Colonial Life & Accident Insurance Company
P.O. Box 1365, Columbia, SC 29202-1365

GROUP SPECIFIED DISEASE INSURANCE EVIDENCE OF INSURABILITY

Enrollment Type : ☐ Initial Enrollment ☐ New Hire ☐ Late entrant
☐ Qualifying Event: Date (mm/dd/yyyy): _____ Event: _____

NAMED INSURED SECTION – 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			Home Phone No. Business Phone No.	
Date Employed	Occupation/Job Title	Annual Base Salary	Hrs. Worked/Wk	Employee Class
Employer Name	Employer Address (Street-City-State-Zip)			Section/Dept. No.

SPOUSE/ DEPENDENT SECTION				
Is your spouse applying for coverage? If yes, provide identifying information below.				Yes ☐ No ☐
Name of Spouse (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
Are there any eligible dependent children applying for coverage?		Yes ☐ No ☐		Number Deps:

PLAN SECTION					
Type of Coverage	**Plan Code(s)**	**Units**	**Rider Code**	**P = Pre-Tax A = After-Tax**	**Monthly Premium**
☐ Named Insured ☐ Named Insured & Spouse ☐ One-Parent Family ☐ Two-Parent Family				P ☐ A ☐	

ELIGIBILITY INFORMATION – Required for all levels of underwriting	
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?	Yes ☐ No ☐

AIDS SECTION – Complete for all Products	**Proposed Insured**	**Spouse**	**Dependent**
3. Have you been diagnosed with, treated or tested positive for the Human Immunodeficiency Virus (HIV) or for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

SIMPLIFIED ISSUE – Complete questions 4 and 5 for Cancer. Complete question 6 for Critical Illness.			
	Proposed Insured	**Spouse**	**Dependent**
4. In the past 5 years, have you received medical advice or sought treatment for cancer, other than basal cell carcinoma, squamous cell carcinoma or melanoma Clark's level I or II?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
5. In the past 12 months have you received preventative hormonal therapy?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
6. Within the past 10 years, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI) — Blood Pressure Reading of 160/100 or above Hepatitis B or C — Heart Disease Heart Surgery — Kidney Disease except stones Organ Transplant — Emphysema Cirrhosis of the Liver — Chronic Obstructive Pulmonary Disease Transient Ischemic Attack — Congestive Heart Failure Stroke — Diabetes Macular Degeneration — Abnormal Catheterization Retinitis Pigmentosa — Glaucoma	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Any dependent with a "Yes" answer on questions 4 – 6 must be listed below and will be excluded under the Group Specified Disease Insurance certificate to which a copy of this evidence of insurability form is attached.

Name (First, MI, Last)	Relationship	Birthdate (mm/dd/yyyy)	Social Security No.

SIMPLIFIED ISSUE LEVEL 1 – Complete question 7 for Cancer. Complete questions 8 – 10 for Critical Illness.	**Proposed Insured**	**Spouse**	**Dependent**
7. Within the last12 months, have you received medical advice, sought treatment, had surgery or had an abnormal diagnostic test for the presence of cancer? If yes, provide details in the health details section.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
8. Indicate Current Height / Weight (Proposed Insured and spouse, if spouse coverage applied for) Proposed Insured: Height _____ Weight_____ Spouse: Height _____ Weight_____			
9. Are you currently prescribed any medication? If "Yes", provide details in the health details section.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10. Within the last 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? If yes, please provide details in the health details section.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

HEALTH DETAILS SECTION

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

ADDITIONAL DATA SECTION

AGREEMENT SECTION

All exceptions and limitations pertaining to the coverage(s) for which I have applied have been explained to me including any pertaining to pre-existing conditions. 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.

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancellation of my Colonial Life Policy/Certificate Number(s) _____. Transfer or cancellation of the base plan will also mean cancellation of all attached riders. If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.

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

(x)_____
Signature of Proposed Insured (if applicable)

AGENT SECTION

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 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.

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

Agent Name_____ License No._____ Code No._____