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

GROUP DISABILITY INSURANCE ENROLLMENT FORM

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

PROPOSED 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.

PLAN SECTION

Type of Coverage	Plan Code(s)	Units	Rider Code	P = Pre-Tax A = After-Tax	Monthly Premium
☐ On/Off-Job ☐ Off-Job Benefit Period_____ Elimination Period___ ____					

ELIGIBILITY INFORMATION

E1. Are you actively working?	Yes ☐ No ☐

REPLACEMENT SECTION

R1. Will any disability insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued? (If yes, provide details)	Yes ☐ No ☐

Insurance Company	Type Coverage	Policy Number

AGREEMENT SECTION

THE APPLICANT AGREES AS FOLLOWS:
To the best of my knowledge and belief, the answers and statements above are true and complete. 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. I understand that this enrollment form will not be binding upon Colonial Life until both: 1) the policy is issued; and 2) the first premium is paid. I understand that any untrue statement or material misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid.

By applying for the coverage indicated above, I am requesting cancellation of existing Disability Insurance with Colonial Life & Accident Insurance Company 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. I hereby certify the answers and statements above are true and have been completed to the best of my knowledge and belief.

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, change or waive 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._____