HOSPITAL CONFINEMENT Plan B

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)	☐Spouse ☐Dependent	☐M ☐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	☐ Full FICA (F)	☐ FICA – Exempt (N)	☐ 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.) ☐ Payor ☐ Owner ☐ 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	☐Spouse ☐Dep. Children	☐ Add Spouse Only ☐ Add Dep. Children Only	Flex Plan ☐Yes ☐ No	Accident Premium $

8. **HEALTH INSURANCE** (In addition, complete section 11) ☐ New ☐ Transfer

Plan	Units	Rider	Annual Income	☐Spouse ☐Dep. Children	☐ Add Spouse Only ☐ Add Dep. Children Only	Flex Plan ☐Yes ☐ No	Health Premium $

9. **CANCER/INTENSIVE CARE** (In addition, complete sections 11d, e & f ☐ New ☐ Transfer

Cancer Plan		☐ Ind ☐1 Parent Family ☐2 Parent Family	Flex Plan ☐Yes ☐ No	Cancer/IC Premium $
IC Plan	Units	☐ Ind ☐1 Parent Family ☐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:

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

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? ☐Yes ☐No	Settlement Option	Life Premium
					Base Plan $

Riders:	☐Spouse Unit(s)	Spouse Beneficiary	Relationship	Age	☐Dependent Children Unit(s)	Other Rider	Riders $
							Total $

a. Has the proposed insured smoked cigarettes during the twelve months before the date of application? ☐Yes ☐No

b. Height ____ Weight ____ 1035 Exchange? ☐Yes ☐No

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

	Yes	No
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.	☐	☐
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.	☐	☐

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

	Yes	No
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)?	☐	☐

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 $

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

Form GAP-92-SC-3 53659-1

EMPLOYEE'S RECEIPT

NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you and any other persons proposed for insurance. Some of that information will come from you and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have a right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceedings.

If you wish to have a more detailed explanation of our information practices, please submit a written request to Manager, Underwriting, P. O. Box 1365, Columbia, South Carolina, 29202