

Group Number _____

Group Name _____

Group Life Plus Special Simplified Application for Basic Group Term Life and AD&D

Please note: Review eligibility requirements on reverse side of this form before completing this application.

Name of Employee (<i>Last Name, First Name, MI</i>)			Name of Spouse (<i>Last Name, First Name, MI</i>)		
Address			Address		
City	State	Zip Code	City	State	Zip Code
Telephone Number			Telephone Number		
Gender: (<i>Male or Female</i>)		Date of Birth (<i>MM/DD/YY</i>)	Gender: (<i>Male or Female</i>)		Date of Birth (<i>MM/DD/YY</i>)
Height (<i>Feet & Inches</i>)	Weight (<i>Pounds</i>)	Age	Height (<i>Feet & Inches</i>)	Weight (<i>Pounds</i>)	Age
Social Security Number		Annual Salary	Social Security Number		Annual Salary
Have you used tobacco products within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No			Have you used tobacco products within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No		

1. Are you actively at work? **Employee:** Yes No
Spouse: Yes No I am not employed but I am performing activities of a person of like age and gender.

2. **Employee:** How many hours per week do you work? 3. **Employee:** What date were you hired by your Employer? (*MM/DD/YY*)

First Application Add Dependents Delete Dependents Increase Coverage Decrease Coverage Cancel All Coverage
 Life Status Change Marriage (*MM/DD/YY*): _____ Birth of Child (*MM/DD/YY*): _____

Employee Coverage: Benefit Amount _____ Class _____ Job Title _____

If you meet the eligibility guidelines, you will be insured for the basic amount of benefit up to the Conditional Guaranteed Issue Limit of \$50,000. For employer-paid insurance in excess of \$50,000, coverage will be provided on a Simplified Issue basis. You must answer the five evidence of insurability questions below. Acceptance is based on the answers to the questions.

Dependent Coverage: Yes No

If you answered "Yes" to dependent coverage, please list all dependents, relationships and dates of birth below. (Attach a list for additional dependents.)

Dependents	Relationship to Insured	Date of Birth	Dependents	Relationship to Insured	Date of Birth

Evidence of Insurability Questions: Answer all questions and give details to any "Yes" answers in the space provided below. (Attach separate sheet for more details.)

- Within the past six months, has any illness, injury or other health problem prevented any person proposed to be insured from: (1) working full-time at a regular occupation; or (2) if not employed, from performing activities of a person of like age and gender? **Employee:** Yes No **Spouse:** Yes No
- Has any person proposed to be insured had any disorder of the heart, chest pain, circulatory problems, blood disease, high blood pressure, respiratory, nervous, digestive, kidney, liver, urinary tract or reproductive system problems, cancer, tumor, diabetes, ulcers, epilepsy, emotional or mental disorders, any disease or abnormality of the brain, drug addiction or alcoholism? **Employee:** Yes No **Spouse:** Yes No
- Within the past five years, has any person proposed to be insured had a sexually-transmitted disease, positive test results to the Acquired Immune Deficiency Syndrome (AIDS) virus or an actual diagnosis of, or treatment by a member of the medical profession for AIDS?
Employee: Yes No **Spouse:** Yes No
- Are you presently taking any medication? **Employee:** Yes No **Spouse:** Yes No
If "Yes," give the name of medication and dosage: _____
- Has any person proposed to be insured received any medical or surgical advice of any ailment, injury or sickness other than listed above?
Employee: Yes No **Spouse:** Yes No

Illness Details	Person(s)	Date(s)	Results

Beneficiary Designation: The Employee will be the beneficiary of any coverage on any eligible child/children.

Employee's Beneficiary	Relationship	Spouse's Beneficiary	Relationship
Contingent Beneficiary	Relationship	Contingent Beneficiary	Relationship

I (we) represent that all statements and answers made above and attached to this application are true and complete to the best of my (our) knowledge and belief. **I (we) understand** that any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. **I (we) understand** that coverage shall be in effect only after all of these conditions have been met: (a) this application has been approved by the applicable Company; and (b) the Contract has been issued while all persons to be insured thereunder are alive; and (c) the answers and statements in this application continue to be true and complete up until the Contract Effective Date and that coverage will not take effect if the facts have been changed. **I (we) have also read, understand and agree** to the additional terms, conditions and requirements mentioned below under *Eligibility Requirements, Authorization to Obtain Information, and Insurance Information Practices*. **LASTLY, I (WE) UNDERSTAND AND THAT COMPLETION OF THIS APPLICATION IN NO WAY IMPLIES THAT I (WE) WILL BE ACCEPTED FOR INSURANCE COVERAGE.**

If I am enrolling for coverage, my signature below authorizes and directs my Employer to make the necessary payroll deductions for the amount of insurance indicated for me and my dependents, if any.

I do not want to apply for coverage.

Signed at: City _____ State _____ **by:** Employee's Signature _____ Date _____

on: Month _____ Date _____ Year _____ Spouse's Signature _____ Date _____

ELIGIBILITY REQUIREMENTS

Employee: (1) If your Employer requires that you must be continuously employed for a minimum number of days (as set forth in the Group Master Policy Schedule), you must be continuously employed for at least that number of days; (2) you must be actively performing the regular duties of your job for the minimum number of hours per week required by your Employer (as set forth in the Group Master Policy Schedule) in the usual manner and at the usual place of employment or business (if you are **not** working due to illness or injury, you will **not** be eligible until you return to work); and (3) you must give us evidence of insurability satisfactory to us, if we ask for it. (See NOTE below.)

Spouse: (1) You must be legally married to the Employee, as determined by the laws of the State in which the Employee lives; (2) if employed, you must be actively performing the regular duties of your job in the usual manner and at the usual place of employment or business (if you are **not** working due to illness or injury, you will **not** be eligible until you return to work); (3) if **not** employed, you must be able to perform the normal activities of a person of the same age and gender (if you are disabled, you are **not** eligible); and (4) you must give us evidence of insurability satisfactory to us, if we ask for it. (See NOTE below.) A Spouse does **not** include anyone who is personally eligible as an Employee.

Dependent Child: is an unmarried child who is: (1) your natural child; or (2) a legally adopted child, or a child for whom adoption proceedings have been started; or (3) a stepchild who lives with you; or (4) a child for whom you have been appointed legal guardian who lives with you. A Dependent Child must: (a) be at least 15 days old, but less than 25 years old; and (b) depend on you for financial support. In the States of New Hampshire and South Carolina, special provisions may apply for children who are physically or mentally challenged. For each Dependent Child, you must give us evidence of insurability that is satisfactory to us, if we ask for it. (See NOTE below.) A Dependent Child does **not** include anyone who is personally eligible as an Employee. If you and your spouse are both eligible as an Employee, your dependent children may be insured as Dependent Children of either you or your spouse, but **not** both of you.

NOTE: We will ask for evidence of insurability from **all** eligible Employees and **all** eligible Spouses who apply for this insurance. We will also ask for evidence of insurability if: (1) an insured converts this group insurance to permanent insurance, and later becomes eligible again for this group insurance; and (2) an insured voluntarily asks to stop his/her insurance, and then asks to reinstate it a later date. We reserve the right to ask for evidence of insurability if an insured's death benefit is increased.

AUTHORIZATION TO OBTAIN INFORMATION

I (we) authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me (us) and any other non-medical information of me (us) to give to the applicable Company or its legal representatives, any and all such information.

I (we) understand the information obtained by use of this Authorization will be used by the applicable Company to determine eligibility for insurance. Any information obtained will not be released by the applicable Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my (our) application, claim, or as may be otherwise lawfully required or as I (we) authorize.

I (we) know that I (we) may request to receive a copy of this Authorization. **I (we) agree** that a photographic copy of this Authorization shall be as valid as the original. **I (we) agree** that this Authorization shall be valid for two and one-half years from the date shown below. **I (we) understand** that if an investigative consumer report is ordered in connection with this application, I (we) may elect to be interviewed in connection with the preparation of the report and, upon request, I (we) will be provided with a copy of the report.

I (we) elect to be interviewed if an investigative consumer report is prepared. **Employee:** Yes No **Spouse:** Yes No

Employee's Signature _____ Date _____ Spouse's Signature _____ Date _____

INSURANCE INFORMATION PRACTICES

The applicable Company may also release information in its files to its reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

Information regarding your insurability will be treated as confidential except that the applicable Company may make a brief report to the Medical Information Bureau, Inc., a non-profit organization of life insurance companies which operates as an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, the Medical Information Bureau, Inc. will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Medical Information Bureau, Inc. will arrange disclosure of any information it may have in your file. Medical information will only be disclosed to your attending physician. If you question the accuracy of information in the Bureau's file, you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is **Post Office Box 105, Essex Station, Boston, Massachusetts 02112**. Their telephone number is **(617) 426.3660**.