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

GROUP ACCIDENT INSURANCE ENROLLMENT FORM

Enrollment Type: ☐ Initial Enrollment ☑ New Hire

☐ Qualifying Event: Date _____ Event:_____

Proposed Insured Section – Always complete					
Proposed Insured (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 Income	Hrs. Worked/ Week	Employee Class
Policyholder Name	Policyholder Address (Street-City-State-Zip)				Section/Dept. No.

Eligibility Information – Always complete	
Are you actively working?	Yes ☐ No ☐

Spouse/Dependent Section – Always complete				
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 dependents applying for coverage?				Yes ☐ No ☐

Beneficiary Information – Employee only					
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.

Plan Section				
Type of Coverage		**Plan Code**	**P = Pre-Tax A = After-Tax**	**Monthly Premium**
☐ Proposed Insured ☐ Proposed Insured & Spouse	☐ One Parent Family ☐ Two Parent Family		P ☐ A ☐	

Agreement Section

I understand that if sickness hospital confinement coverage is applied for, 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 will not be paid. By applying for the coverage indicated above, I am requesting cancellation of existing Accident Insurance with Colonial Life & Accident Insurance Company (base plan and all applicable riders) if the coverage applied for is issued. If for any reason the coverage applied for is not issued, this request for cancellation shall be null and void. 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. All statements and information found in the application are deemed representations and not warranties. The statements are true and have been completed to the best of my knowledge and belief.

Signed at: City_____ State _____ Date _____

(x)_____
Signature of Named 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._____