D1. Within the past 5 years, have you received medical advice or sought treatment for any cancer, other than skin cancer?	Yes ☐ No ☐
D2. Within the past 5 years, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI), Heart Surgery, Heart Disease, Congestive Heart Failure, Stroke, Transient Ischemic Attack, End Stage Kidney (Renal) Disease, Emphysema, Cirrhosis or Liver Disease, Chronic Obstructive Pulmonary Disease, Multiple Sclerosis, Neurological Disorder, Chronic Fatigue Syndrome, Fibromyalgia	Yes ☐ No ☐
D3. Within the past 5 years, have you received medical advice or sought treatment (including medication) for: Back Injury or Illness, Knee Injury or Illness, Neck Injury or Illness, Joint Injury or Illness, Muscular Injury or Illness, Carpal Tunnel Syndrome, Diabetes, Hepatitis B, C, Blood Pressure Reading of 140/90 or Above	Yes ☐ No ☐
D4. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application?	Yes ☐ No ☐
D5. Do you have any individual or group disability insurance now in force with any company, including Colonial Life & Accident Insurance Company?	Yes ☐ No ☐

Insurance Company	Monthly Disability Amount	Elimination Period/Benefit	Policy Number

Simplified Issue Level 1 Section - Hospital Confinement	Applicant	Spouse
H1. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application?	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue Level 1 Section - Critical Illness	Applicant
C1. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application?	Yes ☐ No ☐
C2. Within the past 10 years, have you ever received medical advice or sought treatment for: Heart Disease, Lung Disease, Kidney Disease, Cirrhosis or Liver Disease Hepatitis B, C, Circulatory Disease, Respiratory Disease, Blood Pressure Reading of 140/90 or Above	Yes ☐ No ☐

Health Details Section

For yes answer, provide details below.
For prescribed medication, indicate the condition it was prescribed for, medication name, dosage and date of onset.

Condition Name	Medication Name/ Dosage	Date of Onset and Recovery	Doctor/Hospital Name, Address & Phone #	Date of Treatment	Type Treatment Received

Additional Data Section

Agreement Section

I understand that the policy 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 6 months.

THE APPLICANT AGREES AS FOLLOWS:

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. To the best of my knowledge and belief, the answers and statements above are true and complete. I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial) until both: 1) the policy is issued; and 2) the first premium is paid. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. If applicable, I have received an outline of coverage for the plan(s) applied for and I have been explained all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to pre-existing conditions, if applicable. I understand that any untrue statement or material misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER. If applicable, I understand that anyone to be covered for specified disease is not also covered by any Title XIX program, such as Medicaid or any similar program. 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. Yes☐ No☐

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the Policy indicated. I hereby request cancellation

- ☐ of my Colonial Policy Number(s)_____Transfer or cancellation of the base plan will also mean cancellation of all attached riders.
- ☐ of my rider only_____as of the effective date and hour of my new coverage.

If, for any reason the policy applied for above is not issued, this request for cancellation shall be null and void.

Signed at: (City)_____(State)_____(Date)_____
mm/dd/yyyy

_____ _____
Signature of Applicant Signature of Employee/Payer

Agent Section

Agent's Name (If Present) _____
(please print)

Do you have knowledge or reason to believe that the Applicant is intending to replace any existing insurance?
Yes☐ No☐

I have explained to the Applicant all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to pre-existing conditions, if applicable. I hereby certify that I know nothing affecting the insurability of the Applicant, which is not fully set forth in this application. I have not made, nor agreed to make, any rebate of premium for insurance. I further certify that I am a licensed agent in the state where this application is being taken.

Date_____ (x)_____ License No._____ Code No._____
mm/dd/yyyy Signature of Licensed Agent

Authorization for Colonial Life & Accident Insurance Company

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) 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 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 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 will not re- disclose the information unless permitted or required by those laws. Re-disclosed information may no longer be protected by federal privacy 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 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 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 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.

_____	_____	_____	_____
(Printed name of individual subject to this disclosure)	(Social Security Number)	(Signature)	(Date Signed)

If applicable, I signed on behalf of the proposed insured as _____(indicate relationship). If legal Guardian, Power of Attorney Designee, or Conservator.

_____	_____	_____
(Printed name of legal representative)	(Signature of legal representative)	(Date Signed)