

Employee Enrollment Form

Evidence of Insurability for Small Group Coverage



1133 SW Topeka Blvd, Topeka KS 66629-0001
FAX (785) 290-0727 or Phone (800) 530-5989

Always complete sections A*, E*, F* and G*; and, any other section as indicated for the coverage you are applying for:

- Basic Term Life and AD&D - *, and section B Short Term Disability (STD) - * Long Term Disability (LTD) - *
 Dependent Life - *, and section D Voluntary STD - *, and attach form AICK 6003
 Voluntary Life - *, and sections B and C. If you are applying for spouse or dependent child coverage, include section D.

Section A — The Employee

Name _____ Social Security No. _____
Last First MI
Home address _____ City _____ State _____ ZIP _____
Employer _____ Work phone () _____
Employer's name City
Date of birth (DOB) _____ Gender: Male Female Occupation/job title _____
Month Day Year
Your Height _____ ft. _____ in. Weight _____ lbs. Do you have dependent children under the age of 23? Yes No
Hourly wage \$ _____ Full-time employment date _____ Rehire date _____
Month Day Year Month Day Year
I am actively at work performing all of my job duties. Yes No I work _____ hours each week for this employer.
I am: Single Married Legally separated Does the firm shown above employ your spouse? Yes No

Section B — Your Beneficiary. If space is inadequate, attach a separate signed and dated list providing complete information.

*The **primary beneficiary** will receive the death benefit. If two or more beneficiaries are named, the proceeds will be paid in equal shares unless stated otherwise. If listing a minor child as beneficiary, the proceeds will be paid to a legal representative appointed by the court system on behalf of the child.

Employee primary* beneficiary _____
Last First MI Relationship Age Social Security No.

The **contingent beneficiary, below, will receive the death benefit only if the primary beneficiary is deceased.

Employee contingent** beneficiary _____
Last First MI Relationship Age Social Security No.

Section C — Voluntary Life

I want to enroll in the Voluntary Life Yes No Minimum \$10,000 to \$100,000 maximum or 5 times your annual salary, whichever is less, in increments of \$1,000. If you, as an employee, aren't enrolled in AICK's Basic or Voluntary life, your spouse may apply for \$10,000 to \$25,000 in increments of \$1,000. Employee \$ _____ Spouse \$ _____

Voluntary dependent child(ren) coverage is contingent upon approval of your, or your spouse's, application for voluntary life insurance.
 \$2,500 \$5,000 \$7,500 \$10,000 Ages 6 months to 23 years (ages 15 days to 6 months receive 10% of selected benefit).

Your beneficiary for Voluntary Life insurance will be the same as shown in Section B unless you instruct us otherwise in writing.

Section D — Dependent Life Coverage (Basic and/or Voluntary)

Spouse's Name _____ Gender: Male Female
Last First MI

If your spouse is applying for Voluntary Life, they should complete the information below:

DOB _____ Height _____ ft. _____ in. Weight _____ lbs. Social Security No. _____
Month Day Year

A spouse's beneficiary under Basic Dependent Life coverage is automatically the insured employee. If the space is inadequate for your spouse's Voluntary Life beneficiary(ies), attach a separate signed and dated list providing complete information. (see * and ** in Section B)

Spouse's primary* Beneficiary _____
Last First MI Relationship Age Social Security No.

Spouse's contingent** beneficiary _____
Last First MI Relationship Age Social Security No.

Complete the following only if you are requesting coverage for a dependent child(ren) that is a late enrollee — if additional space is needed, attach a separate signed and dated sheet. A dependent child's beneficiary under Basic Dependent Life is automatically the insured employee; and, the beneficiary of Voluntary Life is automatically the insured parent.

Full name of child _____ Gender: Male Female
Last First MI

DOB _____ Height _____ ft. _____ in. Weight _____ lbs.
Month Day Year

Social Security No. _____ Relationship to employee _____

Full name of child _____ Gender: Male Female
Last First MI

DOB _____ Height _____ ft. _____ in. Weight _____ lbs.
Month Day Year

Social Security No. _____ Relationship to employee _____

Section E — Medical History

Please answer all the questions below, as these questions would apply to you or any of your dependents that are applying for coverage. **Has anyone been diagnosed, treated, or had any of the following conditions?**

	Employee	Spouse	Children (late enrollee)
1. Heart or artery disorder; heart murmur or heart attack; tuberculosis; liver, stomach or intestine disorder; kidney disorder; asthma, lung or other respiratory disorder?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
2. Being treated for high blood pressure? If yes , give last two readings and dates, below.	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
3. Diabetes, albumin, blood or sugar in the urine? If diabetic , give age of onset and how controlled.	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
4. Cancer, leukemia, malignant growth or any form of tumor?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
5. Epilepsy or any mental or nervous system disorder, alcoholism, drug or substance abuse?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
6. Any disorder of immune system, including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or HIV infection?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
7. Back, spine or bone disease or disorder?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
8. Within the past five years have you or any person applying for coverage consulted or been attended by a doctor, psychiatrist, psychologist, or medical practitioner for any health reason or condition other than the ones listed?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
9. Is anyone applying for coverage presently pregnant? If yes , provide expected delivery date.	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
10. Is any person applying for coverage presently under observation or receiving medical treatment? Presently taking medication? If yes , provide the name of the condition, name of the medication, dosage and frequency, below.	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
11. Has any person applying for coverage ever been rated, declined, postponed or limited in any way for life, disability, health or accident insurance?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

Section F — Explain conditions in detail below for any “yes” responses to questions 1-11. If incomplete, this form will be returned to you, causing a delay in the application process. If additional space is needed, please attach separate signed and dated sheet with the response.

Question no.	Applicant's name	Nature of condition	Medication prescribed name/dosage/frequency	Date diagnosed	Last date physician seen	Degree of recovery	Complete name & address of physician

Section G — Authorization. The requested insurance will not be effective until approved by AICK.

I understand that my spouse and I must both sign this section if I am applying for spouse and/or dependent coverage. The signature(s) verifies that the dates of birth, heights and weights are correct; that the answers to the questions and any statements contained therein are true and complete; and, that every occasion and instance as to each item answered ‘yes’ has been disclosed.

My signature authorizes any physician, medical practitioner or provider of services, hospital, clinic, pharmacy or other medically related facility, insurance or reinsurance company, the Medical Information Bureau Inc. (MIB), consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of, and any other non-medical information about, me, my spouse, or my minor children to release and disclose to Advance Insurance Company of Kansas (AICK), or to its reinsurance companies, a complete copy of any and all such information.

I understand that the information obtained by use of this Authorization will be used by AICK to determine eligibility for insurance and that my application for coverage may be delayed or denied if AICK is unable to obtain information necessary to do so.

I understand that information disclosed may no longer be protected and may be re-disclosed without further authorization. Note that AICK will not release information to any person or organization **except** to reinsurance companies or other persons, or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or further authorized.

I have a right, at any time, to revoke this authorization by submitting a written request directly to such persons or entities. My revocation will not be effective to the extent that action has been taken in reliance upon this authorization or AICK otherwise has the right to contest the policy or claims under the policy.

I know that I, or my authorized representative, may request to receive a copy of this application. I agree that a photographic copy of the authorization shall be as valid as the original. I agree this authorization shall be valid for 24 months from the date shown below. If my answers on this application are incomplete, incorrect, or untrue, AICK has the right to deny benefits or rescind coverage.

I (1) request the coverage for which I am or may become eligible under the group policy or policies issued by AICK; (2) authorize the necessary payroll deductions, if any, from my earnings; (3) designate the beneficiary named on this form to receive the benefits, if any, payable in the event of death; (4) understand that among the requirements for continued eligibility is that I be a full-time active employee working the hours per week required for eligibility as stated in the group policy. I believe that all persons for whom I am requesting coverage are resident citizens of the U.S.A. or are aliens legally residing in the U.S.A., and that, to the best of my knowledge, the information which I have provided on this form is true and correct as it pertains to my status with the above employer.

Employee Sign Here X Date Signed _____
 Spouse Sign Here X Date Signed _____