

APPLICATION TO: **COLONIAL LIFE & ACCIDENT INSURANCE COMPANY** P. O. Box 1365, Columbia, SC 29202  
 Is the proposed insured Medicare eligible?  Yes  No Have you received the Important notice to persons on Medicare?  Yes  No

1. Proposed Insured (Print) (First, M.I., Last)		<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (MM/DD/YYYY)	Social Security No.	
Home Address - Street	City	State	Zip	Telephone - Home ( )	Business ( )	
2. Name and Address of Payroll Deduction Account				<input type="checkbox"/> Full FICA (F)	<input type="checkbox"/> FICA - Exempt (N)	<input type="checkbox"/> Medicare Only (P)
3. Job Title/Duties	Date Emp. (MM/DD/YYYY)	Hrs. Wkd./Week	Payroll No.	Section/Dept. No.		
4. Primary Beneficiary - Full Name	Age	Relationship	Contingent - Full Name (Life Only)	Age	Relationship	
5. Payor or Owner if other than Proposed Insured (Name, Address, Social Security No.)				<input type="checkbox"/> Payor	<input type="checkbox"/> Owner	<input type="checkbox"/> Both

**6. DEPENDENTS (Complete For All Dependent Coverage)**

Name (Print First, Last)	Relationship	Birthdate (MM/DD/YYYY)	Social Security No.	Plan

**7. ACCIDENT INSURANCE (In addition, complete section 11f)**  New  Transfer

Plan	Units	Rider	Annual Income	<input type="checkbox"/> Spouse <input type="checkbox"/> Dep. Children	<input type="checkbox"/> Add Spouse Only <input type="checkbox"/> Add Dep. Children Only	Flex Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Accident Premium \$
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**8. HEALTH INSURANCE (In addition, complete section 11)**  New  Transfer

Plan	Units	Rider	Annual Income	<input type="checkbox"/> Spouse <input type="checkbox"/> Dep. Children	<input type="checkbox"/> Add Spouse Only <input type="checkbox"/> Add Dep. Children Only	Flex Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Premium \$
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**9. CANCER/INTENSIVE CARE (In addition, complete sections 11d, e & f)**  New  Transfer

Cancer Plan	<input type="checkbox"/> Ind. <input type="checkbox"/> 1 Parent Family <input type="checkbox"/> 2 Parent Family	Flex Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer/IC Premium \$
IC Plan	Units <input type="checkbox"/> Ind. <input type="checkbox"/> 1 Parent Family <input type="checkbox"/> 2 Parent Family			

To the best of your knowledge and belief, has anyone to be covered under this Policy/Rider ever had or been told they have had any of the following:

1a. (Complete for Cancer Coverage) Cancer, leukemia, Hodgkin's disease, melanoma or malignant tumors of any kind?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
1b. Does any proposed insured have any other cancer insurance with us?	<input type="checkbox"/>	<input type="checkbox"/>
2. (Complete for Intensive Care Coverage) Any disease or disorder of the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>

If answer is "yes" to either of the above, please give details in section 11c.

**10. LIFE INSURANCE (In addition, complete section 11)**  Option A  Option B

Plan	Face Amount	UL Target Premium	Auto. Prem. Loan, If available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Settlement Option	Life Premium
Riders: <input type="checkbox"/> Spouse <input type="checkbox"/> Spouse Beneficiary <input type="checkbox"/> Relationship <input type="checkbox"/> Age <input type="checkbox"/> Dependent Children <input type="checkbox"/> Other Rider	Unit(s)	Unit(s)	Unit(s)		Base Plan \$ _____ Riders \$ _____ Total \$ _____
a. Has the proposed insured smoked cigarettes during the twelve months before the date of application? <input type="checkbox"/> Yes <input type="checkbox"/> No		b. Height Weight 1035 Exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No			

**11. COMPLETE FOR LIFE AND/OR HEALTH (in addition to sections 8 & 10 above)**

a. In the last year, have you missed more than five consecutive days of work due to an illness or injury? If "yes," provide 5-year health history in section 11c including any consultation or treatment by a physician, hospitalization or checkups.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. To the best of your knowledge and belief, have you or any other proposed insured received hospital treatment as an inpatient or outpatient in the last year? If "yes," provide 5-year health history in section 11c including any consultation or treatment by a physician, hospitalization or checkups.	<input type="checkbox"/>	<input type="checkbox"/>

c. Name	Relationship	Nature of illness, injury or medical attention	Date and duration (MM/DD/YYYY)	Name and address of physician, hospital or clinics

d. Have you or any proposed insured tested positive for the HIV virus or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? Yes  No

e. Will any health or life insurance or annuities in this or any other company be modified or discontinued if insurance now applied for is issued?  Yes  No If "yes," list company, amount and policy number.

**Complete Question f only if the proposed insured is 65 or older:**  
 f. Does any proposed insured have any other insurance, other than life, in force with us or any other insurer?  Yes  No  
 If yes, please complete the Accident and Health Insurance Disclosure Form (53657).

12. OTHER Plan Units Rider	Premium \$	Total Premium \$
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To the best of my knowledge and belief, the answers and statements above are true and complete. I understand that this application will not be binding upon the Company until both: 1) the policy is issued; and 2) the first premium is paid. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. If applicable, I have received an outline of coverage for the plan(s) of health insurance applied for. **I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER. FAIR CREDIT REPORTING ACT ACKNOWLEDGEMENT: In compliance with the Fair Credit Reporting Act, we are informing you that as a part of our routine procedures, an investigative consumer report may be made. Under the Act, you have the right to make a written request within a reasonable time for an additional disclosure concerning the nature and scope of the investigation requested.**

Signed At: City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_ (MM/DD/YYYY)

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of Proposed Insured (Signature of parent if proposed insured is a minor child) Signature of Owner/Payor (If other than proposed insured)

AGENT'S STATEMENT: I hereby certify that I have truthfully and accurately recorded on this application the information supplied by the Proposed Insured. I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to pre-existing conditions, if applicable. Will any health or life insurance or annuities in this or any other company be modified or discontinued if insurance now applied for is issued?  Yes  No  
 I further certify that I am a licensed agent in the state where this application is being taken.

Print Name of Soliciting Agent	Code Number	% Credit	Signature of Soliciting Agent
			Signature of Joint Agent (if any) Code Number % Credit