Group Administrator Manual

ADVANCE
Insurance Company of Kansas℠

advanceinsurance.com

Welcome!

We're glad you're a part of the Advance Insurance family.

The purpose of this Group Administration Manual is to give you the valuable information you will need to administer a life and/or disability insurance benefit package. (Note: If your group is self-insured, your guidelines may vary from those presented in this booklet. Check your benefit description for details.) This manual contains important information in an easy-to-read format. It should help you find the following:

- Information on how to contact us
- An explanation of an insured's "first opportunity" to enroll
- Sample enrollment forms and other useful forms

Our experience has shown there is typically one person in a group setting that others go to when they have questions and/or problems related to the insurance program.

We have found it helpful to send necessary program information to one designated person in each group. This is why it is also important that you keep us informed of changes in responsibilities.

We email our semi-annual newsletter, the *Advance Notice*, offering information about group life and/or disability insurance. You will also receive timely mailings of letters and brochures explaining special situations as necessary.

Again, welcome to Advance Insurance Company of Kansas!

Table of contents

General Information

Advance Insurance Company of Kansas (AICK) is a subsidiary of Blue Cross and Blue Shield of Kansas. With $2.7 billion of life insurance in force, AICK covers nearly 102,000 Kansans.[1]

A.M. Best rating

Financial soundness, enrollment and overall earnings are considered in this rating, and AICK is solid. AICK (and our parent company, Blue Cross and Blue Shield of Kansas) received an "excellent" (A) rating from A.M. Best.

Our web address

You have immediate access to our forms and manuals on advanceinsurance.com

[1] Based on business in force as of January 31, 2023

Online eBilling

Through the online convenience of eBilling, you are able to view bills and payment activity 24 hours a day, seven days a week.

- Pay bills
- Print and export bills

To sign up for eBilling, contact AICK at 1-800-530-5989.

Online BluesEnroll℠

For a quick and easy way to manage your benefit plan, turn to BluesEnroll, an online enrollment program, to manage your employee benefits with the click of a mouse.

- Less paperwork
- Central database
- Updates, corrections and reports online

To sign up for BluesEnroll, contact your Blue Cross and Blue Shield of Kansas marketing representative.

Contacting AICK

Our service

AICK is dedicated to providing single point of service contacts whenever possible.

We assign one administrative person to your group to handle your billing, new applications and questions about eligibility. We assign one claims person to your group to handle any questions you may have about the claims process or the status of a claim.

We make it easy to ask questions and get information. The length of service among our employees and the depth of their knowledge allow us to consistently prove our expertise with quality work and dependable follow-through.

Telephone

You can speak with a person by calling us between 8:00 a.m. and 4:30 p.m., Monday through Friday.

Toll-free **1-800-530-5989**

In Topeka **785-273-9804**

Outside of these business hours, our voice mail will take your message.

Email

You may use our website to contact AICK by email (use the "Have a Question?" section) or email your AICK policyholder representative directly.

Returning enrollment forms, change forms or claim forms

Enrollment forms, change forms or claims forms can be faxed to us at **785-290-0727** or emailed to AICK at csc-advance@advanceinsurance.com.

Sending forms by mail

If you are writing to us or mailing a form, please send directly to our headquarters in Topeka:

1133 SW Topeka Boulevard
Topeka, Kansas 66629-0001

Anti-fraud hot line, call 1-800-530-5989

Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. If you or one of your employees suspect fraud, please contact our Fraud Hotline. Callers may identify themselves or remain anonymous.

Eligibility

It is the responsibility of the policyholder's (i.e., the employer's) Group Administrator to submit enrollment only for those employees and dependents who meet the eligibility criteria of both the policyholder and AICK, and to ensure and verify the continued eligibility status of covered employees and dependents.

Your group is including life and/or disability insurance in their employee benefit plan. As this is a group plan, not an individual policy, there are other requirements in addition to any waiting period your company may (or may not) impose that may affect coverage when not met. Some of these requirements are addressed on page 8 (see Who's eligible for coverage and Who's NOT eligible for coverage) with regard to employee coverage. The group policy, however, is the final resource and it will be the document by which we make any necessary determination of coverage.

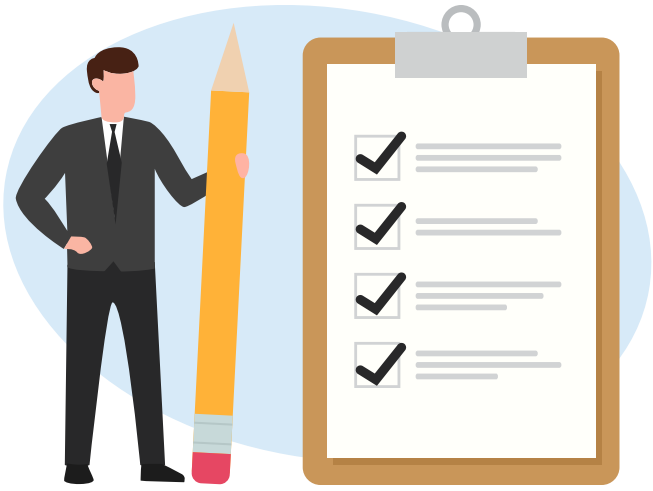
If your group offers dependent coverage, you may wish to review page 9 (Dependent eligibility and Dependents AICK does not cover) with regard to coverage for an employee's spouse, the employee's children or their spouse's children. Again, the group policy is the final resource and it will be the document by which we make any necessary determination of coverage.

Refer to the group policy when you have questions. You're welcome to contact our office for assistance in finding the applicable sections.

Owners, etc.

Board of directors, stockholders, shareholders, partners or proprietors must be actively engaged in and devoting a substantial part of their time to conducting the day-to-day business of the policyholder (the employer) to be eligible for AICK's benefit plans. Proof of active employment satisfying the Eligible Person and Actively at Work provisions of the policy will be required in the event of a claim.

If your group has disability insurance, you should be aware an owner (partner, shareholder, etc.) must also demonstrate a loss of net income to qualify for benefits. An owner (partner, shareholder, etc.) that receives a draw or continues to receive income of some kind while absent may not want to be included in the disability coverage.



Who's eligible for coverage

An eligible employee is one who:

- Is actively working – performing all of the normal duties of his or her job at the usual place of employment
- Is working full-time at least the minimum number of hours required each week
- Is a resident U.S. citizen or an alien legally residing in the U.S.
- Is employed by your group as his/her main occupation
- Has been working at his/her job the length of time required by your group to qualify for benefits (i.e. met the company-imposed waiting period)
- Is in a class of employees covered by your policy (whether or not he or she participates in a health program is not relevant)

Each of the requirements above must be met for the employee to be eligible for your group's life or disability insurance.

Who's NOT eligible for coverage

- Employees who, because of illness or injury, are not actively at work performing all of their normal job duties at his or her usual place of employment
- Retired employees
- Employees working fewer than the required number of hours each week for any reason
- Any person, including but not limited to, the board of directors, stockholders, shareholders, partners, proprietors, or family members of such not actively engaged in and devotes substantial time daily to conducting the business of the policyholder (the employer)
- Seasonal employees
- Temporary employees
- Leased, contracted, or 1099 employees (see *1099 employees* on the next page)
- Persons for whom employment with your group is not their main occupation
- Illegal aliens

1099 employees

Neither a "leased" employee or an employee that has been "contracted" to perform their duties is eligible for group life and disability insurance. Both of these types of employees are issued a 1099 instead of the W-2 form for the purpose of declaring income to the IRS.

Why aren't 1099 employees eligible for coverage?

No permanent relationship exists between the employer and the employee.

Dependent eligibility *(if applicable to your group)*

See pages BDL01 and BDL02 of the group policy for details about your group's dependent coverage. Who is covered, the age limitations, who is not covered, and when the coverage terminates are shared here.

If your group offers dependent coverage, a lawful spouse may be a dependent. Employees unsure of their marital status should be directed to consult with their personal legal counsel.

To be eligible as a dependent child, an employee's children or the children of their legal spouse (step-children) must be unmarried and between the limiting ages shown in the group policy. **This is generally more than 14 days and less than age 23, but your policy may specify other ages or conditions of coverage which will control who is an eligible dependent.**

If an employee's (or their spouse's) dependent child with disabliities is covered by AICK's Dependent Life when they attain the limiting age of coverage, and they are incapable of self-support, they may apply to extend the benefit. We must receive the AICK Dependent with Disabilities Application (AICK 21, which is not the same as your health company's form) within 63 days of reaching the maximum age. AICK will determine whether or not coverage can be extended and will notify you.

A grandchild may be covered only when the employee (or their legal spouse) has court-ordered custody or guardianship and the child is within the covered ages.

Dependents AICK does not cover

- Anyone serving in the Armed Forces of any state or country, except for duty of 30 days or less for training in the Reserves or National Guard
- A spouse or child admitted as an inpatient to a hospital on the date the dependent benefit otherwise would have become effective. Coverage for that particular dependent (spouse or child) will become effective 10 days after their discharge from the hospital
- Children that are not the employee's (or their legal spouse's) by birth, adoption, or placement for adoption
- Grandchildren for whom the employee (or their legal spouse) does not have court-ordered custody or guardianship
- Dependent children with disabilities that are older than the limiting age of coverage when the employee first becomes eligible for the dependent benefit

Non-contributory insurance

- The employer funds 100 percent of the premium for all persons listed on the bill (no premium is collected from the employee).
- The employer enrolls every employee that is regularly working the required number hours each week, that is in a covered class, and the covered class is defined by job function, in the life and/or disability benefit. This includes any employee not participating in your group health insurance plan (for any reason) when they work the required hours and are performing the same job as other persons covered by your group's life insurance.
- The employer pays premium for an eligible person from the earliest possible effective date regardless of when the enrollment form is received by our office. In a non-contributory insurance, we cover an employee as soon as they are eligible (with the payment of back premium) even if the actual enrollment process does not take place in a timely manner.

Waiver of coverage

Employees that refuse an employer's non-contributory insurance plan must complete and sign AICK's Waiver of Coverage. Until AICK receives a completed Waiver, the employer is responsible for paying premium from the date the person first became eligible for the group's coverage.

Persons that waive an employer's company-paid insurance risk being denied coverage at a later date. AICK will medically underwrite any future request for insurance (see the *Late Enrollees* section on page 15).

Contributory insurance

- The employer payroll deducts some or all of the premium from an insured's paycheck.
- The employer has agreed to enroll a percentage of eligible persons in the benefit. While it is generally 70 percent, your group's Proposal of Coverage specifies the actual percentage agreed to by your employer.
- AICK must receive the eligible person's enrollment form within 63 days of meeting the company-imposed waiting period to qualify at their first opportunity for life and/or disability coverage. After that, an employee is considered a "late enrollee".

See the *Late enrollees* section on page 15 for details on how this may affect availability of coverage in the future.

No open enrollment

Open enrollment is not available for life and/or disability plans through AICK. If a person does not enroll at first opportunity, they risk not being able to get coverage later. They must also pay any fees charged to gather their medical records or for an exam — whatever is necessary to prove their insurability to our satisfaction.

See your policy for the effective date provisions.

Voluntary insurance

- The employer payroll deducts the premium from an insured's paycheck.
- The employer has agreed to enroll a specific portion of eligible persons in the benefit. Your group's Proposal of Coverage contains the percentage agreed to by the employer.
- AICK must receive an eligible employee's enrollment form within 63 days of the date the company-imposed waiting period is met to qualify at their first opportunity for coverage. After that, an employee is considered a "late enrollee". See the Late enrollees section on page 15 for details on how this may affect availability of coverage.

Enrollment

Participation requirements

Groups must meet enrollment requirements for life and disability insurance, which counts each person that has met the company-imposed waiting period, is working the required hours, and is performing a job in a covered class.

Employees not participating in your group health insurance plan are to be included in the group life and/or disability plan when they meet their waiting period if they work the required hours and are performing the same job duties as other covered persons. Enrolling in the group life and/or disability insurance has nothing to do with whether or not the person is part of your employer's health insurance plan.

The following percentages are based on group size. Contact your group's BCBSKS sales representative for additional information on participation requirements.

- **Non-contributory** — 100 percent of all eligible employees enrolled, except those who complete a Waiver of Coverage
- **Contributory** — 70 percent of all eligible employees enrolled
- **Voluntary** — See the signed Proposal of Coverage (in the group policy) for the participation percentage

Ideally, each employee should complete either an Enrollment Form (in paper or online if your group enrolls electronically) or a Waiver of Coverage (in paper form). By getting one or the other from an employee, you are documenting that an offer of benefits was made to this employee, which they then either accepted or declined. This record can be useful if an employee's family ever wonders why they didn't have life or disability insurance when other employees that they know do have it.

When an employee refuses group life and/or disability insurance, the Waiver captures the employee's acknowledgement that:

- A late enrollee may be declined for coverage
- **The employee will be responsible for any expense or fees that may be necessary to underwrite a late enrollee's request for coverage** in the future, including (but not limited to) expenses for exams, fees to reproduce medical records, etc.

Copies of the enrollment forms will be maintained by AICK. **Changes in coverage or beneficiary designation will not be effective until received by AICK.**

Enrolling new employees

Waiting period

A company-imposed waiting period is a set number of consecutive days or months a person must be employed before they may participate in your employer's benefit program(s). During the waiting period, the employee and any covered dependents are not eligible for benefits under the life and/or disability insurance program(s).

AICK may also require a waiting period be applied to a plan of coverage on the basis of underwriting guidelines. It may or may not correspond with the company-imposed waiting period.

Typical waiting periods are 0, 30, 60 or 90 days; or, zero, one, two or three months. It is up to the group whether or not the life/disability waiting period matches the health; and if that is your group's choice, you need to advise whenever it changes to keep them in sync.

Waiving the waiting period

If an employer wants to waive the group's waiting period for a new hire, they must:

- Put the request in writing on corporate stationery. It must be signed by either a corporate officer or the group leader; and
- The correspondence requesting the waiting period be waived must be received with the enrollment form within 63 days of becoming eligible for coverage.

The request to waive the waiting period will be reviewed by AICK. If accepted, we will add the new employee to your billing with an effective date reflecting the entire waiting period was removed (we will not waive only part of the waiting period — it must be all or none). If we do otherwise, we will contact you.

We will not accept a request to waive the waiting period that is not accompanied by the employee's enrollment form (no telephone requests or retroactive requests once the enrollment form has already been received and processed by AICK) or requests not received within 63 days of eligibility.

First opportunity

This is defined as the earliest date in which an eligible employee may enroll following completion of the company imposed waiting period, if applicable.

If a group benefit is non-contributory, we will backbill from the earliest possible effective date of coverage.

If a group is contributory or voluntary, the employee's enrollment form must be received by AICK within 63 days of satisfying your company's waiting period to be considered enrolling "at first opportunity". The "first opportunity" for covered dependents is within 63 days of the date the employee acquires their first dependent (marriage or the birth/adoption of a child).

Determining effective dates when enrolling at first opportunity:

- **When the waiting period expires other than first of the month:** The effective date will generally be the first of the month following the completion of the company-imposed waiting period.

- **When the waiting period expires on the first day of the month:** The effective date will generally be that date.
- **When there is no waiting period and the employment date is other than first day of the month:** The effective date will generally be the first of the month following date of employment.
- **When there is no waiting period and the employment date is the first day of the month:** The effective date will generally be the employment date.

Important: The application must be **signed and received by AICK** within 63 days of the date of hire or completion of the waiting period for the person to be considered as "enrolling at their first opportunity".

See the policy for eligibility and effective date of coverage provisions.

Look over the enrollment form

Please make sure the appropriate insurance benefit is selected and the enrollment form is fully completed, showing the employee's:

- Name
- Social Security number
- Number of hours being worked each week
- Employment date
- Actively at Work status
- Earnings and occupation if the benefit is based on earnings
- Beneficiary

The enrollment form must be signed and dated accordingly. Incomplete forms cannot be processed and may be returned to you.

Late enrollees

Enrollees in a Non-contributory insurance are established and billed from the earliest possible effective date of coverage (i.e., from the date they should have first appeared on your group's billing).

When the insurance is Contributory or Voluntary, if the employee's enrollment form is not received within 63 days from the date an employee becomes eligible for coverage (or 63 days from the date of acquiring the first dependent to enroll in dependent life), they are a "late enrollee" and obtaining coverage at some future date is subject to their ability to provide AICK with satisfactory proof of their insurability.

The employee (and the enrollee, if not the same person) will fill out a form containing medical questions. The employee will be financially responsible for fees to obtain medical records for AICK's review and an exam, if necessary, that the enrollee may be asked to take in the course of determining their insurability. AICK will evaluate the enrollee's health information and will determine whether or not to approve the requested coverage (see *Processing evidence of insurability* on page 17).

In addition to requiring evidence of insurability, some policies may also require a late enrollee to wait until an annual enrollment period to request the coverage. If the policy does so, the annual enrollment period is the month immediately preceding the group's anniversary date each year.

Check the policy to see if your group has an annual enrollment period.

Determining effective dates for late enrollees:

If we agree to cover the late enrollee, the effective date of coverage is the later of:

- The date we approve the coverage; or
- The first of the month following an annual enrollment period (if applicable)

If we decline coverage for a late enrollee or close an application for coverage, we notify you, the employer. The enrollee may write to us to request an explanation of the denial (see *Our decision and confidentiality* on page 17).

Guaranteed issue (GI) limit

The guaranteed issue (GI) limit is the largest amount of insurance a person can have without proving to AICK that they are insurable according to AICK's guidelines (i.e., providing satisfactory evidence of their insurability). An enrollment form containing medical questions will need to be completed by persons whose coverage is above the plan's GI limit. AICK evaluates the enrollee's health information to determine whether or not to approve the amount of insurance requested above the GI limit (see *Processing evidence of insurability* on page 17).

If we agree to extend coverage above the GI limit, the effective date is the later of the date we approve it or the date the insured's group coverage began.

If we decline coverage above the GI limit,

- The enrollee is set up for the group's coverage at the amount of the GI limit; and
- We notify you, the employer. The enrollee may write to us to request an explanation of the denial of coverage above the GI limit.

See your policy to determine if your group's plan has a GI limit or any other features tied to the group's GI.

If a person is enrolling more than 63 days after they first become eligible to do so, they are a late enrollee. Late enrollees are not eligible for GI. The employee is financially responsible for any fees resulting from medically underwriting a request for coverage for a late enrollee.

Processing evidence of insurability

Submission date

To be considered current, the enrollment form containing the enrollee's health statement must be received by us within 60 days of the date it was signed.

If the enrollment form is not received within 60 days of being signed, a newly completed, signed, and dated form will be requested.

Complete answers

The more detailed the answers are to the medical questions on the evidence form, the greater the possibility of receiving a quick decision. An incomplete response results in a request for more information.

Requests for additional information

Requests may be made to providers of service for more information including (but not limited to) exams and medical records. The employee will be financially responsible for any fees charged to obtain the information we need to determine a late enrollee's insurability.

When more information must be requested, it generally takes 45-60 days (or longer) for us to receive it. The process can usually be completed more quickly when all questions on the evidence form have been completed thoroughly, in detail.

Our decision and confidentiality

The employer will receive a notice if coverage is declined. The person declined for coverage may write us to request an explanation of the denial of coverage and it will be sent directly to them. (If a minor is declined, the employee should make the request for an explanation.)

In the event we must close a request to enroll, we will also notify the employer with an explanation. Once we close the request to enroll, the employee (or person we were underwriting, if different) will have to reapply if they are still interested in the coverage.

Certificate of coverage

Each employee that is insured under your group's plan will receive a certificate of coverage. The form relied upon to enroll the employee will be attached to the certificate. The certificate, and the form that is attached to it, must be distributed to the employee.

Life changes… is the employee's beneficiary current?

Regardless of the number of years that pass since an enrollment form was first completed, the insured employee's designated beneficiary does not change until AICK receives a change form naming a different beneficiary. Were you aware that an insured employee's Last Will and Testament does not override the beneficiary they have designated on the life enrollment/change forms on file with AICK?

Insureds that are making changes to other employee benefits because of life events (marriage, divorce, etc.) may want to review their existing beneficiary, too. Do they still want the proceeds paid according to the information on that old enrollment form/change form? **To make a change and update their beneficiary, the change form or beneficiary designation form must be signed, dated and received by AICK's home office prior to the insured's death to be valid.**

Changes to existing coverage

When your employees need to make changes to their existing coverage, you should submit a change form to AICK. (See a sample of the change form in the forms section.)

Send a change form for:

- Change of beneficiary
- Change of name
- Change of dependent coverage
- Class change

Beneficiary

Beneficiary tips

- An insured cannot name themselves as a beneficiary
- An insured cannot name their employer as a beneficiary
- The first name of the beneficiary should be completely spelled out — using only initials can cause confusion and a delay in payment of benefits
- The relationship between the employee and the beneficiary should be listed next to each name
- Naming a contingent beneficiary keeps payment from being delayed for a court settlement in the event the primary beneficiary is also deceased.

The form must be signed, dated and received in AICK's home office prior to the insured's death to be valid.

Naming a beneficiary

Beneficiary designations should be as clear as possible, so that there will be no question as to how the insured intended for the proceeds to be distributed in the event of his or her death. AICK requires a primary beneficiary be named; naming a contingent beneficiary is the option of the employee.

- The primary beneficiary is the person(s) who will receive the death benefit on the insured's death. The contingent beneficiary will receive the death benefit only if the primary beneficiary is deceased.
- If there is more than one beneficiary and the proceeds are to be divided equally, each person must be named specifically on the appropriate line, whether it be as a primary or contingent. (For example, if the proceeds are going equally to the spouse and each of their children, as each new baby is born, the employee must add that child by name to the beneficiary designation.)
- If there is more than one beneficiary and proceeds are not intended to be divided equally, a percent should be shown by each name spelling out the exact details of the division (i.e. 75% to Jane Doe, 25% to James Doe).
- If children are named as beneficiary, payment of the proceeds cannot be made to them while they are under 18 years of age. Benefits to minor children must be paid to a court-appointed conservator or guardian.
- The employee is always the beneficiary of the basic dependent life benefit.
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- A Last Will and Testament will not override the beneficiary named on an insured's enrollment form or change form. If an insured wants to distribute the proceeds of the insurance according to their will, they may want to consider stating "the Executors or Administrators of the Insured" or "the Estate of the Insured" in the beneficiary section and consult their estate professional for the appropriate wording.
- Employees with living trusts or estate planning vehicles should contact their legal or tax counsel to choose the beneficiary designation wording best suited to their needs.
- Charities or churches may be named as beneficiaries with the provision of their legal name and address.

The beneficiary may be changed at any time, in the absence of an irrevocable beneficiary or an absolute assignment.

> Samples follow of properly worded beneficiary designations:
>
> Kathy L. Smith — wife
>
> John A. Smith and Mary L. Smith — father and mother
>
> The First Baptist Church, 1114 Adams, Topeka, KS 66611
>
> Joe T. Smith — son, 40%;
> Karen L. Jones — daughter, 40%;
> Mary L. Smith — mother, 20%

To change a beneficiary, the employee should complete, sign and date a new beneficiary designation form. It may be faxed or mailed to AICK; however, the change will not go into effect until it is received in our office. Do not delay forwarding this information to us.

Irrevocable beneficiary and absolute assignments

- An irrevocable beneficiary may only be changed with the consent of the existing beneficiary. If an insured has made an irrevocable beneficiary designation, his/her right, title and interest in the group policy cannot be assigned.
- An absolute assignment is the permanent, legal transfer of a person's right, title and interest under a life insurance policy from the insured (assignor) to another party (assignee).

The assignee becomes the owner of the assignor's right, title and interest under the life policy. In a group term life insurance context, it includes the right to name a beneficiary and to convert to a personal policy in the event the insured qualifies for the group policy's conversion privilege.

Billing statement

You will receive a billing statement, which is a listing of all enrolled employees in your group. The billing statement will show each employee's name, each coverage they are enrolled in, and their current premiums plus any unpaid premiums.

When is your payment due?

Your AICK coverage is a prepaid life and/or disability plan. Payment of the premium is due no later than the first of the month. Premium must be paid before claims can be paid for the period of time the billing covers.

Included with each billing is a premium cover sheet with a payment stub at the bottom of the page and a detailed billing report. If you do not pay as billed, please submit a copy of the detail showing the changes. Please make sure your check or money order reflects your group number and return the payment stub (and a copy of the detail showing changes, if any) along with the paid premium.

Delinquent letters

Your policy provides for a 31-day grace period that starts on the day after your premium due date. After premium payment is approximately 15 days late, a delinquent letter will be sent. If premium payment is not received by the 31st day of the grace period, the coverage expires and a letter will be sent cancelling the group's coverage back to the premium due date.

Late payments

Your last billing must be paid current to receive the next premium notice. We will not bill for more than one premium cycle (the last monthly bill must be paid if your group pays monthly, for the last quarter if paying quarterly, etc.).

Late payment of premium will result in delayed claims processing — employees will be told claims are pended for premium payment.

Verifying the monthly billing

Each month, verify the monthly billing with your current enrollment records, and contact us if you feel someone that should be on the billing is missing. Keep in mind that:

- When the plan is salary-based, benefits are determined using the employee's base salary (no overtime, no commission, no bonuses, no other extra pay) unless the Schedule of Benefits in your group's policy specifically includes those types of compensation.
- If your group has short term disability (STD) or long term disability (LTD), you may contact your policyholder representative when you need to know a new employee's premium amount and they will be glad to help you identify the premium amount or send you a premium worksheet.

You will find examples of calculating STD and LTD premium on pages 22-24.

- Changes in the benefit (adding more coverage or terminating a benefit) may affect the amount of premium due for an employee.
- Age-based life insurance reductions will affect an employee's premium. Our billing system will accommodate reductions in premium due to age. The billing statement will reflect the new amount in the first period to which the reduction applies.

Note: See an example of the report we will forward to the group leader reflecting the new reduced life and AD&D amounts approximately two months before the change on page 64 of the *Sample Forms* section.

Example for age reduction on group term life and AD&D:

Insurance benefit — $50,000

Monthly premium rate — .20 per $1,000 of insurance, or .20 x $50,000 = $10.00

Reduces 35% at age 65; after applying 35% reduction insurance benefit — $32,500

Premium after reduction — .20/$1000 x 32,500 = $6.50

See your policy for your group's source of income, reductions and termination provisions.

Examples of calculating a short term disability (STD) premium:

Step 1 — Figuring the weekly benefit for an employee.

1a. Hourly wage

Hourly wage x Hours per week = Weekly Salary x Benefit Percentage = Maximum Weekly Benefit

Sample equation

Hourly wage is $7.25. STD benefit percentage for this group is 60 percent.

$7.25 x 40 hours week = $290.00 x 60 percent = **$174.00**

1b. Salaried wage

Base annual wage ÷ 52 weeks = Weekly Income x Benefit Percentage = Maximum Weekly Benefit

Sample equation

Base annual wage $54,000. STD benefit percentage for this group is 60 percent.

$54,000 ÷ 52 weeks = $1,038.46 x 60 percent = **$624**

Step 2 — Calculate the estimated cost of an employee's STD benefit using the following formula:

Maximum Weekly Benefit Amount x STD rate (the rate is on the proposal or renewal), then move the decimal to the left one place.

Sample equation

Using the two Maximum Weekly Benefit figures from Step 1 (Hourly and Salaried) with an STD rate of .18%:

Hourly wage from Step 1a

Maximum Weekly Benefit $174.00 x .18 = $31.32
Move the decimal one places to the left; estimated monthly premium is **$3.13**.*

Salaried wage from Step 1b

Maximum Weekly Benefit $624 x .18 = $112.14
Move the decimal one places to the left; estimated monthly premium is **$11.21**.*

* This is an estimate of monthly premiums. Actual cost will be calculated by AICK's billing system when final salaries are provided. The final premium cost will be generated by the billing system.

Note: If you have highly-paid employees particpating in your group's STD benefit, their weekly income benefit cannot exceed the maximum. To avoid overcalculating their premium, locate the group's benefit maximum as shown in the proposal of coverage or the group's policy. You will need to apply this calculation:

Weekly Income ÷ Benefit percent

If this amount is over the Maximum Benefit amount, reduce it before determining the STD premium.

Sample equation

Weekly benefit maximum is $500. Base annual wage is $54,000. STD benefit percentage for this group is 60 percent.

- $54,000 ÷ 52 weeks = $1,038.46 x 60 percent = **$624**

Since this is higher than the weekly benefit maximum, reduce the $624 to $500 before calculating the premium.

Maximum Weekly Benefit $500 x .18 = 90.00.
Move the decimal one places to the left; estimated monthly premium is **$9.00**.

Examples of calculating a long term disability (LTD) premium:

Step 1 — Figuring Monthly Covered Payroll for an employee.

1a. Hourly wage

Hourly wage x hours per week x 52 weeks = annual earnings ÷ 12 months = Base Monthly Covered Payroll

Sample equation

Hourly wage is $8.69. Employee works 32 hours per week.

- $8.69 x 32 x 52 = $14,460.16 ÷ 12 = **$1,205.01**

1b. Salaried wage

Base annual wage ÷ 12 months = Base Monthly Covered Payroll

Sample equation

Base annual wage is $72,132.07.

- $72,132.07 ÷ 12 = **$6,011.01**

Step 2 —Calculate the estimated cost of an employee's LTD benefit using the following formula:

Base monthly wage x LTD rate (the rate is on the proposal or renewal), then move the decimal to the left two places.

Sample equation

Using the two Monthly Covered Payroll figures from Step 1 (Hourly and Salaried) with an LTD rate of .32%:

Hourly wage from Step 1a

Base monthly wage $1,205.01 x .32 = $385.60

Move the decimal two places to the left; estimated monthly premium is **$3.86**.*

Salaried wage from Step 1b

Base monthly wage $6,011.01 x .32 = $1,923.52

Move the decimal two places to the left; estimated monthly premium is **$19.24**.*

* This is an estimate of monthly premiums. Actual cost will be calculated by AICK's billing system when final salaries are provided. The final premium cost will be generated by the billing system.

Note: If you have highly-paid employees particpating in your group's LTD benefit, their maximum monthly covered payroll may need to be identified to avoid overcalculating their premium. To determine the maximum monthly covered payroll, locate the group's benefit maximum as shown in the proposal of coverage or the group's policy. You will need to apply this calculation:

Benefit maximum ÷ Benefit percent =
Maximum Monthly Covered Payroll

Sample equation

Benefit maximum is $6,000. Benefit percentage for this group is 60 percent.

$6,000 ÷ .60 = **$10,000**

If a person's salary is higher than the Maximum Monthly Covered Payroll shown in your group's policy, lower the employee's Monthly Covered Payroll to the Maximum Monthly Covered Payroll amount to avoid overestimating their monthly premium.

Enrollments or coverage amounts pending for evidence of insurability

If an employee must fill out an Evidence of Insurability form to apply for coverage, do not pay or send AICK any premium until we bill your group for their coverage. This is usually someone who is either a late enrollee or a person that wants to enroll in an amount of coverage that is greater than your group's Guaranteed Issue (GI) limit. If your group has a GI limit and we can bill for that amount to begin with, we will. If the Evidence of Insurability is approved, we will bill your group for the late enrollee or increased coverage amount on the billing immediately following our approval. In the meantime, pay premiums based on the actual amount of coverage showing for the employee on the billing.

Salary changes

Salary changes will be effective the first of the month following receipt of the notice of the change unless your group's policy states otherwise.

When there are no changes

When you are paying the exact amount billed, **return the payment stub with the group's check or money order.**

If you do make changes

We prefer that you pay the amount as billed and allow us to make adjustment to your next billing accordingly. If you do change it, however, indicate all changes on the detailed billing notice. Add or subtract any additions, changes, terminations or cancellations from the total amount of your bill and return the adjusted amount to us along with the detailed billing notice and the payment stub.

When you pay for more than one division of your group plan

Include the detailed billing page for each subgroup and the payment stubs provided, indicating the amount paid for each subgroup. Please indicate all changes on the appropriate subgroup billing page.

Removing insureds

Report terminations or monthly salary updates promptly by email or fax (or through BluesEnroll, if applicable) to your policyholder representative at AICK. Pay the premium notice as billed. The credit due/debit owed from the resulting change will appear on your next billing.

Policy cancellation

In the event your group decides to cancel this insurance policy, please notify AICK in writing at your earliest opportunity. Premiums will be due for any coverage extended between the premium due date and the date of cancellation.

If a policy cancels, coverage ceases and no new claims will be payable under the policy.

Options for electronic bill payment

- **eBilling –** Pay and view your bill online through our secure eBilling feature. Your payment can be deducted from your company's bank account. Bills can be printed and exported. Go to ebillingks.com to get started. If you do not have a login, please contact AICK.
- **Automatic payment option –** Simply provide us with the checking or savings account number from a credit union, bank, or savings and loan institution and your employee's premium will automatically be deducted from that account on your next premium due date.

When you have questions

If you have questions regarding your billing statement contact your policyholder representative at the telephone number shown on the premium statement.

Please do not:

- Use red ink, highlighters or pencil when completing your forms.
- Send personal checks from your employee(s).
- Send partial payments.

Please do:

- Use only black or blue ink.
- Cross through the employee's name on the billing and note the reason for the cancellation and the effective date. We will credit the overpayment (if any) to your next premium billing.
- Check your billing for any new enrollments. Do you see the employee's name? If not, please contact your policyholder representative to ensure that we have received the enrollment form.
- Indicate the amount paid as the result of any changes made to the billing on the payment stub (always return it with the premium check).

Continuation of premium for persons not actively at work

Sometimes the life insurance premium can be continued for a limited time when an employee can't work because they are on FMLA, on a leave of absence, or disabled due to illness or injury. Disability insurance, however, cannot be extended unless the employee is ill or disabled.

Continuation is dependent on the benefit and the reason for continuation. Each group policy describes under what circumstances coverage may be continued and for how long. The circumstances are very specific and cannot be extended beyond the stated provisions; for example, coverage cannot be extended as part of a severance package.

An employer should apply any such continuations of coverage the same way for all employees.

The examples on pages 22, 23, and 24 may provide you with guidance on continuation of premium. However, your group policy will be the document upon which all final determinations will be based if it is different than as shown in the leave chart. Please email your claims representative or call if you need assistance or clarification.

Termination

A person's coverage will terminate according to the reasons stated in your group's policy when no continuation is available. The group's basic term life insurance must be converted to an individual policy to continue coverage.

Upon termination, it is the employer's responsibility (as the group policyholder) to provide the terminating employee with a Notice of Conversion Privilege form (AICK 12) if they are losing their group life insurance. You will find more information about Conversion on page 29.

Contact your AICK claims representative if you have questions about the continuation or termination provisions in your group's policy.

Portability

Portability is found only in our voluntary life insurance coverage.

If an insured employee is terminating employment for reasons other than disability, is less than 70 years of age; and is not on waiver of premium, they may apply for the portability option within 31 days of terminating employment or becoming ineligible for the group plan.

If the portability option is elected, an insured employee may apply to keep up to the same amount of life insurance (and AD&D, if applicable) and the coverage will be billed at the group's premium rate to their home address.

Portability coverage can be continued until:

- the group cancels with AICK
- the insured employee terminates insurance
- the insured employee becomes 70 years old

whichever occurs first. Continued insurance will be subject to any reductions required by the policy due to age.

Portability is available to covered family members if the insured employee elects to apply for the portability option and includes them.

If the portability option is not available, the insured may convert to an individual permanent life policy if he or she terminates employment, retires or becomes ineligible for coverage as provided in the group policy — regardless of health — by exercising the conversion privilege.

Conversion privilege

The conversion privilege carries a "limited time offer" that enables insured persons to convert all or a portion of the group life insurance coverage to an individual permanent life policy if he or she becomes ineligible for coverage as provided in the group policy, regardless of the state of their health.

Generally, insured persons may exercise the conversion privilege by applying within 31 days of their last physical day on the job when:

- He or she terminates employment, retires or is no longer in an eligible class
- Insurance is reduced due to age or a change in class — the amount of coverage lost due to the reduction may be converted
- The group policy cancels and the insured has been covered by the group policy more than five years — a limited amount of coverage may be converted
- Dependents may convert the dependent life insurance when they are no longer eligible for the coverage for any of the reasons discussed above except group cancellation

Conversion is not available for accidental death & dismemberment (AD&D) nor for short term or long term disability insurance coverage.

See your group's policy for detailed information about the conversion privilege.

Don't forget the conversion form!

It is the employer's responsibility to provide a Notice of Conversion Privilege form to a person losing their group life insurance as an employee or for a dependent (if your group has dependent insurance).

The opportunity to convert is available only for a short period of time. AICK must have the application and the first premium payment within 31 days of the last day the insured was actively at work, or within 31 days of the last day the dependent was eligible for dependent insurance.

The Notice of Conversion Privilege form (AICK 12) can be printed from our website at: advanceinsurance.com/forms/miscellaneous forms/notice of conversion privilege

Claims procedures

Each policy and certificate of coverage contains a Schedule of Insurance outlining the benefit amount, claims provisions, disability elimination periods (as applicable) and other limiting provisions affecting the payment of benefits. Please encourage employees to review their certificates.

Term life

In the event of an insured's death, a claim for this benefit may be made by submitting:

- An original certified copy of the death certificate
- A copy of the obituary from the paper, if available, and
- A completed Death Claim Form (AICK 16)

Accidental death & dismemberment (AD&D)

AD&D claims are generally submitted with the term life claim and by furnishing additional information about the accident causing the insured's death. Typically, a claim for this benefit may be made by including:

- A copy of the police report
- A copy of the accident report, or
- A copy of the coroner's report

Waiver of premium

Any insured employee whose employment is terminated due to a disability may be eligible to continue their life insurance and their dependent's life insurance without cost, if the employee is less than 60 years of age and:

- Is totally disabled and unable to work at any occupation
- Continues to be totally disabled for six consecutive months, and
- Was disabled on the date employment terminated

An insured employee may apply for this benefit by submitting a completed Disability Claim Form (AICK 18). **Proof of disability must be received by AICK within 12 months of the day the employee became disabled.**

Short term disability (STD)

As soon as an employer realizes that an insured employee will be unable to work due to accident or illness for a period of time that will be longer than their STD elimination period, they may be given a Disability Claim Form (AICK 18) to begin the processing of the STD claim. Typical STD elimination periods may range from one day to 30 days.

All sections of the claim form should be completed and returned as soon as possible. The Disability Claim Form should be completed in the following order:

- The insured employee's statement
- The attending physician's statement
- The employer's statement

It is very important that all questions on the claim form be completed and the employer provides the claimant's salary.

Benefits are paid bi-weekly and at the end of the bi-weekly benefit period (in arrears). All payments are sent directly to the employer to distribute to the employee. The group leader will receive a monthly and annual statement showing the benefits paid to the employee. The employer is responsible for paying their own portion of the taxation and providing the employees with W-2s.

Proof of loss of income must be given within 90 days after the end of the period in which AICK is liable.

Long term disability (LTD)

The elimination period requires an insured employee to be unable to work due to accident or illness for a specified period before becoming eligible for benefits. Typical LTD elimination periods are 90 or 180 days. You must continue to pay premium for the insured through the elimination period.

An insured employee who anticipates being off work beyond the elimination period may be given a Disability Claim Form (AICK 18) to begin the processing of the LTD claim. All sections of the claim form should be completed and returned as soon as possible. The disability claim form should be completed in the following order:

- The insured employee's statement
- The attending physician's statement
- The employer's statement

It is very important that all questions on the claim form be completed and the employer provides the claimant's salary.

All LTD payments are sent directly to the insured employee. The group leader will receive a monthly and annual statement showing the benefits paid to the employee. The employer is responsible for paying their own portion of the taxation and providing the employees with W-2s.

Proof of loss of income must be given within 90 days after the end of the period in which AICK is liable.

Maternity benefits

If you have an insured employee that you anticipate will be disabled due to pregnancy, disability benefits may be payable. The employee's physician must state that the claimant is totally disabled; we apply the elimination period, **and the disability benefits generally end six weeks from the date of delivery (of any type).** Claim forms for maternity should be completed after delivery.

Return to work after disability

Immediately upon an employee's recovery from disability, notify AICK of the return to work. Provide us with a copy of the written release to return to work from the employee's physician.

Living benefit

A living benefit, or an accelerated benefit, allows a terminally ill insured employee to apply for a portion of their life insurance proceeds while still living. A terminal condition means a medically determinable condition that can be expected to result in the insured's death within 24 months.

How an insured applies for an accelerated benefit, the exceptions, and the limitations are explained in your group policy and the insured employee's certificate. It reduces the face amount of the life insurance proceeds available under the policy when paid upon an insured employee's death.

The balance available is called the "reduced face amount". The living benefit is paid in a lump sum and may be used in any way. It is not a long-term care benefit. The full amount of the living benefit paid may be taxable income to the insured and may affect Medicaid eligibility. A tax advisor or social service agency should be consulted before an insured employee applies for an accelerated benefit.

I.R.C., Sec. 79(a)

Simply stated, I.R.C., Sec 79(a) says if the amount of the group term life insurance coverage is $50,000 or less, an employer's contribution is not considered taxable income to the employee. If the group life insurance is over $50,000, however, the cost for coverage above the $50,000 threshold must be included in the gross income of the employee for the taxable year. If the employee contributes toward the cost of the insurance, his/her contributions are subtracted from the cost of the coverage over $50,000.

The cost of the insurance over $50,000 will not be taxed to the employee if a qualified charity is the sole beneficiary for the entire taxable period, or if employment has terminated due to reaching the employer's normal retirement age or due to disability.

For details on the application of Section 79(a) to your plan, please consult a tax professional.

FICA

AICK is required by law to deduct the employee's share of the FICA tax from any disability payments for the first six months an employee is disabled. The disability benefit is no longer subject to FICA tax after six months.

The employer's share of the FICA tax is payable by each employer upon notification from AICK.

According to federal regulations, it is the responsibility of the employer to provide the employee with a W-2 form as long as we provide you with a monthly and an annual summary of benefits paid and taxes withheld.

Reports

As part of our reporting, AICK will:

- Deduct the employee's portion of FICA (Social Security and Medicare) tax from taxable benefits paid during the first six months of the claimant's disability.
- Remit any deducted amounts to the IRS.
- Advise you of the amount deducted for the employee's share of FICA tax on the statement of payment so you can deposit the matching portion of the FICA tax. The statement of payment shows you the gross benefits paid and taxes withheld.
- Provide you (the employer) with year-end summaries of disability benefits paid to employees, including any deductions and withholding.
- Early in January, AICK will send you (the employer) an annual disability statement summarizing the information shown on the individual statement of payments issued over the course of the previous year to help you prepare your W-2 forms and reconcile the employer's tax liability with the amount of taxes withheld during that period. The taxable portion is based on the information you provided on the claim form. The taxable amount of disability benefits shown on the statement must be reported on the W-2 or supplemental W-2 forms issued to the employee.

Frequently asked questions

How does an employee find out who they designated as the beneficiary of their life insurance?

This is confidential information, so we cannot provide it by telephone. If you or the employee do not have a copy of their enrollment form (or last change form), a request can be made by phone, fax or mail for a copy of the beneficiary designation and we will send it directly to you for the employee.

Is the death benefit taxable?

The death benefit received under a group term life insurance policy is generally not subject to federal income tax. Employees should check with their own tax consultant for tax advice.

Can a husband and wife enroll in dependent life if both are employed with our group?

Yes, unless your policy specifically states otherwise.

What happens when a dependent is no longer eligible for coverage?

Unlike health insurance, we do not roster and track dependents. A dependent has 31 days from the date they are no longer eligible for dependent coverage to use their conversion privilege. It is the employee's responsibility to communicate to their group leader when a dependent is no longer eligible for coverage. Send AICK a change form (AICK 5) to drop the coverage if the employee doesn't have a spouse or eligible dependent children.

If we have disability insurance, who determines the tax-reportable amount of the disabled employee's disability benefit?

The percentage that results from the employer's contribution and/or from an employee's pre-tax contribution determines the amount of disability benefit that is tax-reportable. It may be impacted by whether or not your employee's disability plan is included in a Section 125 or flexible benefit program. This amount must then be shown as income on the W-2 form issued to the employee.

If the insurance is not included in a cafeteria or flexible benefits plan, how is the tax-reportable figure determined?

For non-cafeteria plans, the tax-reportable benefit is determined by how much of the premium the employer pays.

> *A general example:*
> The cost of the disability coverage is $144 annually. The employer pays 50% of the cost, or $72, and the employee pays remaining 50%, or $72. Any disability benefit received by that employee will be 50% taxable, so if they receive $15,000 in benefits during the year, $7,500 (50%) will be taxable.

What happens if the disability plan is part of a cafeteria or flexible benefits plan?

Because of the way the IRS views contributions made in a cafeteria plan, the full amount of the benefits would be taxable, or the full $15,000 benefit in the example given above.

Sample forms

NOTICE: Forms may not be altered without the permission of Advance Insurance Company of Kansas and may require the approval of the Kansas Insurance Department.

Original (and complete sets of all pages) of the sample forms shown may be obtained:

- From our website (advanceinsurance.com)
- By calling us or sending an email stating which forms you need

Unless otherwise noted, the forms are 8½ x 11 in size.

Printing of forms (from email attachments or our website) should be on white paper only.

AICK 4 – Enrollment Form (for group coverage)

Enrollment Form

for group term life and/or disability coverage

ADVANCE Insurance Company of Kansas℠

Instructions: attach form AICK 4EV if a Late Enrollee or requesting more than the Guarantee Issue amount.

Your employer is:_____ **AICK group no.**_____ Class

Section 1 – Employee and employment information

Last name _____ First name _____ MI ___ Suffix ___

Residential address _____ City _____ State ___ Zip _____ +4 _____

Birth date ___ ___ ___ Gender: ☐ Male ☐ Female Social security number ___ ___ ___ Date of hire ___ ___ ___

Employee Occupation/Job Title _____

Your phone number: ☐ Home/Cell _____ (Area code + number) ☐ Work _____ (Area code + number)

I am actively at work performing all my job duties: ☐ Yes ☐ No **and** I work _____ (indicate number) hours weekly for this employer.

$_____ ☐ HR ☐ WK ☐ MO ☐ ANN Base earnings (do not include commission, bonuses, overtime or any other extra compensation except as shown in the group policy)

Check one:

☐ I am a new employee enrolling at my first opportunity.

☐ I am a rehired employee. Rehire date: ___ ___ ___

☐ I am an existing employee enrolling due to: Date of occurrence (of the event checked below) ___ ___ ___

☐ Temporary to permanent ☐ Other (explain) _____

I am enrolling in:

Basic term life and AD&D ☐ Yes ☐ No

Dependent life ☐ Yes ☐ No

Short term disability ☐ Yes ☐ No

Long term disability ☐ Yes ☐ No

Are you married? ☐ Yes ☐ No Date of marriage ___ ___ ___

Do you have unmarried dependent children under 23 years of age? ☐ Yes ☐ No

Section 2a – Your primary beneficiary

The **primary beneficiary receives the benefit upon your death**. If you name two or more primary beneficiaries, the proceeds will be paid in equal shares unless stated otherwise. If you need more space, attach a separate sheet with complete information that **you have signed and dated.**

First name _____ MI ___ Last name _____ Suffix ___

Relationship to applicant _____ Date of birth or age _____

First name _____ MI ___ Last name _____ Suffix ___

Relationship to applicant _____ Date of birth or age _____

You must sign and date page 2

For office use only: Group #_____ Subgroup #_____ Class _____

☐ STD ☐ LTD Subscriber #_____

Section 2b – Your contingent beneficiary

A contingent beneficiary **receives the benefit only if the primary beneficiary(ies) listed in the previous section is** (**are**) **deceased**. If you need more space, attach a separate sheet with complete information **that you have signed and dated.**

First name | MI | Last name | Suffix

Relationship to applicant | Date of birth or age

First name | MI | Last name | Suffix

Relationship to applicant | Date of birth or age

First name | MI | Last name | Suffix

Relationship to applicant | Date of birth or age

Section 2c – Beneficiary tips

1. This form must be signed, dated, **and received by AICK's Home Office** to be considered valid.
2. Payment cannot be made to children under 18 years of age. Benefits to minor children must be paid to a court-appointed conservator or guardian.
3. An insured cannot name their employer as a beneficiary.
4. Charities or churches may be named and must include the legal name and complete address.
5. Attach a separate sheet containing complete beneficiary information **that you have signed and dated** if the primary or contingent sections did not provide sufficient space to do so.

Section 3 – Dependent life beneficiary (if enrolling and applicable to your group's benefit plan)

You (the employee) will be beneficiary in the event of a payment of a dependent life benefit unless stated otherwise in writing.

Section 4 – Your authorization

I understand that if I am not at work on the effective date of the coverage, this coverage will not begin until the day I return to active work. I understand that to be insured I must be actively at work 1) performing all the normal duties of my job, 2) at the usual place, 3) for the required hours each week as stated in the group policy. I authorize the necessary payroll deductions from my earnings and designate the beneficiary(ies) named on this form to receive the benefit payable in the event of death. 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 the information which I have provided on this form is true and correct as it pertains to my status with the named employer.

Your signature required

Employee's signature | Date signed

Print your name

AICK Waiver – Waiver of Enrollment

Waiver of Enrollment

Declining Group Life or Disability Insurance

ADVANCE Insurance Company of Kansas℠

A copy of this completed Waiver of Enrollment must be submitted to Advance Insurance Company of Kansas (AICK).
1133 SW Topeka Blvd., Topeka, KS 66629-0001 • Fax: (785) 290-0727 • Toll Free: (800) 530-5989

Section 1 – Important Notice

Whether or not you participate in your employer's health insurance plan does not affect your right to participate in the group life or disability benefits as long as the job you perform is included in a covered class of employees, you meet the company-imposed waiting period requirement, and you continue to actively work the number of hours each week that is required for your group's life and/or disability plan(s).

Section 2 – Employee Information

First Name _____ MI _____ Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Last Name _____ Suffix _____ Employer Name _____

Mailing Address (if different from residential address) _____ Employee's Date of Hire _____/_____/_____

City _____

State _____ ZIP Code _____ +4 _____

Section 3 – Waiver of Insurance Coverage

The group insurance has been offered to me, and I am waiving my right to participate in the coverages marked below:

Life Insurance:

☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)

☐ Voluntary Term Life (and AD&D, if applicable)

Please tell us why _____

☐ Dependent life

Please tell us why _____

Disability Insurance:

☐ Short Term Disability

☐ Long Term Disability

Please tell us why _____

Section 4 – Authorization

I understand that by waiving life and/or disability insurance for myself (and my dependents if my employer offers Dependent Life), I am giving up the right to be covered without being medically underwritten. If I decide to enroll later, I will be responsible for paying any expense necessary to determine my insurability (or that of my dependents) including, but not limited to, the expense of obtaining medical records or medical exams. AICK will determine whether I (or my dependents) may be insured; and I recognize that I (or my dependents) may be at risk for being declined coverage.

Your signature required _____ Employee _____/_____/_____ Date Signed

Group's signature required _____ Person Authorized to Sign for Employer

AICK Waiver 10/19

An independent licensee of the Blue Cross Blue Shield Association.

AICK 21 – Dependent with Disabilities Application

Application for Dependent with Disabilities

ADVANCE Insurance Company of Kansas℠

1133 SW Topeka Blvd, Topeka, KS 66629-0001
Phone (785) 273-9804 • Toll-free (800) 530-5989
Fax (785) 290-0727 • advanceinsurance.com

Complete "Section 1 – Insured's Statement" and "Section 2 – Authorization" below.
The dependent's doctor is to complete "Section 3 – Attending Physician's Statement."
Mail or fax the completed form to Advance Insurance Company of Kansas.

I am applying for continuation of benefits for: ☐ Basic Dependent Life ☐ Voluntary Child Life

Section 1 – Insured's Statement

Employee First Name ____ MI

Employee Last Name

_____-_____-_____ Employee Social Security Number

Group Number

Name of Group Policyholder/Employer

Insured Parent's First Name (if not the employee listed above) ____ MI

Insured Parent's Last Name

Insured's Home Address

City

State ZIP Code +4

_____-_____-_____ Insured's Social Security Number

Dependent's First Name ____ MI

Dependent's Last Name

Dependent's Home Address

City

State ZIP Code +4

_____-_____-_____ Dependent's Social Security Number

_____/_____/_____ Dependent's Date of Birth

Relationship to Employee

Is dependent married? ☐ Yes ☐ No

Are you responsible for the chief support and maintenance of the dependent? ☐ Yes ☐ No

Is the dependent an established beneficiary under Medicare or receiving SSA/SSI disability benefits? ☐ Yes ☐ No
(If yes, complete only Section 1 and include beneficiary verification with this application.)

Has the dependent had any income during the past year? ☐ Yes ☐ No
If yes, please state the following:

Source of Income

Amount of Income

Is the dependent attending school? ☐ Yes ☐ No
If yes, please state the following:

Name of School

Number of Hours Enrolled

List your dependent's physician information below:

Dependent's Physician Name

Physician's Address

City

State ZIP Code

(_____) _____-_____ Physician's Phone Number

List other members of the dependent's healthcare team (specialist in rehabilitation, mental healthcare provider, etc.) Attach a separate signed and dated listing if needed.

Name

Address

City

State ZIP Code

(_____) _____-_____ Phone Number

Please continue on the next page.

Section 2 – Authorization

The above statements are true and complete to the best of my knowledge and belief, and I hereby authorize any hospital or physician who has treated me, other person who has attended me, examined me, or any government agency to furnish to Advance Insurance Company of Kansas (AICK) providing this form, or their representatives, any and all information with respect to any illness, injury, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this authorization will be as valid as the original. I may revoke this authorization by notifying AICK in writing of my desire to do so. This authorization expires two years from the date signed.

Your signature required

_____ Employee Signature

_____ / _____ / _____ Date Signed

_____ Dependent or Their Legal Representative

_____ / _____ / _____ Date Signed

Section 3 – Attending Physician's Statement

_____ Patient Name

_____ / _____ / _____ Patient's Date of Birth

Disability

_____ ICD-9 Code

1. Diagnosis of condition causing disability, indicate degree of severity:

2. Prognosis (estimate in months or years):

3. Is the dependent incapable of self-support by reason of mental or physical disability? ☐ Yes ☐ No

4. Is the dependent now confined to an institution? ☐ Yes ☐ No

If yes, please provide the following details:

_____ Institution Name

_____ Institution Address

_____ City

_____ State

_____ ZIP Code

(_____) _____-_____ Institution Phone Number

Please print clearly. Your signature is required before this application can be processed.

_____ Physician's Full Name

_____ Physician's Address

_____ Physician's Specialty

(_____) _____-_____ Physician's Phone Number

_____ City

_____ State

_____ ZIP Code

Your signature required

_____ Physician Signature

_____ / _____ / _____ Date Signed

Notice

Advance Insurance Company of Kansas will request written proof from time to time related to this child's incapacity and dependence and, when the child is no longer disabled, they will cease to be a dependent and will be ineligible for continued coverage as a dependent.

Warning

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline at (800) 530-5989.

AICK 7 – Beneficiary Designation Form

Beneficiary Designation Form

Please retain a copy for the insured.

ADVANCE Insurance Company of Kansas℠
advanceinsurance.com

Employer _____ AICK Group Number _____ Class _____

Section 1 – Insured Information (always complete this section)

First Name _____ MI _____ Social Security Number _____-_____-_____

Last Name _____ Suffix _____

Section 2A – Primary Beneficiary Designation

This beneficiary designation will apply to all benefits with Advance Insurance Company of Kansas (AICK). If it does not, you should indicate which benefits the change applies to:

- ☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)
- ☐ Voluntary Term Life (and AD&D, if applicable)
- ☐ Voluntary Employee Accident/Family Accident

Primary beneficary information (receives the benefit upon death of the insured): The proceeds will be paid in equal shares to the persons shown below unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____/_____/_____ or Age _____

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____/_____/_____ or Age _____

Section 2B – Contingent Beneficiary Designation (you must complete Section 2A if you fill out this section)

Contingent beneficary information (receives the benefit only if the beneficiary(ies) in Section 2A is/are deceased): If there is more than one Contingent Beneficiary listed below, the proceeds will be paid in equal shares unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____/_____/_____ or Age _____

First Name _____ MI _____ Relationship to Applicant _____

Last Name _____ Suffix _____ Date of Birth _____/_____/_____ or Age _____

Section 3 – Authorization (signature and date are required)

Your signature required _____ _____/_____/_____

Insured Employee Signature Date Signed

Email completed form to: csc-advance@advanceinsurance.com; or fax to 785-290-0727

AICK 7 09/18

An independent licensee of the Blue Cross Blue Shield Association.

AICK 4EV – Evidence of Insurability

Evidence of Insurability

For Group Voluntary Life/AD&D Coverage

ADVANCE Insurance Company of Kansas℠

Employer Name _____ Group Number _____

Section 1 – Applicant (Employee) Information

First Name _____ MI _____

Last Name _____ Suffix _____

_____-_____-_____
Social Security Number

_____ ft. _____ in. _____
Height Weight

(_____) _____-_____
Phone Number

Your Medical Provider's Name _____

Provider's Mailing Address _____

City _____

State _____ ZIP Code _____

(_____) _____-_____
Phone Number

Approximate date of your last visit to your medical provider: _____ /_____ /_____
Date

Section 2 – Spouse Information – if you are applying to cover your spouse

First Name _____ MI _____

Last Name _____ Suffix _____

_____ /_____ /_____
Date of Birth

_____ /_____ /_____
Date of Marriage

Gender ☐ Male ☐ Female

_____-_____-_____
Social Security Number

_____ ft. _____ in. _____
Height Weight

Approximate date of your last visit to your medical provider: _____ /_____ /_____
Date

Spouse's Medical Provider's Name _____

Provider's Mailing Address _____

City _____

State _____ ZIP Code _____

(_____) _____-_____
Phone Number

Section 3 – Child Information – if you are applying to cover your (or your spouse's) child or children

Child 1:

First Name _____ MI _____

Last Name _____ Suffix _____

Relationship to Employee _____

Gender ☐ Male ☐ Female

_____ /_____ /_____
Date of Birth

_____ ft. _____ in. _____
Height Weight

Child 2:

First Name _____ MI _____

Last Name _____ Suffix _____

Relationship to Employee _____

Gender ☐ Male ☐ Female

_____ /_____ /_____
Date of Birth

_____ ft. _____ in. _____
Height Weight

Child 3:

First Name _____ MI _____

Last Name _____ Suffix _____

Relationship to Employee _____

Gender ☐ Male ☐ Female

_____ /_____ /_____
Date of Birth

_____ ft. _____ in. _____
Height Weight

Please continue on the next page.

Section 3 – Child Information (continued)

Attention: If the physician shown at right is not the medical provider for all the children enrolling, you may use the blank space in Section 6 to give us the other providers' details. Print your name and Social Security number at the top of the page, provide complete information, and sign and date it.

Your Medical Provider's Name

Provider's Mailing Address

City

State ZIP Code (_____) _____-_____ Phone Number

Section 4 – Applicant(s) Health Information

Please check the boxes "yes" or "no." For each answer marked "yes," explain in the section(s) provided. (**NOTE:** If you run out of space, you may use the space in Section 6. Print your name and Social Security number at the top of the page, tell us which question you are answering, provide the requested information, then sign and date the response.)

Yes ☐ No ☐ 1. Is anyone applying for coverage currently pregnant?

Name of Pregnant Person | Expected Delivery Date | Physician Name, City and State

☐ ☐ 2. Is anyone applying for coverage currently hospitalized, bedridden due to disease, confined to a nursing facility, confined to a wheelchair, or receiving hospice or home health care services?

Name of Person Treated | Diagnosis or Details About Condition | Physician Name, City and State

☐ ☐ 3. Has anyone ever been diagnosed with, sought treatment by, or been recommended to have, an organ transplant by a medical professional?

Name of Person Treated | Diagnosis/Details of Condition and Medication Name/Dosage | Physician Name, City and State

4. In the last five years, has anyone been diagnosed with, treated for, or prescribed medication by a medical professional for:

☐ ☐ A. Heart or artery disorder, heart murmur or heart attack, tuberculosis, hepatitis, liver disease, stomach or intestine disorder, gastric bypass, kidney disorder, asthma, lung or other respiratory disorder?

☐ ☐ B. Cancer, leukemia, malignant growth or any form of tumor?

☐ ☐ C. Epilepsy, any nervous system disorder, alcoholism, drug abuse, substance abuse, Alzheimer's, dementia, progressive memory loss, bipolar disorder, schizophrenia, or any other mental illness?

☐ ☐ D. Back or spine injury, back pain, bone disease or disorder, osteoporosis, systemic lupus, joint pain, rheumatoid arthritis, carpal tunnel, chronic fatigue syndrome, fibromyalgia, or other musculoskeletal disorders?

☐ ☐ E. Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?

Explain any "yes" response(s) to Questions 4A through 4E:

Name of Person Treated | Diagnosis/Details of Condition and Medication Name & Dosage | Date Diagnosed | Date Last Seen | Physician or Pharmacy Name, City and State

Name of Person Treated | Diagnosis/Details of Condition and Medication Name & Dosage | Date Diagnosed | Date Last Seen | Physician or Pharmacy Name, City and State

Please continue on the next page.

Section 4 – Applicant(s) Health Information (continued)

Yes No

4. In the last five years, has anyone been diagnosed with, treated for, or prescribed medication by a medical professional for:

☐ ☐ F. High blood pressure?

Name of Person Treated	Medication Name & Dosage	Last Reading and Date	Next-to-Last Reading and Date	Physician or Pharmacy Name, City and State

☐ ☐ G. Diabetes, albumin, blood or sugar in the urine?

Name of Person Treated	Medication Name & Dosage	Age of Onset	How Controlled	Physician or Pharmacy Name, City and State

☐ ☐ 5. Have you or anyone requesting coverage been seen by any type of medical (or mental health) doctor or practitioner – or presently under observation or receiving medical treament – for any reason or condition other than those listed in Questions 1 through 4?

Name of Person Treated	Diagnosis/Details of Condition and Medication Name/Dosage	Date Diagnosed	Date Last Seen	Physician or Pharmacy Name, City and State

Name of Person Treated	Diagnosis/Details of Condition and Medication Name/Dosage	Date Diagnosed	Date Last Seen	Physician or Pharmacy Name, City and State

☐ ☐ 6. In the last five years, has anyone applying for coverage been declined, postponed or limited in any way for life, disability, health or accident insurance?

Name of Person Treated	Type of Insurance	Declined, Postponed or Limited?	Reason

Section 5A – Important Information

I understand that I must sign below if I am applying for coverage. My signature verifies that I have read all the information on this form and represent that all statements made herein are complete and true to the best of my knowledge.

I understand Advance Insurance Company of Kansas (AICK) may correct premium, terminate or rescind the policy: 1) if within two years of the policy effective date my answers are found to be incorrect; or 2) at any time, if the information provided herein intentionally misrepresents a material fact or was fraudulent.

I understand coverage is subject to the health of the Applicant remaining unchanged to the effective date of coverage. AICK's Underwriting Department must be notified of any such change prior to the effective date of coverage at (800) 530-5989.

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.

The insurance being applied for will become effective, subject to the terms and conditions of the policy for which application is made, the first day of the month following approval at the home office of AICK; an official contract issued and delivered; and the required premium paid to and accepted by AICK. If this application is not approved, no insurance will become effective.

The Applicant should not cancel any other coverage until notified by AICK that this application has been approved.

No agent or broker is authorized to bind coverage, approve applications, modify policies or alter or waive any rights or requirements of AICK.

A photographic copy of this authorization shall be as valid as the original.

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, 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.

Please continue on the next page.

Section 5B – Authorization

The requested insurance will not be effective until approved by Advance Insurance Company of Kansas (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 4 has been fully disclosed in Section 5.

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 within two years of the policy effective date.

I understand I will be responsible for any fees or cost associated with the physical or for obtaining medical records to prove my insurability as 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.

Your signature required

_____ Employee Signature — _____ / _____ / _____ Date Signed

_____ Print Name — _____ / _____ / _____ Date of Birth

Spouse's signature required

_____ Spouse Signature (if spouse is applying for coverage) — _____ / _____ / _____ Date Signed

_____ Print Name — _____ / _____ / _____ Date of Birth

Signature of adult dependent child (over age 18) required

_____ Adult Dependent Signature (if dependent over age 18 is applying for coverage) — _____ / _____ / _____ Date Signed

_____ Print Name — _____ / _____ / _____ Date of Birth

Thank you for your application – Your group administrator will send this form to AICK

By fax: 785-290-0727

Questions? Call us at (800) 530-5989.

By mail: Advance Insurance Company of Kansas
1133 SW Topeka Blvd.
Topeka, KS 66629-0001

Please continue on the next page.

Section 6 – Additional Information

If you run out of space to respond to the questions in Sections 3 or 4, please use the blank space below. Print the employee's name and Social Security number where indicated below, tell us the question(s) you're answering, tell us who it applies to, provide the requested information, and **sign and date your response(s) below.**

First Name _____ MI ____ Last Name _____ Suffix ____

_____-_____-_____
Social Security Number

Your signature required

Employee _____ Date Signed _____/_____/_____

Page 5

AICK 5 – Group Change Form

Group Change Form

Please retain a copy for the insured.

ADVANCE Insurance Company of Kansas SM

Advance Insurance Company of Kansas (AICK) is requested to make the following changes in connection with my insurance under:

Employer: _____ AICK Group no. _____ Class

Section 1 – Insured information (always complete this section)

First Name _____ MI ___ Social Security Number _____

Last Name _____ Suffix ___

Section 2 – Change of name for insured

Change insured's name to:

First Name _____ MI ___

Last Name _____ Suffix ___

Reason for change:

☐ Marriage ☐ Divorce Date: ____ ____ _____

☐ Other (explain): _____

Section 3 – Class change

From Class _____ to Class _____ Effective date ____ ____ _____

Reason for change: _____

Section 4A – Change of **primary beneficiary**

Only the Insured may change the beneficiary. The change of beneficiary must be received prior to the Insured's death and will be effective as of the date it is received by AICK's home office.

This change of beneficiary will apply to all benefits with AICK. If it does not, you should indicate which benefits the change applies to:
☐ Basic Term Life and Accidental Death & Dismemberment (AD&D)
☐ Voluntary Term Life (and AD&D, if applicable)
☐ Voluntary Employee Accident/Family Accident

Primary beneficiary information (receives the benefit upon death of the insured). The proceeds will be paid in equal shares to the persons shown below unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name _____ MI ___ Last Name _____ Suffix ___

Relationship to Applicant _____ Date of Birth or Age _____

First Name _____ MI ___ Last Name _____ Suffix ___

Relationship to Applicant _____ Date of Birth or Age _____

First Name _____ MI ___ Last Name _____ Suffix ___

Relationship to Applicant _____ Date of Birth or Age _____

Please continue on the next page

Section 4B – Change of contingent beneficiary (you must also complete section 4A if you fill out this section)

Contingent beneficiary information (**receives the benefit only if the primary beneficiary[ies] in section 4A is[are] deceased**). If there is more than one Contingent Beneficiary listed below, the proceeds will be paid in equal shares unless you state otherwise. If you need more space, attach a separate sheet with complete information. You must sign and date the separate sheet.

First Name ____ MI ____ Last Name ____ Suffix ____

Relationship to Applicant ____ Date of Birth ____ or Age ____

First Name ____ MI ____ Last Name ____ Suffix ____

Relationship to Applicant ____ Date of Birth ____ or Age ____

First Name ____ MI ____ Last Name ____ Suffix ____

Relationship to Applicant ____ Date of Birth ____ or Age ____

Section 5 – Benefit change

☐ **Add Dependent Life effective** ____ ____ ____ Date of marriage ____ ____ ____

Date first child acquired ____ ____

☐ **Remove a benefit effective** ____ ____ ____

- ☐ Basic Term Life and AD&D for you
- ☐ Basic Dependent Life (Note: marking this box removes dependent life coverage for all dependents; which includes your spouse and all eligible children.
- ☐ Voluntary Term Life (and AD&D, if applicable) for: ☐ you ☐ your spouse ☐ all eligible child(ren)
- ☐ Voluntary Employee Accident or Family Accident
- ☐ Short Term Disability (basic or voluntary) for you
- ☐ Long Term Disability (basic or voluntary) for you

Reason for change: ____

Section 6 – Authorization (signature and date always required)

I hereby apply for amendment of my enrollment as indicated on this form. I understand that if I want to add the benefit at a later date I may have to complete a form asking medical questions and that AICK may request other information to determine whether or not I may be insured under the group program. I understand that I will be responsible for any fees or cost including, but not limited to, obtaining medical records or an exam necessary to determine insurability and that AICK may refuse to cover me (or my dependent, if applicable). I understand that I must be actively at work 1) performing all the normal duties of my job, 2) at the usual place, and 3) for the required hours each week before a benefit can be added. It is mutually agreed that such change shall not become effective unless and until accepted, and that this request for change will become a part of my original enrollment form and will be subject to the terms of the group policy.

Your signature required ____ Insured employee signature ____ Date signed

Print name ____ Social security number

Group signature required ____ Group policyholder/participating employer signature

Contact us at:

Advance Insurance Company of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001

advanceinsurance.com
In Topeka: 785-273-9804 or Toll-free: 1-800-530-5989
Fax: 785-290-0727

AICK 300 – Employee Enrollment Form (Voluntary Coverage)

Employee Enrollment Form

FOR VOLUNTARY COVERAGE

ADVANCE Insurance Company of Kansas
An Independent Licensee of the Blue Cross and Blue Shield Association
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 and G (If a late enrollee, also complete E and F)

☐ **Voluntary Term Life** – complete sections A, B, D, E, F and G

☐ **Voluntary Accidental Death & Dismemberment** – complete sections A, B, C and G

☐ **Voluntary Long Term Disability** – complete sections A and G (If a late enrollee, also complete E and F)

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

Name _____ (Last / First / MI) Social Security No. ___ ___ ___ ___ ___ ___ ___ ___ ___

Address _____ City _____ State _____ ZIP _____

Date of Birth ___ ___ ___ ___ ___ ___ ___ ___ (M M D D Y Y Y Y) Height ____ ft. ____ in. Weight _____ lbs. Gender: ☐ Male ☐ Female

Employed by _____ (Employer's Name / City) Work Phone ( ) _____

Date of Hire ___ ___ ___ ___ ___ ___ ___ ___ (M M D D Y Y Y Y) Hourly Wage $ _____ Occupation/Job Title _____

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 and 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**

1. _____ (Last / First / MI / Street, City, State / Relationship / Age)
2. _____ (Last / First / MI / Street, City, State / Relationship / Age)

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

**Contingent Beneficiary

1. _____ (Last / First / MI / Street, City, State / Relationship / Age)
2. _____ (Last / First / MI / Street, City, State / Relationship / Age)

Section C – 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 D – Voluntary Term Life

If enrolling, you and your spouse must complete the appropriate sections, answer the medical questions in sections E & F, and sign and date section G.

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 you or your spouse, this coverage may be requested. All eligible unmarried dependent children from the age of 6 months to 23 years of age will receive the benefit amount selected below; and from the age of 15 days to 6 months will receive 10 percent of the selected benefit.

Select only one amount for all the children in the family: ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

AICK 300 12/10

Section D, continued – Voluntary Term Life

If requesting Spouse coverage, this section must be completed along with sections E and F, and your spouse must sign and date section G.

Spouse Name ______________________ (Last / First / MI) Social Security No. ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth __ __ __ __ __ __ __ __ (M M D D Y Y Y Y) Height ____ ft. ____ in. Weight ________ lbs. Gender: ☐ Male ☐ Female

Spouse's Employer: ______________________

Spouse's Physician's Name: ______________________

Spouse's Physician's Complete Address: ______________________ (Street or PO Box)

______________________ (City, State and 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**

1. ______________________ (Last / First / MI / Street, City, State / Relationship / Age)
2. ______________________ (Last / First / MI / Street, City, State / Relationship / Age)

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

****Spouse's** Contingent Beneficiary

1. ______________________ (Last / First / MI / Street, City, State / Relationship / Age)
2. ______________________ (Last / First / MI / Street, City, State / Relationship / Age)

If requesting Dependent Child coverage, this section must be completed (if the child is a late enrollee also complete sections E and F). Any dependent child 18 years of age or older must sign and date section G.

Child's (Children's) Physician's Name: ______________________

Child's (Children's) Physician's Complete Address: ______________________ (Street or PO Box)

______________________ (City, State and 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 ______________________ (Last / First / MI) Relationship to employee ______________

Date of Birth __ __ __ __ __ __ __ __ (M M D D Y Y Y Y) Height ____ ft. ____ in. Weight ________ lbs. Gender: ☐ Male ☐ Female

Child's Full Name ______________________ (Last / First / MI) Relationship to employee ______________

Date of Birth __ __ __ __ __ __ __ __ (M M D D Y Y Y Y) Height ____ ft. ____ in. Weight ________ lbs. Gender: ☐ Male ☐ Female

Child's Full Name ______________________ (Last / First / MI) Relationship to employee ______________

Date of Birth __ __ __ __ __ __ __ __ (M M D D Y Y Y Y) Height ____ ft. ____ in. Weight ________ lbs. Gender: ☐ Male ☐ Female

Child's Full Name ______________________ (Last / First / MI) Relationship to employee ______________

Date of Birth __ __ __ __ __ __ __ __ (M M D D Y Y Y Y) Height ____ ft. ____ in. Weight ________ lbs. Gender: ☐ Male ☐ Female

Section E – 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 F, 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. High blood pressure? **If yes, give last two readings and dates**.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Diabetes, albumin, blood or sugar in the urine? **If Diabetic**, give age of onset and how controlled.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Cancer, leukemia, malignant growth or any form of tumor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Epilepsy or any mental or nervous system disorder, alcoholism, drug or substance abuse?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Any disorder of the immune system, including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or HIV infection?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Back, spine or bone disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Is anyone presently pregnant? **If Yes**, provide expected date of delivery.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11. Has anyone ever been rated, declined, postponed or limited in any way for life, disability, health or accident insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section F – Medical Details

For any "Yes" response to questions 1-11 in Section E, 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: ______________________
Street or PO Box, City State, ZIP

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: ______________________
Street or PO Box, City State, ZIP

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: ______________________
Street or PO Box, City State, ZIP

AICK 300 12/10

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 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 E has been fully disclosed in Section F.

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** X _____ 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 X _____ 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 X _____ 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 X _____ Date Signed _____

AICK 300 12/10

AICK 400 – Employee Enrollment Form (Voluntary Life)

AICK has several forms that employees can use to request the voluntary term life coverage. Please contact your policyholder representative to obtain the correct form. You may call us toll-free at 1-800-530-5989, or you may email us for a copy of the form (see page 6).

AICK 16 – Death Claim Form

Death Claim Form

to be completed by the Group Policyholder

ADVANCE Insurance Company of Kansas℠

Section 1 – Benefit Information (All death claims require an original certified copy of the death certificate.)

Applying for death benefits for:

☐ Life ☐ Accidental Death ☐ Dependent Life

$ _____
Amount of Insurance

_____ _____
Employee's First Name MI

_____-_____-_____
Employee's Social Security Number

_____ /_____ /_____
Date of Employment

_____ _____
Employee's Last Name Suffix

_____
Job Title or Occupation

What was the last date this employee physically reported to work and performed their normal job duties? _____ /_____ /_____

What date was this employee last carried on your company's payroll? _____ /_____ /_____

Section 2 – Decedent Information

_____ _____
Decedent's First Name MI

_____ /_____ /_____
Decedent's Date of Birth

_____ /_____ /_____
Date of Death

_____ _____
Decedent's Last Name Suffix

_____
Cause of Death

_____
Decedent's Home Address

Was death due to an accident? ☐ Yes ☐ No

If yes, describe the accident:

_____
City

_____ _____ _____
State ZIP Code +4

Section 3 – Beneficiary Information

_____ _____
Beneficiary's First Name MI

_____
Beneficiary's Home Address

_____ _____
Beneficiary's Last Name Suffix

_____
City

_____-_____-_____
Social Security Number

_____ /_____ /_____
Date of Birth

_____ _____ _____ _____
State ZIP Code +4 Relationship to Deceased

_____ _____
Beneficiary's First Name MI

_____
Beneficiary's Home Address

_____ _____
Beneficiary's Last Name Suffix

_____
City

_____-_____-_____
Social Security Number

_____ /_____ /_____
Date of Birth

_____ _____ _____ _____
State ZIP Code +4 Relationship to Deceased

Section 4 – Policyholder Information

Remarks: _____

The company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form or investigating the claim.

_____
Group Policyholder Name

_____
Policyholder Address

_____
Title of Employer Representative

_____
City

(_____) _____-_____
Policyholder Phone Number

(_____) _____-_____
Policyholder Fax Number

_____ _____ _____
State ZIP Code +4

Your signature required _____
Employer Signature

_____ /_____ /_____
Date Signed

AICK 16 07/23 An independent licensee of the Blue Cross Blue Shield Association. Page 1

Section 3 – Important Information

The company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form and investigating the claim.

Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline at 800-530-5989.

Section 4 – Special Instructions

Upon the death of the insured employee or dependent send this claim form, an original certified copy of the death certificate and any other relevant attachments to our claims department at:

Advance Insurance Company of Kansas
1133 SW Topeka Blvd., Topeka, KS 66629-0001
Phone: 785-273-9804 or Toll-free 800-530-5989

The claim form should be fully completed and signed by an authorized representative of the group policyholder. Failure to complete all questions may cause a delay in the claim settlement.

If your plan includes dependent life coverage:

- The beneficiary will be the insured employee if basic dependent coverage.
- The beneficiary of a spouse covered under a voluntary life plan will be as designated.
- The insured parent will be the beneficiary of voluntary life dependent child coverage.

Submit medical proof of death on all death claims in the form of an original **certified copy** of the death certificate.

If death was due to an accident, additional information will be requested and may include one or more of the following in addition to other required documentation:

- Coroner's report
- Police report
- Accident report
- Toxicology report

Self-administered group policyholders should include the original enrollment form and all change of beneficiary forms with the claim form.

If insurance proceeds are payable to the estate of the insured, we will require a copy of the appointment of an administrator or executor of the insured's estate.

If insurance proceeds are payable to a minor child or mentally incompetent person, we will require a copy of the legal documents appointing a conservator for the beneficiary.

If the designated beneficiary is deceased, a copy of his or her death certificate should be furnished with the claim form.

Office Use Only

Claim Number

AICK 18 – Disability Claim Form

Disability Claim Form

ADVANCE Insurance Company of Kansas℠

The instructions:
1. Pages 1 and 2 are to be completed by you, the employee;
2. Page 3 must be completed by the Group Policyholder (your employer); and,
3. Pages 4 and 5 must be completed by the doctor that advised you to stop working.
4. Fax or mail the completed forms to Advance Insurance Company of Kansas.

For office use only

Claim number

Employee's statement

Benefit being requested:

☐ Short term disability ☐ Long term disability ☐ Waiver of premium

Your first name MI Last name Suffix Gender: ☐ Male ☐ Female Your date of birth

Your home address City State ZIP code

Social security no. Your home phone number Your occupation

1) Is this disability due to: ☐ an Accident ☐ a Sickness?

2) I have been unable to work due to this disability since (what date?): ____ ____ _____

3) I returned to work (check one): ☐ part-time on (what date?): ____ ____ _____
☐ full-time on (what date?): ____ ____ _____

4) What was the date of your accident or that you first noticed the symptoms of your sickness? ____ ____ _____

5) Describe how and where the accident occurred or describe the first symptoms of your sickness:

6) Is your accident or sickness related to your occupation? ☐ Yes ☐ No If yes, please explain:

7) What date were you first treated for your injury or sickness? ____ ____ _____

8) Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, when? ____ ____ _____

9) Have you been hospitalized for this disability? ☐ Yes ☐ No If yes, provide the information requested below about your stay:

a) Dates of hospitalization: from ____ ____ _____ to ____ ____ _____

b) Hospital: _____
Name Street or PO Box City State Zip code

c) Physician: _____
Name Street or PO Box City State Zip code

10) Name of physician treating you for this disability: _____

a) Your treating physician's phone number: ____ ____ _____

b) Your treating physician's address: _____
Street or PO Box City State Zip code

Please continue the employee's statement on page 2.

1133 SW Topeka Blvd. • Topeka, KS 66629-0001 • Phone (785)273-9804 or Toll-free (800)530-5989 • Fax (785)290-0727
An Independent Licensee of the Blue Cross Blue Shield Association.

Employee's statement continued

11) What other income are you receiving? (include any form of employment) What other income are you eligible for as a result of this disability? (e.g., Personal Injury Protection under auto insurance, other employer-sponsored/payroll-deducted disability policy, Social Security, Worker's Comp, Unemployment Benefits, etc.):

☐ No other source of income

☐ I am receiving other income which is explained below:

a) Source of income: _____ Amount: _____

b) Date other income began and ended: from ____ ____ _____ to ____ ____ _____

12) Marital status: ☐ Married ☐ Single ☐ Legally separated

a) If married, is your spouse employed? ☐ Yes ☐ No

b) How many children do you have?_____

13) List the names and dates of birth for your spouse and dependent children (if you need more space, attach a separate sheet with complete information; and, sign and date the separate sheet):

Name	Date of birth	Relationship

Authorization

The statements above are true and complete to the best of my knowledge and belief. I understand the Company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form and investigating the claim.

I hereby authorize any hospital or physician who has treated me, other person who has attended me, examined me, or any government agency to furnish to Advance Insurance Company of Kansas (AICK) providing this form, or their representatives, any and all information with respect to any illness, injury, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this authorization will be as valid as the original. I may revoke the authorization by notifying AICK in writing of my desire to do so. This authorization expires two years from the date signed.

Employee sign here _____ Date signed ____ ____ _____

Employer's statement (answer all questions to avoid delay)

Benefit being requested:

☐ Short term disability ☐ Long term disability ☐ Waiver of premium

Employee's first name _____ MI _____ Last name _____ Suffix _____ Social security no. _____

Employee's date of hire _____ Employee's effective date of insurance _____

1) Employee's work schedule _____ days a week; _____ hours a day

2) What was the employee's occupation at the time of the disability? _____

3) What date did the employee last physically report to work? _____

4) What was the reason for stopping work? _____

5) Employee's salary: $ _____ per hour @ _____ hours per week as of _____ Date salary went into effect

6) Does the salary provided include the following (check all that apply): ☐ Overtime ☐ Bonuses ☐ Commissions

7) What percentage of the premium does this **employee** pay for the benefit being applied for? _____ %

8) Is the premium for this benefit run through a Section 125 or Flexible Benefit plan? ☐ Yes ☐ No (Notice: if you answered yes, the disability benefits will be taxed at 100 percent for FICA taxes.)

9) Employee returned to work: part-time on (what date?): _____

full-time on (what date?): _____

10) Will (or has) employee receive(d) salary continuance, such as vacation pay, sick pay, or PTO, anytime during this disability period? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ through _____

11) Will (or has) employee apply(ied) for Worker's Compensation? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ through _____ and amount received: $ _____ per _____

12) Will (or has) employee file(d) for unemployment compensation for disability benefits provided by an Employer-Employee Labor Management of Union Welfare Plan? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ through _____ and amount received: $ _____ per _____

13) Is this employee applying for or receiving benefits from any other employer-sponsored/payroll-deducted policy? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ through _____

14) Is this employee eligible for pension disability? ☐ Yes ☐ No **If yes,** tell us the date it began: _____ through _____ and amount received: $ _____ per _____

15) Is your company subject to ERISA guidelines? ☐ Yes ☐ No

16) If applying for Long Term Disability benefits, please attach a job description for this employee that includes the physical requirements of the job.

17) Remarks: _____

Please print clearly. A signature is required before any claim can be processed.

Name of Group Policyholder _____ Phone no. _____ Fax no. _____

Employer's full address _____ City _____ State _____ ZIP code _____

Employer sign here _____ Title of signatory _____ Date signed _____

Attending physician's statement (to be completed only by the treating physician or their staff member at the physician's direction. Please answer all questions to avoid delay).

Patient's first name _____ MI _____ Last name _____ Suffix _____ Date of birth _____ _____ _____

1) History

a) When did the accident occur or the symptoms of sickness first appear? _____

b) On what date did the physician tell the patient to cease work because of this disability? _____ _____ _____

c) Has the patient ever had the same or a similar condition? ☐ Yes ☐ No If yes, when? and describe:

_____

d) Is condition due to an accident? ☐ Yes ☐ No If yes, indicate the date of the accident: _____ _____ _____

e) Is condition due to an injury or sickness arising out of the patient's employment? ☐ Yes ☐ No ☐ Unknown

f) Name(s) and adress(es) of other treating physicians: _____

_____

2) Disability

a) Diagnosis (including any complications)? _____ ICD-10 code _____

b) Subjective symptoms? _____ ICD-10 code _____

c) If disability is due to pregnancy, EDC? _____ _____ _____ Delivery date _____ _____ _____

Type of delivery _____

3) Dates of treatment

a) Date you **first** treated patient for this episode of disability: _____ _____ _____

b) Date of most recent treatment: _____ _____ _____

c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

d) Date of next scheduled visit: _____ _____ _____

4) Nature of treatment

a) Treatment prescribed (including surgery, medication, physiotherapy, etc.): CPT code _____

_____

_____

b) To your knowledge, is the patient following the recommended treatment program? ☐ Yes ☐ No

5) Progress

a) Has patient? ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

b) Is patient? ☐ Ambulatory ☐ House confined ☐ Hospital confined

c) Has patient been hospital confined? ☐ Yes ☐ No If yes, provide dates of confinement:

a) Dates of hospitalization: from _____ _____ _____ to _____ _____ _____

b) Hospital: _____

Name Street or PO Box City State Zip code

6) Cardiac (if applicable) American Heart Association

a) Functional capacity: ☐ Class 1 - no limitation ☐ Class 3 - marked limitation
☐ Class 2 - slight limitation ☐ Class 4 - complete limitation

b) Blood pressure reading (last visit): Systolic _____ Diastolic _____

Attending physician's statement continued

Patient's first name | MI | Last name | Suffix | Date of birth

7) Physical impairment (which of these classes applies to your patient for **this** episode of disability?)

- ☐ Class 1 - no limitation of functional capacity; capable of heavy work (No restrictions).
- ☐ Class 2 - medium activity; capable of medium work.
- ☐ Class 3 - slight limitation of functional capability; capable of light work.
- ☐ Class 4 - moderate limitation of functional capacity; capable of clerical/administrative activity.
- ☐ Class 5 - severe limitation of functional capacity; incapable of even minimum sedentary work.

8) Mental/Nervouse impairment (if applicable)

- ☐ Class 1 - patient is able to function under stress and engage in interpersonal relations (No limitations).
- ☐ Class 2 - patient is able to function in most stressful situations and engage in most interpersonal relations (Slight limitations).
- ☐ Class 3 - patient is able to engage only in limited stressful situations and only limited interpersonal relations (Moderate limitations).
- ☐ Class 4 - patient is unable to engage in stressful situations or engage in interpersonal relations (Marked limitations).
- ☐ Class 5 - patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitations).

9) Status and prognosis

	Patient's job	**Any other work**
a) Does this disability prevent this patient from working at:	☐ Yes ☐ No	☐ Yes ☐ No
b) What duties of patient's job is he/she unable to perform?		
c) Do you expect a fundamental or marked change in the future:	☐ Yes ☐ No	☐ Yes ☐ No
If yes, indicate date patient will recover sufficiently to perform duties:	____ ____ _____	____ ____ _____
If no, please explain:		
d) Estimated recovery time for this disability: _____ (no. of weeks) or	☐ 1 month ☐ 2-3 months ☐ 4-6 months ☐ Never	☐ 1 month ☐ 2-3 months ☐ 4-6 months ☐ Never

10) Rehabilitation

	Patient's job	**Any other work**
a) Is patient a suitable candidate for further rehabilitation services?	☐ Yes ☐ No	☐ Yes ☐ No
b) Can present job be modified to allow for handling with impairment?	☐ Yes ☐ No	☐ Yes ☐ No
c) When could trial employment commence? ☐ full-time ☐ part-time	____ ____ _____	____ ____ _____
d) Would vocational counseling and/or retraining be recommended?	☐ Yes ☐ No	

11) Remarks _____

Please print clearly. A signature is required before any claim can be processed.

Physician's full name | Phone no. | Fax no.

Physician's full address | City | State | ZIP code

Physician's specialty

Physician sign here | Date signed

Notice of Terminated Employees

ADVANCE Insurance Company of Kansas
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: advanceinsurance.com

Notice of Terminated Employees

- Continuation of coverage for employees that are not Actively Working the required hours each week is limited. If the absence is because of disability due to illness or injury, your group only has 12 months to either carry the coverage and/or submit a claim for Waiver of premium. If you have someone on your bill that has not been able to work the required hours each week because of an illness or injury that began more than three months ago, contact our office for more information about your options to continue the group coverage.
- If an employee wishes to drop an employee paid benefit, please complete a Request for Change form.
- If an employee wishes to drop an employer paid benefit, please have the employee complete a Waiver of Coverage Form and submit to our office.

Requested by:_____
Group Contact

_____
Company Name

_____
Group Number

Employee Name	SSN or Subscriber ID	Termination Reason (required)	Date of Termination

Don't forget to provide each terminating employee with a Conversion Privilege form, AICK 12.

It is the employer's responsibility to provide this form to a person losing their group life insurance as an employee or a dependent (if your group offers dependents insurance). See our website at advanceinsurance.com under the Forms tab to print a copy of this form from the Miscellaneous Forms for your terminating employee(s).

AICK 12 – Notice of Conversion Privilege

Notice of Conversion Privilege

ADVANCE Insurance Company of Kansas℠

This is not an application – it is a request for information only.
Returning this form is not an obligation to continue coverage.

Subscriber ID _____ Group Number _____

Name of Employer (the group policyholder) _____

Please read this notice.

This group life insurance program under which you (and your insured dependents, if applicable) have been insured contains an important conversion privilege. The conversion privilege entitles you (and your insured dependents, if applicable) to apply for and purchase an individual whole life insurance policy without evidence of insurability when:

1) your active employment terminates;
2) the amount of group life insurance decreases due to a change in classification;
3) the amount of group life insurance reduces or terminates due to age; or
4) the number of hours you work each week drops below the minimum required to be eligible for your group's life insurance plan.

provided the application and payment of the first premium is made to us within 31 days after the group life insurance terminates.

In order to receive an application and premium information, the following information must be completed and returned to Advance Insurance Company of Kansas (AICK). The premium for the individual whole life insurance policy is based on your age nearest the issue date of the policy.

Section 1 – Insured Information

First Name _____ MI _____ Gender ☐ Male ☐ Female Date of Birth _____

Last Name _____ Suffix _____ Social Security Number _____

Mailing Address _____ Home Phone Number _____ Cell Phone Number _____

City _____ Work Phone Number _____

State _____ ZIP Code _____ +4 _____

Section 2 – Conversion Coverage

Amount of life insurance at termination:

$ _____

The amount of group life insurance being converted may not be more than you were entitled to under the group life plan but may be any lesser amount (in increments of $1,000) that you choose instead.

Reason for termination: ☐ Disability* ☐ Retirement ☐ Other _____

What date did you last physically report to your job at the usual place of employment and perform all normal duties of your job? And your official termination date?

Date last reported to work _____ Termination Date _____

* If termination of the group life insurance coverage is due to disability, you may want to inquire about the Waiver of Premium benefit. For more information, please call our office.

Section 3 – Authorization

Your signature required

Signature of Insured _____ Date Signed _____

Print Name _____

Advance Insurance Company of Kansas – 1133 SW Topeka Blvd. • Topeka, KS 66629-0001 • Phone: (800) 530-5989 • Fax (785) 290-0727

AICK 12 04/17

AICK 170 – Application for Portability

Application for Portability

ADVANCE Insurance Company of Kansas℠

Application for portability plus remittance for the first premium must be given to Advance Insurance Company of Kansas (AICK) within thirty-one days of the date of termination of the former insured's group life insurance as provided in the group policy.

In accordance with and subject to all terms and conditions of said group policy, the person shown in Section 1 is making application to continue their insurance pursuant to the terms of the portability provision of the group policy. Such policy is to be continued in accordance with the following requests and statements of fact:

Section 1 – Insured Information

Name of Employer (the group policyholder)

First Name ____ MI ____ Gender ☐ Male ☐ Female ____/____/____ Date of Birth

Last Name ____ Suffix ____-____-____ Social Security Number

Address to which the premium notices should be mailed (____) ____-____ Home Phone Number (____) ____-____ Cell Phone Number

City (____) ____-____ Work Phone Number

State ____ ZIP Code ____ +4 ____/____/____ Date Employment Terminated

If your employment is terminating because you are disabled, you are not eligible for portability.

Section 2 – Portability Coverage

Coverage is to be continued for:

☐ Myself (the employee) ☐ Life ☐ Life/AD&D Amount: $ ____

☐ My spouse* ☐ Life ☐ Life/AD&D Amount: $ ____

☐ My dependent child(ren)* ☐ Life ☐ Life/AD&D Amount: $ ____

* Coverage for your spouse or dependent children may be ported only if you (the employee) are making application for the portability of your coverage too. Otherwise, they will need to request continuation of coverage under the Conversion Privilege.

If you wish to be autodrafted for premiums, please complete form AICK 25A – Automatic Payment Authorization, which is available on our website: www.advanceinsurance.com

Section 3 – Beneficiary Information

If the designation of beneficiary shown below is different than the designation for the group policy, it will be deemed written notice of change of beneficiary under the group policy effective from the date of execution of this application.

If you need more space, attach a separate sheet with complete information that **you have signed and dated.**

First Name ____ MI ____ Relationship to Applicant ____/____/____ Date of Birth

Last Name ____ Suffix

Section 4 – Authorization

Your signature required

____ Signature of Insured ____/____/____ Date Signed

____ Print Name

Advance Insurance Company of Kansas – 1133 SW Topeka Blvd. • Topeka, KS 66629-0001 • Phone: (800) 530-5989 • Fax (785) 290-0727

AICK 170 01/21 An independent licensee of the Blue Cross Blue Shield Association.

The company will not be held to admit the validity of any claim or to waive the breach of any condition of the policy by furnishing this form and investigating the claim.

Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. Report fraud to our Fraud Hotline at 800-530-5989.

Section 4 – Special Instructions

Upon the death of the insured (or insured child, if applying for child insurance) send this claim form, a newspaper clipping, a certified copy of the death certificate and the policy, if available, to our claims department at:

Advance Insurance Company of Kansas
1133 SW Topeka Blvd., Topeka, KS 66629-0001
Phone: 785-273-9804 or Toll-free 800-530-5989

The claim form should be fully completed and signed. Failure to complete all questions will cause a delay in the claim settlement.

Please be sure to include the Social Security Number, relationship, age and address of each beneficiary. If there is insufficient room on the front of this form, please provide the requested information, signed and dated, on a separate piece of paper.

If your plan includes child insurance coverage:

- Answer questions in Section 2 relating to the deceased as they apply to the child; the beneficiary will be the insured.
- Answer beneficiary questions in Section 3 for Beneficiary A as they apply to the insured.
- The insured should sign and date as Beneficiary A in Section 3.

Submit medical proof of death on all death claims in the form of a **certified copy** of the death certificate.

If insurance proceeds are payable to the estate of the Insured, we will require a copy of the appointment of an administrator or executor of the Insured's estate.

If insurance proceeds are payable to a minor child or mentally incompetent person, we will require a copy of the legal documents appointing a conservator for the beneficiary.

If the designated beneficiary is deceased, a copy of his or her death certificate should be furnished.

Office Use Only

Claim Number

AICK 25A – Automatic Payment Authorization

Automatic Payment Authorization

Return this authorization to: Advance Insurance Company of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Please draft my ☐ checking or ☐ savings on a ☐ monthly or ☐ quarterly basis.

Insured/Company name _____ Identification no. _____

Address _____
Street City State Zip

Financial institution name _____

Address _____
Street City State Zip

Routing/transit no. _____ Account no. _____

Financial institution phone no. ( ) _____

Important: Please return a voided check with this form to ensure accurate processing. I hereby authorize Advance Insurance Company of Kansas to charge my account for the requested mode for payment of premium(s). Should any draft entry be dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, Advance Insurance Company of Kansas agrees that your financial institution shall be relieved of any liability.

Date: _____ Signature: _____

ADVANCE Insurance Company of Kansas

AICK 25A 08/08

An independent licensee of the Blue Cross Blue Shield Association.

Automatic Payment

Member Premium Change Report

OD-23274 Confidential

Client ID: AD

Group 00000000

Subgroup 0001

Advance Insurance Company of Kansas

Member Premium Change Report

1/4/2017

Member ID	Member Name	Age	Current Volume	Current Premium	New Volume	New Premium	Billing Cycle	Effective Date	Plan
		65	41,000	$4.51	26,650	$2.93	Monthly	03/01/2017	LIFE
			41,000	$1.23	26,650	$0.80	Monthly	03/01/2017	AD&D

Summary of Claims Paid

ADVANCE Insurance Company of Kansas

SUMMARY OF CLAIMS PAID

LTD BENEFITS

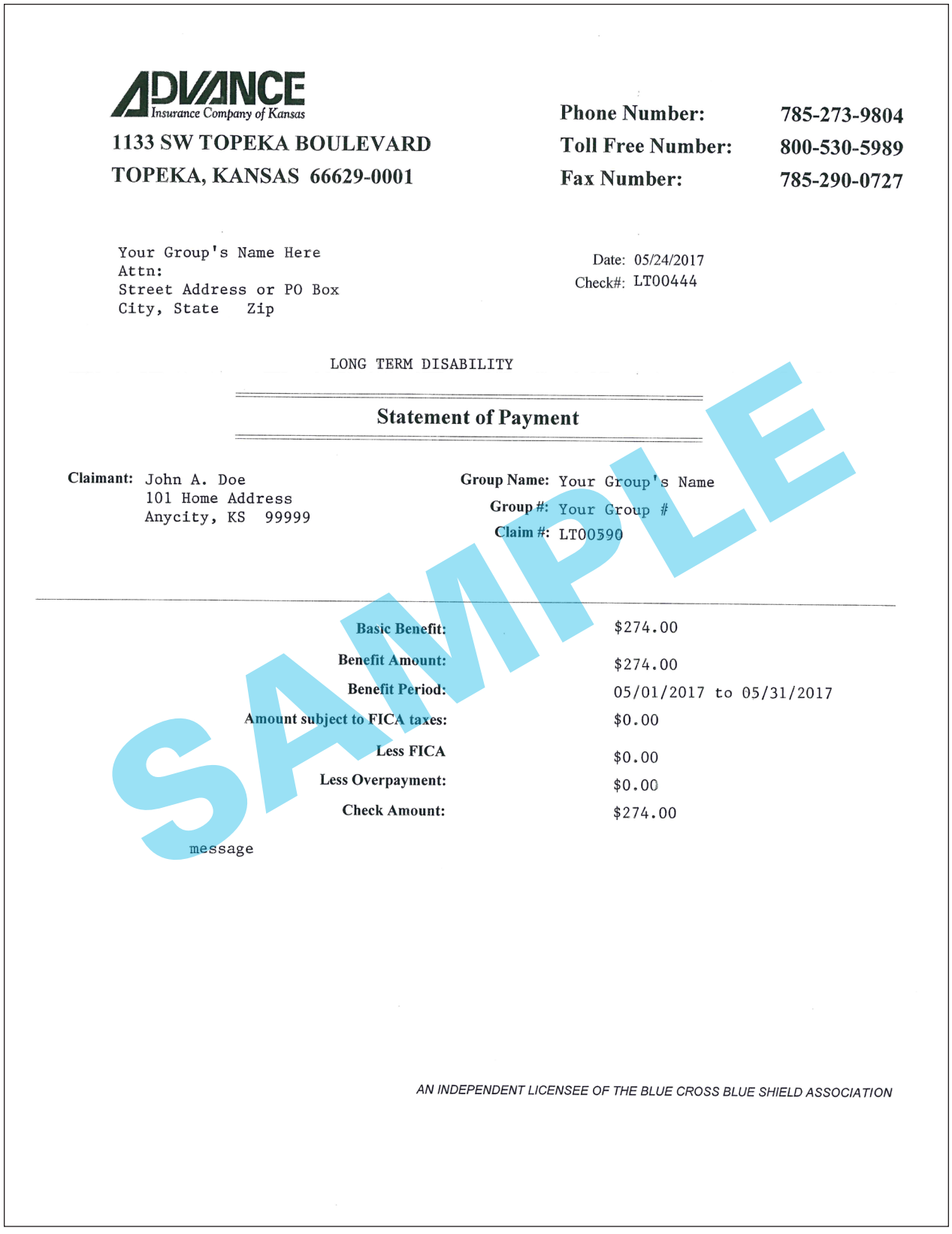
For the period 05/01/2017 - 05/30/2017

GROUP NAME: Your Group's Name Here
Attn:
Street Address or PO Box
City, State Zip

GROUP #: Your Group's #

Benefit Code	Claim Number	Claimant	SSN	Disability Dates From	Disability Dates To	Date Paid	Benefit Amt	FICA %	Amount Subject to FICA	FICA Witheld	Social Security	Medicare	Overpayment	Net Amt
LT000069	C LT00590	Claimant's name	SS#	05/01/2017	05/31/2017	05/24/2017	$274.00	0%	$0.00	$0.00	$0.00	$0.00	$274.00	$0.00
			***** CLAIMANT TOTAL *****				**$274.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$274.00**	**$0.00**
			***** GROUP TOTAL *****				**$274.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$274.00**	**$0.00**

Statement of Payment



ADVANCE
Insurance Company of Kansas

1133 SW TOPEKA BOULEVARD
TOPEKA, KANSAS 66629-0001

Phone Number: 785-273-9804
Toll Free Number: 800-530-5989
Fax Number: 785-290-0727

Your Group's Name Here
Attn:
Street Address or PO Box
City, State Zip

Date: 05/24/2017
Check#: LT00444

LONG TERM DISABILITY

Statement of Payment

Claimant: John A. Doe
101 Home Address
Anycity, KS 99999

Group Name: Your Group's Name
Group #: Your Group #
Claim #: LT00590

Basic Benefit:	$274.00
Benefit Amount:	$274.00
Benefit Period:	05/01/2017 to 05/31/2017
Amount subject to FICA taxes:	$0.00
Less FICA	$0.00
Less Overpayment:	$0.00
Check Amount:	$274.00

message

SAMPLE

AN INDEPENDENT LICENSEE OF THE BLUE CROSS BLUE SHIELD ASSOCIATION

Schedule A Insurance Information

OD-23173 Confidential **Schedule A Insurance Information** 9/1/2017

Plan Information

Group:

Plan / Contract ID:		Executive Contact:	
Original Effective Date:	09/01/2010	BCBSKS Rep:	
Policy / Contract Year:	9/01/2016 To 8/31/2017		
Billed Lives at Beginning of Plan:	101	Billed Lives at End of Plan:	116

Insurance Carrier

Name of Insurance Carrier:	Advance Insurance Company of Kansas		
EIN:	200947315	NAIC Code:	12143

Commission Information

None

Premiums

Total Premium Paid:

Type of Benefits

Life Insurance
Accidental Death & Dismemberment Insurance
Voluntary Life Insurance
Voluntary Spouse Life Insurance
Long Term Disability
Voluntary Child Life Insurance
Short Term Disability

AICK 4SP – Enrollment Form (Spanish)

Formulario de inscripción

para la cobertura de seguro de vida grupal y/o discapacidad

ADVANCE Insurance Company of Kansas

Instrucciones: Adjunte el formulario AICK 4EV si usted es asegurado tardío o solicita más del monto de emisión con garantía.

Su empleador es:_____ **AICK N.° de grupo**._____ Clase

Sección 1: Información del empleado y del empleo

Apellido _____ Primer nombre _____ ISN ____ Sufijo ____

Dirección residencial _____ Ciudad _____ Estado ____ Código postal _____ +4 _____

Fecha de nacimiento ____ ____ _____ Sexo: ☐ Masculino ☐ Femenino Número de Seguro Social _____ Fecha de contratación ____ ____ _____

Título del puesto/ocupación del empleado _____

Su número de teléfono: ☐ Casa/celular _____ (Código de área + número) ☐ Trabajo _____ (Código de área + número)

Me encuentro activo en el trabajo desempeñando todas mis tareas laborales: ☐ Sí ☐ No **y** trabajo _____ horas a la semana para este empleado (indique el número)

$_____ ☐ HR ☐ SEMANA ☐ MES ☐ AÑO Ganancias base (no incluya la comisión, bonos, horas extras o cualquier otra compensación adicional, excepto como se indica en la póliza grupal)

Marque una opción:

☐ Soy un empleado nuevo inscribiéndome en mi primera oportunidad.

☐ Soy un empleado recontratado. Fecha de recontratación: ____ ____ _____

☐ Soy un empleado vigente inscribiéndome debido a: Fecha del caso (del suceso que está marcado a continuación) ____ ____ _____

☐ Temporal a permanente ☐ Otro (explique)_____

Me estoy inscribiendo en:

Seguro de vida básico y muerte accidental y pérdida de extremidades (AD&D, en inglés)	Seguro de vida para derechohabientes	Seguro por discapacidad de corto plazo	Seguro por discapacidad de largo plazo
☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

¿Está casado? ☐ Sí ☐ No Fecha de matrimonio ____ ____ _____

¿Tiene hijos derechohabientes solteros menores de 23 años de edad? ☐ Sí ☐ No

Sección 2a: Su beneficiario principal

El **beneficiario principal recibe el beneficio al momento de su muerte**. Si nombra dos o más personas como beneficiarios principales, los procedimientos se pagaran en partes iguales a menos que se especifique de otra manera. Si necesita más espacio, agregue una hoja por separado con la información completa, que esté **firmada y fechada por usted.**

Primer nombre _____ ISN ____ Apellido _____ Sufijo ____

Relación con el solicitante _____ Fecha de nacimiento o edad _____

Primer nombre _____ ISN ____ Apellido _____ Sufijo ____

Relación con el solicitante _____ Fecha de nacimiento o edad _____

Debe firmar y fechar en la página 2

Para uso exclusivo de la oficina: Group #_____ Subgroup #_____ Class _____

☐ STD ☐ LTD Subscriber #_____

Sección 2b: Su beneficiario de contingencia

Un beneficiario de contingencia **recibe el beneficio únicamente si el(los) beneficiario(s) primario(s) indicado(s) en la sección anterior falleció** (**fallecieron**). Si necesita más espacio, agregue una hoja por separado con la información completa, **que esté firmada y fechada por usted.**

Primer nombre | ISN | Apellido | Sufijo

Relación con el solicitante | Fecha de nacimiento o edad

Primer nombre | ISN | Apellido | Sufijo

Relación con el solicitante | Fecha de nacimiento o edad

Primer nombre | ISN | Apellido | Sufijo

Relación con el solicitante | Fecha de nacimiento o edad

Sección 2c: Sugerencias para los beneficiarios

1. Para que se considere válido, este formulario tiene que estar firmado, fechado **y recibido por la Oficina local de AICK**.
2. No se puede realizar el pago a menores de 18 años de edad. Los beneficios para los menores de edad tienen que pagarse a un tutor legal o a un custodio nombrado por un tribunal.
3. Un asegurado no puede nombrar a sus empleadores como beneficiarios.
4. Se pueden designar iglesias o instituciones de caridad y tienen que incluir el nombre legal y la dirección completa.
5. Si las secciones del beneficiario primario o contingente no proveen suficiente espacio para completar la información, adjunte una hoja por separado que contenga la información completa del beneficiario, **firmada y fechada por usted**.

Sección 3: Beneficiario de seguro de vida para derechohabientes (si está solicitando cobertura médica y aplica a su plan de beneficios de grupo)

Usted (el empleado) será el beneficiario en caso del pago de un beneficio de seguro de vida para derechohabientes a menos que se especifique de otra manera por escrito.

Sección 4: Su autorización

Yo entiendo que si no estoy en el trabajo en la fecha de entrada en vigor de la cobertura, esta cobertura no empezará hasta el día que regrese a su actividad laboral. Yo entiendo que para estar asegurado tengo que estar activamente en el trabajo 1) realizando todas las tareas normales de mi trabajo, 2) en el lugar usual, 3) durante las horas requeridas cada semana según lo establecido en la póliza grupal. Yo autorizo que se hagan las deducciones salariales necesarias de mis ingresos y nombro al(los) beneficiario(s) que se indica(n) en este formulario para que reciba(n) el beneficio pagadero en caso de muerte. Creo que todas las personas para quienes solicito cobertura son ciudadanos residentes de EE. UU. o son extranjeros que residen legalmente en EE. UU., y que la información que proporcioné en este formulario es verdadera y correcta en lo que corresponde a mi estado con el empleador indicado.

Se requiere su firma

Firma del empleado | Fecha de la firma

Escriba su nombre

AICK 5es – Change Form (Spanish)

Formulario de inscripción

para la cobertura de seguro de vida grupal y/o discapacidad

ADVANCE Insurance Company of Kansas

Instrucciones: Adjunte el formulario AICK 4EV si usted es asegurado tardío o solicita más del monto de emisión con garantía.

Su empleador es:_____ **AICK N.° de grupo**._____ Clase

Sección 1: Información del empleado y del empleo

_____ _____ ____ ____
Apellido | Primer nombre | ISN | Sufijo

_____ _____ ____ _____ _____
Dirección residencial | Ciudad | Estado | Código postal | +4

_____ _____ _____ Sexo: ☐ Masculino ☐ Femenino _____ _____ _____ _____ _____ _____
Fecha de nacimiento | Número de Seguro Social | Fecha de contratación

_____
Título del puesto/ocupación del empleado

Su número de teléfono: ☐ Casa/celular _____ ☐ Trabajo _____
Código de área + número | Código de área + número

Me encuentro activo en el trabajo desempeñando todas mis tareas laborales: ☐ Sí ☐ No **y** trabajo _____ horas a la semana para este empleado
indique el número

$_____ ☐HR ☐SEMANA ☐ MES ☐ AÑO Ganancias base (no incluya la comisión, bonos, horas extras o cualquier otra compensación adicional, excepto como se indica en la póliza grupal)

Marque una opción:

☐ Soy un empleado nuevo inscribiéndome en mi primera oportunidad.

☐ Soy un empleado recontratado. Fecha de recontratación: _____ _____ _____

☐ Soy un empleado vigente inscribiéndome debido a: Fecha del caso (del suceso que está marcado a continuación) _____ _____ _____

☐ Temporal a permanente ☐ Otro (explique)_____

Me estoy inscribiendo en:

Seguro de vida básico y muerte accidental y pérdida de extremidades (AD&D, en inglés)	Seguro de vida para derechohabientes	Seguro por discapacidad de corto plazo	Seguro por discapacidad de largo plazo
☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

¿Está casado? ☐ Sí ☐ No Fecha de matrimonio _____ _____ _____

¿Tiene hijos derechohabientes solteros menores de 23 años de edad? ☐ Sí ☐ No

Sección 2a: Su beneficiario principal

El **beneficiario principal recibe el beneficio al momento de su muerte**. Si nombra dos o más personas como beneficiarios principales, los procedimientos se pagaran en partes iguales a menos que se especifique de otra manera. Si necesita más espacio, agregue una hoja por separado con la información completa, que esté **firmada y fechada por usted.**

_____ ____ _____ ____
Primer nombre | ISN | Apellido | Sufijo

_____ _____
Relación con el solicitante | Fecha de nacimiento o edad

_____ ____ _____ ____
Primer nombre | ISN | Apellido | Sufijo

_____ _____
Relación con el solicitante | Fecha de nacimiento o edad

Debe firmar y fechar en la página 2

Para uso exclusivo de la oficina: Group #_____ Subgroup #_____ Class _____

☐ STD ☐ LTD Subscriber #_____

AICK 7es – Beneficiary Designation Form (Spanish)

Formulario de designación de beneficiario

Por favor, guarde una copia para el asegurado.

ADVANCE Insurance Company of Kansas SM
advanceinsurance.com

Empleador | Número de grupo de AICK | Clase

Sección 1 – Información del asegurado (siempre complete esta sección)

Primer nombre | Inicial del segundo nombre | Número de Seguro Social

Apellido | Sufijo

Sección 2A – Designación del beneficiario principal

Esta designación de beneficiario aplicará a todos los beneficios de Advance Insurance Company of Kansas (AICK). De no ser así, usted debe indicar los beneficios a los que aplica el cambio:

- ☐ Seguro de vida a término básico y por muerte accidental y desmembramiento (AD&D, por sus siglas en inglés)
- ☐ Seguro de vida a término voluntario (y AD&D, si aplica)
- ☐ Seguro voluntario de accidentes para el empleado/seguro familiar de accidentes

Información del beneficiario principal (quien recibe el beneficio después de la muerte del asegurado): Los beneficios se pagarán en partes iguales a las personas que aparecen abajo, a menos que usted lo indique de otra manera. Si necesita más espacio, adjunte una hoja separada con la información completa. Usted debe firmar y poner fecha a la hoja separada.

Primer nombre | Inicial del segundo nombre | Relación con el solicitante

Apellido | Sufijo | Fecha de nacimiento | o | edad

Primer nombre | Inicial del segundo nombre | Relación con el solicitante

Apellido | Sufijo | Fecha de nacimiento | o | edad

Sección 2B – Designación de beneficiario contingente (usted debe completar la Sección 2A si llena esta sección)

Información del beneficiario contingente [quien recibe el beneficio solo si el (los) beneficiario(s) en la Sección 2A muere(n)]: Si se enumera abajo a más de un beneficiario contingente, los beneficios se pagarán en partes iguales, a menos que usted indique lo contrario. Si necesita más espacio, adjunte una hoja separada con la información completa. Usted debe firmar y poner fecha a la hoja separada.

Primer nombre | Inicial del segundo nombre | Relación con el solicitante

Apellido | Sufijo | Fecha de nacimiento | o | edad

Primer nombre | Inicial del segundo nombre | Relación con el solicitante

Apellido | Sufijo | Fecha de nacimiento | o | edad

Sección 3 – Autorización (requiere firma y fecha)

Se requiere su firma

Firma del empleado asegurado | Fecha de la firma

Envíe el formulario completado al correo electrónico: csc-advance@advanceinsurance.com o por fax al 785-290-0727.

AICK 7es 09/18

An independent licensee of the Blue Cross Blue Shield Association.

AICK 12es – Notice of Conversion Form (Spanish)

Aviso de privilegio de conversión

ADVANCE Insurance Company of Kansas℠

Esto no es un formulario de solicitud; es únicamente un pedido de información.
Enviar este formulario no es una obligación para continuar la cobertura.

Identificación del suscriptor

Número del grupo

Nombre del empleador (el titular de la póliza grupal)

Lea este aviso.

Este programa de seguro de vida grupal bajo el cual usted (y sus derechohabientes asegurados, si aplica) han sido asegurados, incluye un importante privilegio de conversión. El privilegio de conversión le da el derecho a usted (y a sus derechohabientes asegurados, si aplica) de solicitar y comprar una póliza de seguro de vida entera sin evidencia de asegurabilidad cuando:

1) su empleo activo termina;
2) el monto del seguro de vida grupal disminuye debido a un cambio en la clasificación;
3) el monto del seguro de vida grupal se reduce o termina debido a la edad; o
4) el número de horas de trabajo semanal cae por debajo del mínimo requerido para ser elegible para el plan de seguro de vida de su grupo.

siempre y cuando haga la solicitud y el pago de la primera prima dentro de los 31 días posteriores a la fecha de finalización del seguro de vida grupal.

Para recibir la información sobre la solicitud y la prima, debe completar la siguiente información y enviarla a Advance Insurance Company of Kansas (AICK). La prima de su póliza de seguro de vida entera se basa en su edad más próxima a la fecha de emisión de la póliza.

Sección 1 – Información del asegurado

Primer nombre

Inicial del segundo nombre

Género ☐ Masculino ☐ Femenino

Fecha de nacimiento

Apellido

Sufijo

Número de Seguro Social

Dirección de correo postal

Número de teléfono de la casa

Número de teléfono móvil

Ciudad

Número de teléfono del trabajo

Estado

Código postal

+4

Sección 2 – Cobertura de conversión

Monto del seguro de vida al momento de la terminación:

$

El monto del seguro de vida que se va a convertir no puede ser mayor al monto al que usted tenía derecho bajo el plan del seguro de vida grupal, pero puede ser por una cantidad menor (en incrementos de $1,000) que usted elija.

Motivo de la terminación: ☐ Discapacidad* ☐ Jubilación ☐ Otro

¿En qué fecha se presentó usted físicamente por última vez en el lugar usual de trabajo y realizó todas sus actividades laborales normales? Y ¿cuál es la fecha oficial de terminación?

Fecha en la que asistió al trabajo por última vez

Fecha de terminación

* Si la terminación de la cobertura del seguro de vida grupal se debió a discapacidad, es posible que quiera preguntar sobre el beneficio de exención de la prima. Llame a nuestra oficina para recibir más información.

Sección 3 – Autorización

Se requiere su firma

Firma del asegurado

Fecha de la firma

Nombre escrito en letra de molde

Advance Insurance Company of Kansas – 1133 SW Topeka Blvd. • Topeka, KS 66629-0001 • Teléfono: (800) 530-5989 • Fax (785) 290-0727

AICK 12es 04/17

AICK Waiver ES – Waiver Form (Spanish)

Renuncia a la inscripción

Renuncia al seguro grupal de vida o por discapacidad

ADVANCE Insurance Company of Kansas SM

Debe presentar una copia de esta Renuncia de inscripción completada a Advance Insurance Company of Kansas (AICK).
1133 SW Topeka Blvd., Topeka, KS 66629-0001 • Fax: (785) 290-0727 • Línea gratuita: (800) 530-5989

Sección 1 – Aviso importante

Ya sea que participe o no en el plan de seguro médico de su empleador, esto no afecta su derecho a participar en los beneficios grupales del seguro vida o por discapacidad, siempre y cuando el trabajo que lleve a cabo esté incluido en una clase cubierta de empleados, usted cumpla con el período de espera requerido por la compañía y continúe trabajando activamente el número de horas requeridas cada semana por el plan de seguro grupal de vida o por discapacidad.

Sección 2 – Información del empleado

Primer nombre _____ Inicial del segundo nombre _____

Apellido _____ Sufijo _____

Dirección postal (si es diferente a la dirección de residencia) _____

Ciudad _____

Estado _____ Código postal _____ +4 _____

_____-_____-_____ Número de Seguro Social

_____ / _____ / _____ Fecha de nacimiento

Nombre del empleador _____

_____ / _____ / _____ Fecha de contratación del empleado

Sección 3 – Renuncia de la cobertura de seguro

Se me ha ofrecido el seguro grupal y estoy renunciando a mi derecho a participar en las coberturas señaladas a continuación:

Seguro de vida:

☐ Seguro de vida a término básico, y muerte accidental y desmembramiento (AD&D, en inglés)

☐ Seguro de vida a término fijo voluntario (y AD&D, si aplica)

Explique el motivo _____

☐ Seguro de vida para dependientes

Explique el motivo _____

Seguro por discapacidad:

☐ Discapacidad a corto plazo

☐ Discapacidad a largo plazo

Explique el motivo _____

Sección 4 – Autorización

Comprendo que al renunciar al seguro de vida y/o discapacidad para mí (y mis derechohabientes si mi empleador ofrece seguro de vida para dependientes), estoy renunciando al derecho de cobertura sin estar médicamente asegurado. Si decido inscribirme después, seré responsable de pagar cualquier gasto necesario para determinar mi asegurabilidad (o la de mis derechohabientes) incluyendo, pero sin limitarse a los gastos para obtener registros o exámenes médicos. AICK determinará si yo (o mis derechohabientes) puedo recibir cobertura, y reconocerá si yo (o mis derechohabientes) puedo estar en riesgo de no obtener la cobertura.

Se requiere su firma _____ Empleado

_____ / _____ / _____ Fecha de la firma

Se requiere la firma del grupo _____ Persona autorizada a firmar por el empleador

AICK Waiver ES 10/19

An independent licensee of the Blue Cross Blue Shield Association.

AICK 25Aes – Automatic Payment Autorization Form (Spanish)

Autorización de pago automático

ADVANCE Insurance Company of Kansas

Sección 1 – Información del pago

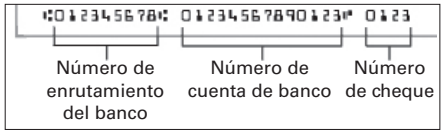
Nombre del asegurado/compañía

Número de identificación

Dirección

Ciudad

Estado Código postal +4



Por favor deducir de: ☐ Cuenta corriente ☐ Cuenta de ahorro

Elija su opción de pago: ☐ Mensual ☐ Trimestral

Nombre de la institución financiera

Dirección de la institución financiera

Ciudad

Estado Código postal +4

(_____) _____-_____
Número de teléfono de la institución financiera

Número de enrutamiento/tránsito

Número de cuenta

Devuelva esta autorización a: Advance Insurance Company of Kansas
1133 SW Topeka Blvd.
Topeka, KS 66629-0001

Importante: Por favor, envíe un cheque anulado con este formulario para garantizar el procesamiento preciso.

Por este medio autorizo a Advance Insurance Company of Kansas para que cargue a mi cuenta el modo de pago solicitado de la(s) prima(s). En caso de que se desestime una entrada de giro por cualquier razón, o se extraiga después de que se haya revocado la autorización del depositante, Advance Insurance Company of Kansas acepta que mi institución financiera será exonerada de cualquier responsabilidad.

Se requiere su firma

Firma del solicitante

_____/_____/_____
Fecha de la firma

AICK 170es – Application for Portability Form (Spanish)

Solicitud de portabilidad

ADVANCE Insurance Company of Kansas℠

Debe presentar la solicitud de portabilidad y enviar la primera prima a Advance Insurance Company of Kansas (AICK) dentro de los treinta y un días siguientes a la fecha de terminación del seguro de vida grupal anterior del asegurado según lo indica la póliza grupal.

De acuerdo con y sujeto a todos los términos y condiciones de la póliza grupal mencionada, la persona en la Sección 1 hace la solicitud para continuar con su seguro, conforme a los términos de la estipulación de portabilidad de la póliza grupal. Dicha póliza debe continuar de acuerdo con las siguientes solicitudes y declaraciones de hecho:

Sección 1 – Información del asegurado

Nombre del empleador (titular de la póliza grupal)

Primer nombre | Inicial del segundo nombre | Género ☐ Masculino ☐ Femenino | Fecha de nacimiento (_____/_____/_____)

Apellido | Sufijo | Número de Seguro Social (_____-_____-_____)

Dirección a la que se deben enviar los avisos sobre las primas | Número de teléfono de la casa (_____) _____-_____ | Número de teléfono móvil (_____) _____-_____

Ciudad | Número de teléfono del trabajo (_____) _____-_____

Estado | Código postal | +4 | Fecha de terminación del empleo (_____/_____/_____)

Si su empleo termina porque está discapacitado, usted no es elegible para la portabilidad.

Sección 2 – Cobertura de la portabilidad

La cobertura continúa para:

☐ Mí mismo (el empleado)	☐ Vida	☐ Vida/AD&D	Monto: $ _____
☐ Mi cónyuge*	☐ Vida	☐ Vida/AD&D	Monto: $ _____
☐ Mi hijo(s) derechohabiente(s)*	☐ Vida	☐ Vida/AD&D	Monto: $ _____

* La cobertura para el cónyuge o hijos derechohabientes solo se puede transferir si usted (el empleado) también hace una solicitud de portabilidad para su cobertura. De otro modo, ellos tendrán que solicitar la continuación de la cobertura bajo el privilegio de conversión.

Si desea que las primas se deduzcan automáticamente, complete el formulario AICK 25A de autorización de pago automático, el cual está disponible en nuestro sitio web: www.advanceinsurance.com

Sección 3 – Información del beneficiario

Si la designación del beneficiario que se muestra abajo es diferente de la designación de la póliza grupal, se considerará un aviso escrito de cambio de beneficiario bajo la póliza grupal con entrada en vigor en la fecha de ejecución de esta solicitud.

Si necesita más espacio, adjunte una hoja separada con la información completa que **haya firmado y con fecha.**

Primer nombre | Inicial del segundo nombre | Relación con el solicitante | Fecha de nacimiento (_____/_____/_____)

Apellido | Sufijo

Sección 4 – Autorización

Se requiere su firma

Firma del asegurado | Fecha de la firma (_____/_____/_____)

Nombre escrito en letra de molde

Advance Insurance Company of Kansas – 1133 SW Topeka Blvd. • Topeka, KS 66629-0001 • Teléfono: (800) 530-5989 • Fax (785) 290-0727

AICK 170es 01/21

An independent licensee of the Blue Cross Blue Shield Association.

Notes

Visit us at bcbsks.com

BlueCross BlueShield Kansas

1133 SW Topeka Blvd, Topeka, KS 66629

MC170A 04/24