

# Employee Enrollment Form

FOR VOLUNTARY COVERAGE



1133 S.W. Topeka Boulevard, Topeka, KS 66629-0001  
 Phone in Topeka (785)273-9804, in Kansas (800)530-5989  
 Fax (785)290-0727 website: www.advanceinsurance.com

- Voluntary Short Term Disability** – complete sections A, C and H, (If a late enrollee, also complete F and G)
- Voluntary Term Life** – complete sections A, B, E, F, G and H
- Voluntary Accidental Death & Dismemberment** – complete sections A, B, D and H
- Voluntary Long Term Disability** – complete sections A and H (If a late enrollee, also complete F and G)

## Section A – The Employee (Always complete this section and sign and date section H.)

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Last First MI  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Date of Birth                         Height    ft.    in. Weight    lbs. Gender:  Male  Female  
M M D D Y Y Y Y

Employed by \_\_\_\_\_ Work Phone (    ) \_\_\_\_\_  
Employer's Name City

Date of Hire                         Hourly Wage \$ \_\_\_\_\_ Occupation/Job Title \_\_\_\_\_  
M M D D Y Y Y Y

Reason for change in employment:  Part-time to full-time  Temporary to permanent  Rehire/recall  Other (specify)  
 Date this occurred                          
M M D D Y Y Y Y

Are you actively at work performing all of your job duties?  Yes  No I am working \_\_\_\_\_ hours weekly for this employer.

Your Physician's Name: \_\_\_\_\_

Your Physician's Complete Address: \_\_\_\_\_  
Street or PO Box, City State, ZIP

## Section B – The Employee's Beneficiary

\*The **Primary Beneficiary** receives your death benefit. If naming two or more beneficiaries, proceeds will be paid in equal shares unless stated otherwise. If listing a minor, proceeds will be paid to a conservator appointed by the court system for the child. **If space is inadequate for your beneficiaries, attach a separate signed and dated list providing complete information.**

**\*Primary Beneficiary**

Last	First	MI	Relationship	Date of Birth	City, State
Last	First	MI	Relationship	Date of Birth	City, State

\*\*The Contingent beneficiary, below, will receive the death benefit **ONLY** if the primary beneficiary is deceased.

**\*\*Contingent Beneficiary**

Last	First	MI	Relationship	Date of Birth	City, State
Last	First	MI	Relationship	Date of Birth	City, State

## Section C – Voluntary Short Term Disability

(Select one plan.) Circle the plan you have selected. The maximum weekly benefit may not exceed 70% of your basic weekly income.

Plan	To select this weekly benefit	Your annual salary must be at least	Plan	To select this weekly benefit	Your annual salary must be at least	Plan	To select this weekly benefit	Your annual salary must be at least	Plan	To select this weekly benefit	Your annual salary must be at least
1	\$100	\$ 7,430	6	\$350	\$26,000	11	\$600	\$44,570	16	\$850	\$63,145
2	\$150	\$11,140	7	\$400	\$29,715	12	\$650	\$48,285	17	\$900	\$66,860
3	\$200	\$14,860	8	\$450	\$33,430	13	\$700	\$52,000	18	\$950	\$70,570
4	\$250	\$18,570	9	\$500	\$37,145	14	\$750	\$55,715	19	\$1,000	\$74,285
5	\$300	\$22,285	10	\$550	\$40,860	15	\$800	\$59,430			

## Section D – Voluntary Accidental Death & Dismemberment

Amount of Principal Sum \$ \_\_\_\_\_ Monthly Premium \$ \_\_\_\_\_  Employee Plan  Family Plan

The Employee will be the beneficiary for a spouse and/or dependent child(ren)'s benefit unless stated otherwise in writing.

**Section E – Voluntary Term Life**

**The medical questions in sections F & G must be answered; and, you and your spouse and any dependent child 18 years of age or older (if enrolling) must sign and date section H.**

**Employee or Spouse: Minimum is \$10,000.** Coverage amounts above the minimum may be selected in \$1,000 increments up to the maximum group benefit amount. What is the amount of the Voluntary Term Life coverage being requested?

Employee \$ \_\_\_\_\_ Spouse \$ \_\_\_\_\_

**Dependent Child:** With approval of at least \$10,000 of coverage for either the employee or their spouse, Dependent Child coverage may be requested. Eligible dependent children ages 6 months to 23 yrs. receive the selected benefit. (The benefit for a dependent child from 15 days of age up to 6 months of age is 10 percent of the selected benefit).

Select only one amount for all children in the family:

\$2,500                       \$5,000                       \$7,500                       \$10,000

**If requesting Spouse coverage – complete this section, sections F, and G; and, sign and date section H.**

Spouse Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Date of Birth <sup>Last</sup> \_\_\_\_\_ <sup>First</sup> \_\_\_\_\_ <sup>MI</sup> \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Gender:  Male  Female  
M M D D Y Y Y Y

Spouse's Employer: \_\_\_\_\_

Spouse's Physician's Name: \_\_\_\_\_

Spouse's Physician's Complete Address: \_\_\_\_\_  
Street or PO Box, City State, ZIP

**\*Spouse's Primary Beneficiary** receives the Spouse's death benefit. If naming two or more beneficiaries, proceeds will be paid in equal shares unless stated otherwise. If listing a minor, proceeds will be paid to a conservator appointed by the court system for the child. **If space is inadequate for your beneficiaries, attach a separate signed and dated list providing complete info.**

**\*Spouse's Primary Beneficiary**

Last	First	MI	Relationship	Date of Birth	City, State
Last	First	MI	Relationship	Date of Birth	City, State

**\*\*The Spouse's Contingent beneficiary, below, will receive the death benefit ONLY if the Spouse's primary beneficiary is deceased.**

**\*\*Spouse's Contingent Beneficiary**

Last	First	MI	Relationship	Date of Birth	City, State
Last	First	MI	Relationship	Date of Birth	City, State

**Dependent Child Coverage**

Child's (Children's) Physician's Name: \_\_\_\_\_

Child's (Children's) Physician's Complete Address: \_\_\_\_\_  
Street or PO Box, City State, ZIP

**If more than one child is enrolling and the physician shown above is not their medical provider, attach a separate signed and dated list providing complete information.**

A dependent child's beneficiary will be the Insured through whom the child has the Voluntary Term Life coverage.

Child's Full Name \_\_\_\_\_ Relationship to employee \_\_\_\_\_  
Last First MI  
 Date of Birth <sup>Last</sup> \_\_\_\_\_ <sup>First</sup> \_\_\_\_\_ <sup>MI</sup> \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Gender:  Male  Female  
M M D D Y Y Y Y

Child's Full Name \_\_\_\_\_ Relationship to employee \_\_\_\_\_  
Last First MI  
 Date of Birth <sup>Last</sup> \_\_\_\_\_ <sup>First</sup> \_\_\_\_\_ <sup>MI</sup> \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Gender:  Male  Female  
M M D D Y Y Y Y

Child's Full Name \_\_\_\_\_ Relationship to employee \_\_\_\_\_  
Last First MI  
 Date of Birth <sup>Last</sup> \_\_\_\_\_ <sup>First</sup> \_\_\_\_\_ <sup>MI</sup> \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Gender:  Male  Female  
M M D D Y Y Y Y

Child's Full Name \_\_\_\_\_ Relationship to employee \_\_\_\_\_  
Last First MI  
 Date of Birth <sup>Last</sup> \_\_\_\_\_ <sup>First</sup> \_\_\_\_\_ <sup>MI</sup> \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. Gender:  Male  Female  
M M D D Y Y Y Y

**Section F—Medical History**

Please answer all the medical questions below as they would apply to any eligible person that is requesting coverage.

Has anyone been diagnosed, treated for, receiving treatment, or had any of the following conditions? (Provide details to "Yes" responses in Section G, below.)				Employee	Spouse	Children	
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. High blood pressure? <b>If yes, give last two readings and dates.</b>	<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? <b>If Diabetic, give age of onset and how controlled.</b>	<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 the 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. Have you or anyone requesting coverage been seen in the past five years by any type of a medical (or mental health) doctor or practitioner for any reason or condition other than those listed in questions 1-7?	<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 presently pregnant? <b>If Yes, provide expected date of delivery.</b>	<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 anyone 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.	<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 anyone 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 G – Medical Details**

For any "Yes" response to questions 1-11 in Section F, above, explain conditions in detail below. If incomplete, this form will be returned to you, causing a delay in the application process. If additional space is required for a complete response, please attach a separate signed and dated sheet providing the details.

Question No.	Enrollee's Name	Nature of Condition	Medication Prescribed (Name, dosage, frequency)	Date diagnosed	Date last seen for this condition	Degree of recovery
Treatment provided by: _____						
Provider's complete address: _____ <small>Street or PO Box, City State, ZIP</small>						

Question No.	Enrollee's Name	Nature of Condition	Medication Prescribed (Name, dosage, frequency)	Date diagnosed	Date last seen for this condition	Degree of recovery
Treatment provided by: _____						
Provider's complete address: _____ <small>Street or PO Box, City State, ZIP</small>						

Question No.	Enrollee's Name	Nature of Condition	Medication Prescribed (Name, dosage, frequency)	Date diagnosed	Date last seen for this condition	Degree of recovery
Treatment provided by: _____						
Provider's complete address: _____ <small>Street or PO Box, City State, ZIP</small>						

**Section H – 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 requesting coverage for my spouse; and, that my dependents 18 or older must sign this section, as well, if I am requesting coverage for them. 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 that should be answered “yes” in Section F has been fully disclosed in Section G.

My signature authorizes any physician, medical practitioner or provider of medical or dental services or supplies, 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, consultation, 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 health information. This information includes, but is not limited to, x-rays, photocopies of medical records, medical histories, physical, mental or diagnostic examinations, and treatment notes. For the purposes of this authorization, health information specifically includes confidential information regarding HIV/AIDS; sexually transmitted diseases and communicable diseases, alcohol or drug use, and treatment of mental illness but excludes psychotherapy notes as defined by HIPAA.

I understand that the information obtained by use of this authorization will be used by AICK to underwrite the insurance being requested to determine eligibility for insurance; and, that 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 understand I will be responsible for any fees or cost associated with the physical or for obtaining medical records for a late enrollee(s) in the insurance program.

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.

Print name of employee \_\_\_\_\_ Date of Birth                                
M M D D Y Y Y Y

Employee address \_\_\_\_\_  
Street or PO Box, City, State, ZIP

**REQUIRED** → **Employee Sign Here**  \_\_\_\_\_ Date Signed \_\_\_\_\_

Print name of spouse \_\_\_\_\_ Date of Birth                                
M M D D Y Y Y Y

Spouse address \_\_\_\_\_  
Street or PO Box, City, State, ZIP

**Spouse Sign Here**  \_\_\_\_\_ Date Signed \_\_\_\_\_

**If any child is 18 years of age or older, and you are requesting Dependent Child coverage, they must also sign and date this section:**

Print name of Dependent \_\_\_\_\_ Date of Birth                                
M M D D Y Y Y Y

Dependent address \_\_\_\_\_  
Street or PO Box, City, State, ZIP

**Dependent Sign Here**  \_\_\_\_\_ Date Signed \_\_\_\_\_

Print name of Dependent \_\_\_\_\_ Date of Birth                                
M M D D Y Y Y Y

Dependent address \_\_\_\_\_  
Street or PO Box, City, State, ZIP

**Dependent Sign Here**  \_\_\_\_\_ Date Signed \_\_\_\_\_