

Administered by:



CORPORATE BENEFIT SERVICES OF AMERICA, INC.
400 Highway 169 South, Suite 800
Minneapolis, Minnesota 55426-1141

Medical, Dental and Disability Insurance Underwritten by:
Unified Life Insurance Company
Overland Park, Kansas

Life and AD&D Insurance Underwritten by:
Jefferson Pilot Financial Ins. Co.
Omaha, Nebraska

Employee Application for Insurance

This Section to be Completed by Your Employer	_____			
	Group Name	Group Number	Division Number	Class

1. REASON FOR APPLICATION

<input type="checkbox"/> New Coverage	<input type="checkbox"/> Change in Coverage: Requested Effective Date of Change _____
	<input type="checkbox"/> Add <input type="checkbox"/> Delete Coverage for (name) _____
	<input type="checkbox"/> Other (Please describe) _____
<input type="checkbox"/> Enrolling for Coverage that I Previously Waived/Declined (Please check reason at right)	<input type="checkbox"/> COBRA Coverage Exhausted <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Spouse's Employer No Longer Contributes to Premium <input type="checkbox"/> Marriage <input type="checkbox"/> Lost Coverage Through Spouse Date of Event _____

2. INFORMATION ABOUT YOU

Email Address _____ Height _____ Weight _____

Social Security Number _____ Occupation _____ Male Female

Name _____ Birthdate _____

Last First Middle Initial

Address _____ ()

Number & Street City County State Zip

Spouse Address (if different) _____ ()

Work Phone

Marital Status: Single Married; date of marriage _____ Separated; date separated _____

Divorced; date of divorce _____ Widowed; date widowed _____

Hours Worked per Week _____ Date Hired/Rehired (circle one) to full-time _____ Monthly Earnings\$ _____

Are you currently covered by Worker's Compensation? Yes No

3. INFORMATION ABOUT YOUR DEPENDENTS (complete Section 8 if waiving dependent coverage)

PLEASE PRINT NAME OF DEPENDENTS APPLYING FOR COVERAGE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT	IF CHILD AGE 19 TO 25 INDICATE IF FULL TIME COLLEGE STUDENT	DATE OF BIRTH MO./DAY/YEAR	HEIGHT	WEIGHT
			<input type="checkbox"/> YES <input type="checkbox"/> NO	/ /		
			<input type="checkbox"/> YES <input type="checkbox"/> NO	/ /		
			<input type="checkbox"/> YES <input type="checkbox"/> NO	/ /		
			<input type="checkbox"/> YES <input type="checkbox"/> NO	/ /		
			<input type="checkbox"/> YES <input type="checkbox"/> NO	/ /		

4. COVERAGE OPTIONS

Please check the coverage(s) you're applying for below. Availability of coverage(s) is based on your employer's selected plan of insurance.

Medical	Dental	Disability	Life	Designate Beneficiary if Electing Life Insurance:
Employee <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Name of Beneficiary _____
Spouse <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationship _____
Child(ren) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

FOR HOME OFFICE USE ONLY

<input type="checkbox"/> New <input type="checkbox"/> Late	<input type="checkbox"/> Previously Insured	<input type="checkbox"/> APS attached (confidential) on _____
<input type="checkbox"/> Timely	<input type="checkbox"/> Employee <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Questionnaire attached on _____
<input type="checkbox"/> Special	<input type="checkbox"/> Spouse <input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> PVS attached
look.date _____	<input type="checkbox"/> Children <input type="checkbox"/> Medical <input type="checkbox"/> Dental	Effective Date _____

5. OTHER COVERAGE INFORMATION

This information you provide about other coverage (either prior or current) is necessary to determine whether you will have any waiting periods for pre-existing conditions. It will also help us to coordinate benefits with any other group health plan you may have. **To ensure proper credit towards the pre-existing clause of the policy, attach a Certificate of Creditable Coverage.**

1. Have you or your dependents had health insurance coverage with another carrier(s) at anytime during the last 12 months?
 Yes No If yes, answer the following:

****Provide information (below) about all the health insurance coverage you have had during the previous 12 months****

Name of Policyholder _____ SS# of Policyholder _____

Effective date of policy / / Termination date of policy / /
mo day year mo day year

Reason coverage ended: _____

Type of Plan: Group Individual Other Persons covered: Self Spouse Child/ren

Name of insurance company _____ Telephone number _____

Was this a group policy offered through an employer? Yes No If yes, provide the following:

Name of employer _____ Telephone number () _____

2. Will you or your dependents continue to be covered under another health insurance plan while you are covered under this Unified Life Insurance Company plan? Yes No If yes, answer the following:

Who will continue to be covered: Self Spouse Child/ren

Effective date of policy / / Type of plan: Group Individual Other
mo day year

Name of insurance company _____ Telephone number () _____

Is this plan through your spouse's employer? Yes No If yes, provide the following:

Name of employer _____ Telephone number () _____

3. Do you or your dependents currently have **Medicare** coverage? Yes No If yes, answer the following:

Name of person covered by Medicare _____ Medicare claim number _____

Is Medicare eligibility due to? Over age 65 End-stage renal disease Total disability

Part A effective date / / Part B effective date / /
mo day year mo day year

4. Are you or your dependents currently insured by **Unified Life Insurance Company**? Yes No

Were you or your dependents previously insured by **Unified Life Insurance Company**? Yes No

6. HEALTH INFORMATION - Answer All Questions

1. Has anyone named in this application taken any medications prescribed by a physician during the past year? Yes No
If yes, complete the following. If additional space is needed, attach a separate sheet of paper.

NAME OF MEDICATION	DOSAGE	CURRENTLY TAKING	DATE LAST TAKEN
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Within the last 5 years, has anyone named in this application been seen, treated, counseled, or taken medication for:

- | Yes No | Yes No | Yes No |
|--|---|---|
| a. <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | n. <input type="checkbox"/> <input type="checkbox"/> Back, Spine, Joint or Muscle related Diagnosis | x. <input type="checkbox"/> <input type="checkbox"/> Menstrual or Gynecological related Diagnosis |
| b. <input type="checkbox"/> <input type="checkbox"/> Heart related Diagnosis | o. <input type="checkbox"/> <input type="checkbox"/> Migraine or Headache | y. <input type="checkbox"/> <input type="checkbox"/> Infertility |
| c. <input type="checkbox"/> <input type="checkbox"/> Stroke, Clot or Circulatory related Diagnosis | p. <input type="checkbox"/> <input type="checkbox"/> Depression, Anxiety, Bipolar or other Psychological related Diagnosis | z. <input type="checkbox"/> <input type="checkbox"/> Kidney, Bladder or Prostate related Diagnosis |
| d. <input type="checkbox"/> <input type="checkbox"/> Diabetes | q. <input type="checkbox"/> <input type="checkbox"/> Attention Deficit (ADD or ADHD) or Behavioral related Diagnosis | aa. <input type="checkbox"/> <input type="checkbox"/> Anemia, Blood or Lymph Node related Diagnosis |
| e. <input type="checkbox"/> <input type="checkbox"/> Allergies, Asthma or Sinus related Diagnosis | r. <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | bb. <input type="checkbox"/> <input type="checkbox"/> Alcohol, Drug or Chemical Abuse |
| f. <input type="checkbox"/> <input type="checkbox"/> Emphysema, Respiratory or Lung related Diagnosis | s. <input type="checkbox"/> <input type="checkbox"/> Arthritis, Lupus, Scleroderma, Connective Tissue related Diagnosis | cc. <input type="checkbox"/> <input type="checkbox"/> Any diagnosis within the last 5 years |
| g. <input type="checkbox"/> <input type="checkbox"/> Cancer or malignant growth | t. <input type="checkbox"/> <input type="checkbox"/> Epilepsy, Seizure or Neurological related Diagnosis | dd. <input type="checkbox"/> <input type="checkbox"/> Has anyone named in this application been advised of the possibility for future testing, surgery or hospitalization |
| h. <input type="checkbox"/> <input type="checkbox"/> Hepatitis related Diagnosis | u. <input type="checkbox"/> <input type="checkbox"/> Thyroid, Adrenal or Pituitary related Diagnosis | ee. <input type="checkbox"/> <input type="checkbox"/> Is anyone named in this application currently pregnant. Due date _____ |
| i. <input type="checkbox"/> <input type="checkbox"/> Ulcers, Stomach, Esophagus, Intestinal, Rectal or Colon related Diagnosis | v. <input type="checkbox"/> <input type="checkbox"/> Ear, Eye or Skin related Diagnosis | ff. <input type="checkbox"/> <input type="checkbox"/> Is anyone named in this application currently disabled or unable to perform normal work or age related activities. Date of Disability _____ |
| j. <input type="checkbox"/> <input type="checkbox"/> Transplant of any kind | w. <input type="checkbox"/> <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) | |
| k. <input type="checkbox"/> <input type="checkbox"/> Obesity or Gastric Bypass | | |
| l. <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia or Chronic Fatigue Syndrome | | |
| m. <input type="checkbox"/> <input type="checkbox"/> Benign tumor or benign growth | | |

3. In the spaces below, provide full details to questions for which you answered "Yes" above. If additional space is needed, attach a separate sheet of paper.

QUESTION NO. & LETTER	FAMILY MEMBER	DATES OF TREATMENT	DATE OF FULL RECOVERY	LIST THE CONDITION AND TYPE OF TREATMENT RECEIVED	NAME/PHONE NUMBER OF PHYSICIAN/HOSPITAL

7. DISCLOSURES, AUTHORIZATION AND SIGNATURE

The medical policy excludes coverage for health care services relating to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within six months for groups with 2-50 employees, and within 90 days for groups with 51 or more employees, prior to your enrollment date. This waiting period for pre-existing conditions complies with state and federal law and will not exceed a period of 90 days from your enrollment date. The policy's waiting period for pre-existing conditions will be shortened if you had prior qualifying coverage and had no lapse in coverage of 63 days or more (not including probationary periods). Prior qualifying coverage may be demonstrated by providing the Administrator with a Certificate of Creditable Coverage from your prior plan or health insurance carrier. If you don't have a Certificate of Creditable Coverage, contact your prior plan or carrier. Federal law requires your prior plan to provide you with such a Certificate if you send them a written request within 24 months of the date your coverage ended. If you aren't able to obtain a Certificate of Creditable Coverage after requesting one in writing, the Administrator will assist you in obtaining the necessary information to demonstrate prior qualifying coverage.

If applicable, I authorize my employer to make deductions from my earnings for my share of the cost of the coverage to which I am entitled. I have answered the above questions to the best of my knowledge and belief. I understand and agree that no coverage shall be in force until: subscription to the Trust has been accomplished, the Administrator approves this application, eligibility requirements have been met, and certificate of insurance is issued, which shall not be valid unless the first period cost is paid. Coverage for employees and dependents of a small employer group will not be denied due to medical history. I further understand that this application will become a part of my certificate and any coverage afforded will be in consideration of the answers being true and complete and the premium paid. I also understand that any misstatements or failure to provide sought for information may be used as the basis for rescission, retroactive premium rating or nonrenewal of this insurance plan.

Signature of Applicant _____

Date Signed _____

8. WAIVER OF INSURANCE

If you wish to waive coverage for yourself and/or your dependents, please complete this section and sign below.

Employee Name _____ SS # _____ Date of Birth _____

#1 Employee's Refusal of:

- Group Medical Insurance
- Dental Insurance
- Life Insurance

for: myself my spouse my child/ren

#2 Reason for Refusal:

- Insured under spouse's plan
- Insured under another plan
- Contribution required
- Other (list explanation) _____

I hereby certify that I have been given an opportunity to apply for insurance under the Group Insurance policy or policies provided by my employer, and that I have declined to do so.

I understand that by not applying for such insurance, I will not become insured under said policy or policies and will not be entitled to any benefits thereunder.

I further understand that if I and/or my dependents desire to apply for such insurance at a later date, coverage may possibly not be available or I may be required to provide health status information for purposes of group rate setting. Depending on applicable law, coverage may possibly not be issued or penalties such as deferred effective dates or pre-existing limitations may be imposed.

Signature of Applicant _____ Date Signed _____

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents are waiving medical coverage, the following special enrollment periods may be available.

- If you and/or your eligible dependents (including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose eligibility for that other health plan (this includes COBRA coverage), then you and/or your eligible dependents may be able to enroll in this plan provided you request enrollment within 63 days, for groups with 2-50 employees, and within 31 days, for groups with 51 or more employees, of the other coverage ending.
- If you and/or your eligible dependents (including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose the employer contribution for that other plan, then you and/or your eligible dependents may be able to enroll in this plan provided you request enrollment within 63 days, for groups with 2-50 employees, and within 31 days, for groups with 51 or more employees, of the loss of the employer contribution for the other coverage.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days after the event.

Failure to specify that you are declining coverage because you have other coverage may waive your special enrollment rights as described above.