



GROUP INSURANCE ENROLLMENT APPLICATION (2-50 Employees)

TYPE OF APPLICATION

- Types of applications: New Group, Addition to Account #, Adding Dependent Coverage - Account #, Other

EMPLOYEE OPTIONS

- Supplemental Life Amount (Not including base amount) \$
If waiving all coverage, please complete sections I and III and submit only page one of the application.

Please Print All Information Clearly in blue or black ink.

Section I. Employee Information

Form fields for employee information including: LAST NAME, FIRST NAME, M.I., GENDER, COMPANY NAME, SOCIAL SECURITY NUMBER, DATE OF BIRTH, HT, WT, BUSINESS PHONE, STREET ADDRESS, HOME PHONE NUMBER, OCCUPATION/JOB TITLE, CITY, STATE, ZIP CODE, HOURS WORKED PER WEEK, FULL-TIME DATE OF (RE)HIRE, EMAIL ADDRESS, MARITAL STATUS, EMPLOYEE STATUS, ARE YOU CURRENTLY WORKING FULL-TIME?, \*GROUP TERM LIFE INSURANCE BENEFICIARY, SOC SEC NUMBER, RELATIONSHIP, \*IF UNDER AGE 18, NAME OF BENEFICIARY'S GUARDIAN.

Section II. Dependent Information (if applying for insurance)

Table with columns: FIRST NAME, MI (LAST NAME IF DIFFERENT), RELATIONSHIP, DATE OF BIRTH, SOCIAL SECURITY NUMBER, RESIDES WITH EMPLOYEE? Y/N\*\*, GENDER M or F, HT, WT. Rows for Spouse and 1-4 children.

\* If a different relationship exists for a dependent, please indicate.

\*\*If no, provide name and telephone number of custodial parent:

Are any of the dependents listed above age 19-23 (varies by state) enrolled as a full-time student (12 credit hours) in an accredited college or university and primarily dependent upon the applicant for support? (If "Yes", provide name[s] of child[ren] and names[s] and address[es] of school[s]):

Section III. Waiver of Coverage

Although I am eligible to apply for coverage for myself and my dependent(s), if applicable, I do NOT WANT and, therefore, waive coverage for (check all that apply):

- Health insurance coverage only; or all insurance for me
All insurance coverage for: my spouse; my children; all my dependents; my dependent(s) named:

Coverage is being waived because (check below):

- Spousal Coverage
Covered by Medicare/Medicaid/or similar government funded program
Covered through a "state sponsored, high risk pool"
Covered under continuation (e.g., COBRA through another insurance carrier - Date of termination: )
Other - explain:

I hereby certify that: (i) I and/or my dependents have been given the opportunity to participate in the group insurance plan provided through my employer, and I was not induced or pressured by my employer, the agent or CRL into declining coverage, but elected on my own accord to decline such coverage; (ii) the benefits of this plan have been thoroughly explained to me; (iii) I and/or my dependents decline to participate; and (iv) if I and/or my dependent(s) apply for insurance at a later date, we may be considered late enrollees and, as such, may be subject to postponement or an exclusion of coverage for a Preexisting Illness for a period of up to 18 months.

I understand that if I am declining enrollment for me and/or my dependents because of other health insurance or group health plan coverage and notify CRL in writing at the time of such declination that other coverage is the reason for declining CRL's coverage, I may, in the future, be able to enroll myself and/or my dependents in this plan without being considered late enrollees, if I and/or my dependents lose eligibility for that other coverage (or my employer stops contributing toward my and/or my dependents' other coverage). For such timely enrollment, CRL must receive in its Home Office my application for coverage within 31 days after losing my and/or my dependents' other coverage (or after my employer stops contributing towards the other coverage). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and/or my dependents without being considered late enrollees, provided that my application for coverage is received in CRL's Home Office within 31 days after the marriage, birth, adoption, or placement for adoption. Failure to notify CRL in the aforementioned manner will result in me and/or my dependents being treated as late enrollees and subject to the Preexisting Illness postponement or exclusion shown above, should coverage through CRL be desired at a later date. (To request special enrollment or to obtain more information, contact a Customer Service Representative at the address or telephone number shown on the first page of this application.)

Signature of Applicant

Date

### Section IV. Other Coverage

- Will this plan be replacing your employer's prior/current group medical plan or any other medical coverage?  Yes  No  
 If "Yes", please submit copies upon receipt of your Certification of Creditable Coverage for any person proposed for coverage.  
 What date did/will this health coverage terminate? \_\_\_\_\_  
 Is any person proposed for coverage covered by Medicare?  Yes  No  
 If "Yes", provide reason:  Over 65;  Disabled;  Kidney Disease;  Other \_\_\_\_\_; Part  A;  B  
 Does any person proposed for coverage have any condition which involves Workers' Compensation?  Yes  No  
 If "Yes", provide the proposed insured's name, condition, and medications taken: \_\_\_\_\_

### Section V. Health Questionnaire For Groups Enrolling 2 – 50 Employees for Health Coverage

**Please note, any incomplete, incorrect or misleading answers may cause the insurance provided to be voided as stated in CRL's Right to Cancel or Rescind Policy Provisions. (Attach a separate sheet if additional space is needed. Employee must sign and date any additional sheets.)**

**A. Has any person proposed for coverage:**

1. used tobacco in any form within the last 12 months?  Yes  No  
 If "Yes", indicate name, type of tobacco, duration of use, amount per day, and date of last use: \_\_\_\_\_
2. ever been diagnosed as having, had any treatment or counseling for alcohol, chemical or drug abuse or addiction or been advised by a doctor to discontinue or decrease alcohol consumption?  Yes  No  
 If "Yes", indicate name, substance, treatment, amount, date of last use: \_\_\_\_\_
3. ever been diagnosed as having or been examined or treated in any way for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or ever tested positive for Human Immunodeficiency Virus (HIV)?  Yes  No  
 If "Yes", indicate name: \_\_\_\_\_
4. been advised, or is contemplating to have an operation, treatment, or testing which has not yet been performed?  Yes  No  
 If "Yes", explain \_\_\_\_\_

### Section VI. Health Questionnaire For Groups Enrolling 2 – 14 Employees for Health Coverage

**A. In the past 10 years, has any person proposed for coverage had any signs, symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for (Check all that apply and circle condition):**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abnormal test results<br><input type="checkbox"/> Alzheimer's Disease/dementia<br><input type="checkbox"/> Angina/chest pain<br><input type="checkbox"/> Arthritis: Type: _____<br><input type="checkbox"/> Asthma/bronchitis/emphysema/COPD/cystic fibrosis/tuberculosis/lung or respiratory disorders<br><input type="checkbox"/> Back/spine/muscle disorders<br><input type="checkbox"/> Bladder/urinary/prostate disorders<br><input type="checkbox"/> Blood clots/hemophilia/phlebitis/blood disorders<br><input type="checkbox"/> Breast Disorder/Fibrocystic Breast Disease<br><input type="checkbox"/> Cancer/malignancy/leukemia<br><input type="checkbox"/> Circulatory disorders<br><input type="checkbox"/> Colitis/spastic colon/colon polyps<br><input type="checkbox"/> Complications of pregnancy/miscarriage/infertility testing or treatment/currently pregnant (include due date: _____)<br><input type="checkbox"/> Congenital disorders/cleft palate<br><input type="checkbox"/> Diabetes (include name of person with condition, most recent Hemoglobin A1c level, and date taken): _____<br>_____<br>_____ | <input type="checkbox"/> Eating disorders/anorexia/bulimia/obesity<br><input type="checkbox"/> Epilepsy/seizure disorders<br><input type="checkbox"/> Eye disorders (excluding eyeglasses or contacts)<br><input type="checkbox"/> Gastritis/esophageal reflux/ulcer/digestive disorders<br><input type="checkbox"/> Growth/pituitary disorders<br><input type="checkbox"/> Heart or valve disorders/murmur/heart attack/abnormal or irregular heart beat/congestive heart failure/coronary artery disease<br><input type="checkbox"/> Hepatitis __ A __ B __ C __ Other/liver disorders<br><input type="checkbox"/> High blood pressure/hypertension (include name of person with condition, most recent reading, and date taken): _____<br>_____<br><input type="checkbox"/> High cholesterol/triglycerides (include name of person with condition, last reading, and date taken): _____<br>_____<br><input type="checkbox"/> Joint disorders<br><input type="checkbox"/> Kidney stones/disorders | <input type="checkbox"/> Lupus __ systemic __ discoid/connective tissue disorders<br><input type="checkbox"/> Mental, nervous, emotional disorders/anxiety/depression/attention deficit disorder/suicidal attempts<br><input type="checkbox"/> Mental retardation/Down's Syndrome<br><input type="checkbox"/> Migraines/headaches<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Muscular Dystrophy/Cerebral Palsy<br><input type="checkbox"/> Neurological disorders<br><input type="checkbox"/> Pancreatitis/pancreatic disorders<br><input type="checkbox"/> Paralysis<br><input type="checkbox"/> Parkinson's Disease<br><input type="checkbox"/> Reproductive organ disorders/endometriosis/abnormal Pap smears<br><input type="checkbox"/> Sleep apnea/disorders<br><input type="checkbox"/> Stroke/transient ischemic attack (TIA)<br><input type="checkbox"/> Tumors/cysts/polyps/growths<br><input type="checkbox"/> Transplant: Type: _____<br><input type="checkbox"/> Recommended <input type="checkbox"/> Pending<br><input type="checkbox"/> Completed<br><input type="checkbox"/> Ulcerative Colitis/ Crohn's Disease/Regional Ileitis/intestinal disorders |
|--|---|--|

**B. Within the past 5 years, has any person proposed for coverage been examined or treated by a physician, psychotherapist, counselor, or other medical professional or taken any prescription drugs for any illness or condition not already noted (exclude colds, flu and routine exams not related to a medical condition)?** If "Yes", explain below.  Yes  No

**C. Within the past 5 years, has any proposed insured been to the Emergency Room, been hospitalized or operated on ?** If "Yes", explain below.  Yes  No

**D. Give complete details to questions A through C. (Attach a separate sheet if additional space is needed. Employee must sign and date any additional sheets.)**

Question	Name of Individual	Diagnosis/ Onset	Treatment/ Date of Last Occurrence	Medication/ Frequency & Dosage	Date(s) of Treatment	Prognosis/Future Treatment Anticipated/ Degree of Recovery	Doctor's Name and Address

**Section VII. Health Questionnaire for Groups Enrolling 15 – 50 Employees for Health Coverage**

- A. In the past 24 months, has any person proposed for coverage:
1. been confined in a hospital, emergency room or other medical facility OR had medical expenses of \$5,000 or more in any one year?  Yes  No
  2. taken any prescribed medication and/or is currently taking any prescribed medication?  Yes  No
  3. been seen or treated by any health care provider, including follow-up treatment or ongoing medical care, any consultation, treatment, therapy, medication, advice or undergone any testing? (Exclude colds, flu and routine exams not related to a medical condition.)  Yes  No
- B. Within the past 5 years, has any person proposed for coverage had any symptoms, testing, diagnosis, treatment, taken medications or had routine follow-up for any of the following: Cancer/Tumor, Diabetes, Cardiovascular Disease or Heart Disorder, Blood Disorder, Circulatory Disorder, Hodgkin's/Non-Hodgkin's Lymphoma/Leukemia, Kidney Disorder, Liver Disorder, Neurological Disease, Respiratory/Lung Disorder, Stroke, Transplants (recommended, pending or completed), Growth Disorder, Congenital Disorder, Muscular/Systemic Disorder (to include but not limited to Lupus and Multiple Sclerosis), Stomach/Intestinal Disorder or Mental or Emotional Disorder?  Yes  No
- C. Are you or your dependent spouse or children, whether or not applying for coverage currently pregnant, an expectant father, in the process of adopting a child, or have been consulted for or undergone infertility treatment?  Yes  No
- If "Yes" to A, B or C, explain below.

**D. Give complete details to questions A through C. (Attach a separate sheet if additional space is needed. Employee must sign and date any additional sheets.)**

Question	Name of Individual	Diagnosis/ Onset	Treatment	Medication/ Frequency & Dosage	Date(s) of Treatment	Prognosis/Future Treatment Anticipated/ Degree of Recovery	Doctor's Name and Address

**Section VIII. Important Information – Please Read Carefully Before Signing Application**

I represent that all answers given in this application are accurate, complete and true. I understand Central Reserve Life Insurance Company (CRL) is relying on my answers in deciding whether to approve this application and that the requested health information must be fully and completely disclosed on this application. I understand the agent has no authority to alter or waive this, or any other, condition of coverage.

I have not disclosed to the agent any health information which is not disclosed on this application. I understand that this application, if accepted, shall become a part of the policy(ies) and any incomplete, incorrect or misleading answers may operate to void any insurance provided to me and my dependents, as stated in CRL's Right to Cancel or Rescind Policy Provision.

I understand that limitations exist on coverage of Preexisting Illnesses.

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within no more than a six-month 'look-back' period. Generally, this look-back period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the look-back period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior 'creditable coverage.' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of 63 days or more (90 days in Nevada). To reduce the maximum 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the preexisting condition exclusion and creditable coverage should be directed to a Customer Service Representative at the address or telephone number shown on the first page of this application.

I understand no insurance exists unless and until my employer or I receive notification of approval in writing from CRL's Home Office indicating coverage for me and my dependents and the effective date. If at any time prior to such notification, anyone applying for coverage (including myself, spouse, and dependents), is hospitalized, or has any change in health from what is stated in the application, I agree to inform CRL's Home Office immediately.

I understand that the agent does not have the authority to vary or waive any of the provisions of this application, nor any of the provisions, terms or conditions of any other forms or materials supplied by CRL nor to bind CRL to any promise of coverage.

I, the undersigned, understand that CRL may confirm the information on my application for insurance with a verification telephone call. It is my understanding that this verification call takes approximately ten (10) minutes and is a routine process for those applying for coverage with CRL and

that this telephone call will be tape recorded. I understand that I must tell CRL if my health condition or if the health condition of any of my dependents, as stated on the application, changes between the date this application is signed and the date I receive written notification of approval, providing coverage is approved, from CRL's Home Office.

I or my spouse (if applicable) may be contacted at the telephone numbers listed below. [If you cannot be contacted, please call Central Reserve Life at 1-800-253-4651.]

<input type="checkbox"/> Employee ( ) _____ Telephone No	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon Preferred time to call: _____ <input type="checkbox"/> Evening	<input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other
<input type="checkbox"/> Spouse ( ) _____ Telephone No	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon Preferred time to call: _____ <input type="checkbox"/> Evening	<input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other

### Section IX. Application Authorization

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, the Medical Information Bureau (MIB) or other consumer reporting agency, employer, or, except in AZ, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to CRL, or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. CRL may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. However, CRL shall not disclose to an agent information received from MIB. CRL reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask CRL to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed to determine eligibility for insurance. For determination of benefits, the authorization shall be valid for either the term of coverage of the policy for health insurance products or for the duration of the claim for all other insurance products. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

**NOTICE: For New Mexico residents only: We are required by New Mexico law to inform you of the following: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."**

**NOTICE: For Ohio residents only: We are required by Ohio law to inform you of the following: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."**

**NOTICE: For Tennessee residents only: We are required by Tennessee law to inform you of the following: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."**

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

Employee's Printed Name \_\_\_\_\_

Signature of Spouse (Signature of spouse is not required; however, spouse cannot telephone verify application unless signature is provided) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Authorized Representative, if applicable (i.e., Power of Attorney) \_\_\_\_\_ Relationship/ Authority to Represent \_\_\_\_\_ Date \_\_\_\_\_

Authorized Representative's Address \_\_\_\_\_ Authorized Representative's Phone Number \_\_\_\_\_

**THE EMPLOYEE MUST SIGN ABOVE IN INK IN ORDER FOR ANY COVERAGE TO BE CONSIDERED**

### Section X. Medical Information Bureau (MIB) Authorization

Information regarding your insurability will be treated as confidential. CRL or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. I understand that if I apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such member company, the Bureau, upon request, will supply such member company with the information in its file.

**By signing below, I authorize release of my information to MIB and MIB to any member company.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Spouse (If applying for coverage) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Adult Child (If applying for coverage) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Authorized Representative, if applicable (i.e., Power of Attorney) \_\_\_\_\_ Relationship/ Authority to Represent \_\_\_\_\_ Date \_\_\_\_\_

Authorized Representative's Address \_\_\_\_\_ Authorized Representative's Phone Number \_\_\_\_\_