Employee Enrollment Form

FOR VOLUNTARY COVERAGE

ADVANCE Insurance Company of Kansas
An Independent Licensee of the Blue Cross and Blue Shield Association
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CLEAR DATA

☐ **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

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 ______________________________ Social Security No. ___ ___ ___ ___ ___ ___ ___ ___ ___
Last First MI

Date of Birth __ __ __ __ __ __ __ __ Height ____ft. ____in. Weight ________lbs. Gender: ☐ Male ☐ Female
M M D D Y Y Y Y

Spouse's Employer: ______________________________

Spouse's Physician's Name: ______________________________

Spouse's Physician's Complete Address: ______________________________
Street or PO Box

____
City, State 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 ______________________________ Relationship to employee ______________
Last First MI

Date of Birth __ __ __ __ __ __ __ __ Height ____ft. ____in. Weight ________lbs. Gender: ☐ Male ☐ Female
M M D D Y Y Y Y

Child's Full Name ______________________________ Relationship to employee ______________
Last First MI

Date of Birth __ __ __ __ __ __ __ __ Height ____ft. ____in. Weight ________lbs. Gender: ☐ Male ☐ Female
M M D D Y Y Y Y

Child's Full Name ______________________________ Relationship to employee ______________
Last First MI

Date of Birth __ __ __ __ __ __ __ __ Height ____ft. ____in. Weight ________lbs. Gender: ☐ Male ☐ Female
M M D D Y Y Y Y

Child's Full Name ______________________________ Relationship to employee ______________
Last First MI

Date of Birth __ __ __ __ __ __ __ __ Height ____ft. ____in. Weight ________lbs. Gender: ☐ Male ☐ Female
M M D D Y Y Y Y

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

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 _____