Employee Enrollment Form

for Voluntary Coverage

ADVANCE Insurance Company of Kansas SM

☐ Voluntary Short Term Disability – complete sections 1 and 7 (if a late enrollee, also complete sections 5 and 6)

☐ Voluntary Term Life – complete sections 1, 2, 4, 5, 6 and 7

☐ Voluntary Accidental Death & Dismemberment – complete sections 1, 2, 3 and 7

☐ Voluntary Long Term Disability – complete sections 1 and 7 (if a late enrollee, also complete sections 5 and 6)

Section 1 – Employee Information (always complete this section and sign and date Section 7) CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

_____ / _____ / _____
Date of Birth

_____-_____-_____
Social Security Number

Height _____ Weight _____

Physician Name _____

Physician Address _____

City _____

State _____ ZIP Code _____ +4 _____

Employed by _____

Occupation/Job Title _____

(_____) _____-_____
Work Phone Number

_____ / _____ / _____
Date of Hire

$_____
Hourly Wage

Hours Worked Weekly _____

Reason for change in employment:

☐ Part-time to full-time

☐ Temporary to permanent

☐ Rehire/recall

☐ Other (specify) _____

_____ / _____ / _____
Date of Employment Change

Are you actively at work performing all of your job duties? ☐ Yes ☐ No

Section 2 – 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 First Name _____ MI _____

Primary Beneficiary Last Name _____ Suffix _____

Primary Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____

_____ / _____ / _____
Date of Birth

Primary Beneficiary First Name _____ MI _____

Primary Beneficiary Last Name _____ Suffix _____

Primary Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____

_____ / _____ / _____
Date of Birth

Please continue on the next page.

Section 2 – The Employee's Beneficiary (continued)

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

Contingent Beneficiary First Name _____ MI _____

Contingent Beneficiary Last Name _____ Suffix _____

Contingent Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____ Date of Birth ____/____/____

Contingent Beneficiary First Name _____ MI _____

Contingent Beneficiary Last Name _____ Suffix _____

Contingent Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____ Date of Birth ____/____/____

Section 3 – Voluntary Accidental Death & Dismemberment

$_____ Amount of Principal Sum

$_____ Monthly Premium

☐ Employee Plan ☐ Family Plan

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

Section 4 – Voluntary Term Life

If enrolling, you and your spouse must complete the appropriate sections, answer the medical question in Sections 5 and 6, then sign and date Section 7.

Employee or Spouse: Minimum coverage 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 Voluntary Term Life coverage being requested?

$_____ Employee Coverage

$_____ Spouse Coverage

Dependent Child: With approval of at least $10,000 of coverage for you and your spouse, this coverage may be requested. All eligible unmarried dependent children from the age of six months to 23 years of age will receive the benefit amount selected below; and from the age of 15 days to six months will receive 10% of the selected benefit. Select only one amount for all children in the family.

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

Please continue on the next page.

Section 4 – Voluntary Term Life (continued)

If requesting spouse coverage, this section must be completed along with Sections 5 and 6, and your spouse must sign and date in Section 7.

Spouse First Name _____ MI _____

Spouse Last Name _____ Suffix _____

Gender ☐ Male ☐ Female

Date of Birth _____ / _____ / _____

Social Security Number _____ - _____ - _____

Height _____ Weight _____

Spouse Employer _____

Spouse Physician Name _____

Spouse Physician Address _____

City _____

State _____ ZIP Code _____ +4 _____

The **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 information.

Primary Beneficiary First Name _____ MI _____

Primary Beneficiary Last Name _____ Suffix _____

Primary Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____ Date of Birth _____ / _____ / _____

Primary Beneficiary First Name _____ MI _____

Primary Beneficiary Last Name _____ Suffix _____

Primary Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____ Date of Birth _____ / _____ / _____

The **spouse's contingent beneficiary** will receive the death benefit only if their primary beneficiary is deceased.

Contingent Beneficiary First Name _____ MI _____

Contingent Beneficiary Last Name _____ Suffix _____

Contingent Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____ Date of Birth _____ / _____ / _____

Contingent Beneficiary First Name _____ MI _____

Contingent Beneficiary Last Name _____ Suffix _____

Contingent Beneficiary Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Relationship _____ Date of Birth _____ / _____ / _____

Please continue on the next page.

Section 4 – Voluntary Term Life (continued)

If requesting dependent child coverage, this section must be completed (if the child is a late enrollee, you must also complete Sections 5 and 6). Any dependent child 18 years of age or older must sign and date in Section 7.

Child(ren) Physician Name

Child(ren) Physician Address

City

State ZIP Code +4

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 Voluntary Term Life coverage.

Child First Name MI

Child Last Name Suffix

Relation to Employee

Gender ☐ Male ☐ Female ____ /____ /_____
Date of Birth

Height Weight

Child First Name MI

Child Last Name Suffix

Relation to Employee

Gender ☐ Male ☐ Female ____ /____ /_____
Date of Birth

Height Weight

Child First Name MI

Child Last Name Suffix

Relation to Employee

Gender ☐ Male ☐ Female ____ /____ /_____
Date of Birth

Height Weight

Child First Name MI

Child Last Name Suffix

Relation to Employee

Gender ☐ Male ☐ Female ____ /____ /_____
Date of Birth

Height Weight

Please continue on the next page.

Section 5 – Medical History

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

Has anyone been diagnosed, treated for, receiving treatment or had any of the following conditions?
Provide details to "Yes" responses in the Section 6.

	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, provide 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 (Acquire 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 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 name of condition, name of 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

Please continue on the next page.

Section 6 – Medical Details

For any "Yes" responses to the questions in the Section 5, 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 complete details.

Question No. ______ Enrollee's Name ______________________ Name of Treating Physician / Provider ______________________

Nature of Condition ______________________ Physician / Provider's Address ______________________

Medication Prescribed (Name, Dosage and Frequency) ______________________ City ______________________

Date Diagnosed ____ / ____ / ______ Date Last Seen for Condition ____ / ____ / ______ State ______ ZIP Code ________ +4 ______

Degree of Recovery ______________________

Question No. ______ Enrollee's Name ______________________ Name of Treating Physician / Provider ______________________

Nature of Condition ______________________ Physician / Provider's Address ______________________

Medication Prescribed (Name, Dosage and Frequency) ______________________ City ______________________

Date Diagnosed ____ / ____ / ______ Date Last Seen for Condition ____ / ____ / ______ State ______ ZIP Code ________ +4 ______

Degree of Recovery ______________________

Question No. ______ Enrollee's Name ______________________ Name of Treating Physician / Provider ______________________

Nature of Condition ______________________ Physician / Provider's Address ______________________

Medication Prescribed (Name, Dosage and Frequency) ______________________ City ______________________

Date Diagnosed ____ / ____ / ______ Date Last Seen for Condition ____ / ____ / ______ State ______ ZIP Code ________ +4 ______

Degree of Recovery ______________________

Question No. ______ Enrollee's Name ______________________ Name of Treating Physician / Provider ______________________

Nature of Condition ______________________ Physician / Provider's Address ______________________

Medication Prescribed (Name, Dosage and Frequency) ______________________ City ______________________

Date Diagnosed ____ / ____ / ______ Date Last Seen for Condition ____ / ____ / ______ State ______ ZIP Code ________ +4 ______

Degree of Recovery ______________________

Please continue on the next page.

Section 7 – 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 5 has been fully disclosed in Section 6.

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 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.

Your signature required

Employee Signature	Date Signed
Employee Printed Name	Date of Birtth
Spouse Signature	Date Signed
Spouse Printed Name	Date of Birtth
Dependent Child (Over 18) Signature	Date Signed
Dependent Child (Over 18) Printed Name	Date of Birtth
Dependent Child (Over 18) Signature	Date Signed
Dependent Child (Over 18) Printed Name	Date of Birtth