Colonial Life & Accident Insurance Company

Application to: Colonial Life & Accident Insurance Company   PO Box 1365 Columbia, SC 29202

☐ Proposed Insured Section

Proposed Insured's Name (First, MI, Last)	Employee ☐ Spouse ☐ Dependent ☐	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – (Not a PO Box) Street City State Zip Code				State of Birth

Date Employed	Occupation / Job Title	Hrs. Worked/ Week	Annual Base Salary	Telephone Number/ best time to call:

☐ Employee Section (Complete only if Proposed Insured is not the employee)

Employee Name (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Relationship to Proposed Insured	Social Security No.	Date Employed

☐ Billing Section

Payroll Deduction Employer Name	Employer Address (Street-City-State-Zip)	Employee ID/ Payroll No.	Employee Class Salary	Section/ Department No.

☐ Spouse Section

Name of Spouse (First, MI, Last)	Gender M ☐ F ☐	Relationship to Proposed Insured	Birthdate (mm/dd/yyyy)	Social Security No.
Spouse's Employer	Date Employed	Occupation / Job Title	Hours Worked/ Week	Annual Base Salary

☐ Dependent Section

Are there any eligible dependent children applying for coverage? Yes ☐ No ☐   Number of Dependents:

Dependent Child Information – Complete this information only if applying for a Children's Term Rider

Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			

☐ Beneficiary Section (Complete for all products)

Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

Eligibility Section			Proposed Insured	Your Spouse
☐	All Products	1. Is the Proposed Insured actively working? 1.a. If "No", is the Proposed Insured disabled or unable to work?	Yes ☐ No ☐ Yes ☐ No ☐	
☐	All Products	2. Is the spouse (if applying for coverage) actively working? 2.a. If "No", is the spouse (if applying for coverage) disabled or unable to work?		Yes ☐ No ☐ Yes ☐ No ☐

Plan Section

☐ **Accident**	Base Plan Code and Premium	Rider Plan Code and Units	Rider Premium	Type	Tax Status	Monthly Premium
☐ Proposed Insured ☐ Proposed Insured/Spouse ☐ Proposed Insured/Dependents ☐ Proposed Insured/Spouse/Dependents	$		$	☐ New ☐ Transfer ☐ Add a rider	☐ Pre-Tax ☐ After-Tax	$

☐ **Hospital Confinement**	Base Plan Code and Premium	Rider Plan Code	Rider Premium	Type	Tax Status	Monthly Premium
☐ Proposed Insured ☐ Proposed Insured/Spouse ☐ Proposed Insured/Dependents ☐ Proposed Insured/Spouse/Dependents	$		$	☐ New ☐ Transfer ☐ Add a rider	☐ Pre-Tax ☐ After-Tax	$

☐ **Cancer**	Base Plan Code and Premium	Rider Plan Code	Rider Premium	Type	Tax Status	Monthly Premium
☐ Proposed Insured ☐ Proposed Insured/Dependents ☐ Proposed Insured/Spouse/Dependents	$		$	☐ New ☐ Transfer ☐ Add a rider	☐ Pre-Tax ☐ After-Tax	$

☐ **Intensive Care**	Base Plan Code and Premium	Units	Type	Tax Status	Monthly Premium
☐ Proposed Insured ☐ Proposed Insured/Dependents ☐ Proposed Insured/Spouse/Dependents	$		☐ New ☐ Transfer ☐ Add a rider	☐ Pre-Tax ☐ After-Tax	$

☐ **Critical Illness**	Base Plan Code and Premium	Face Amount	Rider Plan Code	Type	Tax Status	Monthly Premium
☐ Proposed Insured ☐ Spouse	$	$		☐ New ☐ Transfer ☐ Add a rider	☐ Pre-Tax ☐ After-Tax	$

☐ **Disability**	Base Plan Code and Premium	Units	Rider Plan Code	Rider Premium	Type	Tax Status	Monthly Premium
Employee Only	$			$	☐ New ☐ Transfer ☐ Add a rider	☐ Pre-Tax ☐ After-Tax	$

☐ **Universal Life**	Base Plan Code and Target Premium	Face Amount	Rider Plan Code and Units	Rider Premium	Total Monthly Premium
Option ☐ A ☐ B	$	$		$	Planned Premium $ $
☐ Existing Policy Number ______________________	☐ Increase ☐ Rider Addition /Conversion	☐ Tobacco to Non-tobacco policy ☐ Exercising Guaranteed Purchase Option			☐ Option Change ☐ Term Life Conversion

NOTE: For rider additions, option changes, a change in smoker status, or UL increases, if the Beneficiary Section of this application is completed, this designation *replaces* any other Beneficiary Designation on file for this Policy.

☐ **Term or Whole Life**	Base Plan Code and Premium	Face Amount	Rider Plan Code and Units	Rider Premium	Total Monthly Premium
Automatic Premium Loan if available for Whole Life? Yes ☐ No ☐	$	$		$	$
☐ Existing Policy Number ______________________	☐ Rider Addition/ Conversion	☐ Tobacco to Non-tobacco policy ☐ Exercising Guaranteed Purchase Option			☐ Term Life Conversion

NOTE: For rider additions or a change in smoker status, if the Beneficiary Section of this application is completed, this designation *replaces* any other Beneficiary Designation on file for this Policy.

Total Monthly Premium $____________

Application Questions

	Non-Medical Questions – Additional forms may be required based on answers to these questions. Please provide if required in your state				Proposed Insured
☐	All Life	3. Does the Proposed Insured have any existing life coverage? **If yes, provide details below.**			Yes ☐ No ☐
☐	All Products	4. Will any health, life insurance or annuities with this or any other company be replaced or changed if the coverage applied for is issued? **If yes, check appropriate box of policy being replaced.**			Yes ☐ No ☐
Insured's Name		Insurance Company	Policy Number	Amount of Coverage	Check yes if replacing
					Yes ☐ No ☐ Yes ☐ No ☐
☐	All except Life and Disability	5. Are you or any person applying for coverage Medicare eligible? **If yes, the Important Notice to Persons on Medicare will be provided.**			Yes ☐ No ☐
☐	All Life and Critical Illness	6. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?			Yes ☐ No ☐
☐	All Critical Illness	7. Does the Proposed Insured have comprehensive health coverage? If no, the Proposed Insured is not eligible for coverage. This coverage is not intended as a replacement or substitute for major medical coverage.			Yes ☐ No ☐
☐	Universal Life Only	8. Are you using funds from your existing policy(s) or contract(s) to fund the new policy (1035 Exchange)? **If yes, complete the 1035 Exchange form.**			Yes ☐ No ☐

	Medical Questions - if you answer Yes to Questions 9 – 11 or 15, you or your family members are not eligible for the product and/or rider.		Proposed Insured	Your Spouse	Your Child
☐	All Products	9. Within the past 10 years, have you, your spouse or your dependent child if applying for coverage, tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
☐	All Disability	10. Have you previously purchased disability coverage that will remain in force which, when combined with the coverage you are applying for, will exceed 70% of your gross annual income? This does not include employer paid group disability coverage.	Yes ☐ No ☐	Yes ☐ No ☐	
☐	All Disability & Hospital Confinement	11. Within the past 12 months, have you or any person applying for coverage: **a.)** been off work (vacation or sick leave) for 10 or more consecutive work days other than colds, flu or normal pregnancy due to an illness or injury, including back, neck, knee, joint or muscle? **b.)** received medical advice or sought treatment (including medication) for: heart attack (Myocardial Infarction), heart surgery, congestive heart failure, stroke, transient ischemic attack, blood pressure reading of 160/100 or above, kidney disease except stones, insulin dependent diabetes, diabetes diagnosed prior to age 40, hepatitis B or C, cirrhosis or cancer (other than skin cancer)?	a.) Yes ☐ No ☐ b.) Yes ☐ No ☐	a.) Yes ☐ No ☐ b.) Yes ☐ No ☐	
☐	All Hospital Confinement Dependent Child Only	12. Within the past 12 months, has any dependent child been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer) or seizures? **If yes, list the dependent name(s) and relationship in the Additional Data Section.**			Yes ☐ No ☐
☐	All Cancer	13. Within the past 10 years, have you, your spouse or your dependent child if applying for coverage, been diagnosed with, or treated for, cancer other than skin cancer? **If yes, please complete the Cancer History Form.**	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
☐	All Cancer	14. Within the past 5 years, have you, your spouse or your dependent child if applying for coverage, received medical advice or sought treatment for Skin Cancer, including basal cell carcinoma, squamous cell carcinoma, or melanoma of Clark's level I or II? **If yes, complete a skin cancer rider.**	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
☐	All Critical Illness and Intensive Care	15. Within the past 10 years, have you or your spouse if applying for coverage received medical advice or sought treatment (including medication) for: heart attack (Myocardial Infarction), heart surgery, heart disease, abnormal catherization, congestive heart failure, stroke, transient ischemic attack, blood pressure reading of 160/100 or above, kidney disease except stones, diabetes, emphysema, chronic obstructive pulmonary disease, cancer (other than skin cancer,) cirrhosis or liver disease, organ transplant, or hepatitis B or C?	Yes ☐ No ☐	Yes ☐ No ☐	
☐	All Life and Critical Illness	16. Indicate Your Current: **Height**______________ **Weight**______________ Indicate Spouse's Current: **Height**______________ **Weight**______________ Indicate Juvenile's Current: **Height**______________ **Weight**______________			

	Medical Questions Continued - if you answer Yes to Questions 17 – 19 or 21 - 26, you or your family members are not eligible for the product and/or rider.		Proposed Insured	Your Spouse
☐	Term Life	17. Within the past 24 months, have you or any person applying for coverage: **a.)** used marijuana, cocaine, heroin or any other illicit drug or controlled substance, with the exception of those prescribed for you by a physician; received medical advice or sought treatment for drug and/or alcohol abuse; or been advised by a doctor to reduce your consumption of drugs or alcohol? **b.)** been charged with operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to, or been convicted of or have a charge pending for any felony or misdemeanor? **c.)** been prescribed 3 or more medications (including diuretic) to be taken concurrently for high blood pressure; or been prescribed medication for elevated cholesterol and high blood pressure?	a.) Yes ☐ No ☐ b.) Yes ☐ No ☐ c.) Yes ☐ No ☐	a.) Yes ☐ No ☐ b.) Yes ☐ No ☐ c.) Yes ☐ No ☐
☐	Term Life	18. Within the past 10 years, have you or any person applying for coverage, received medical advice or sought treatment for internal cancer, including leukemia or melanoma of Clark's level III or higher?	Yes ☐ No ☐	Yes ☐ No ☐
☐	Term Life	19. Within the past 10 years, have you, or any person applying for coverage, received medical advice or sought treatment (including medication) for heart attack (Myocardial Infarction)/angina, cardiac/circulatory surgery, peripheral vascular disease, stroke, chronic kidney (renal) failure, systemic lupus (SLE) disease, congestive heart failure/cardiomyopathy, emphysema, manic depressive disorder (Bipolar), insulin dependent diabetes, diabetes diagnosed prior to age 40, chronic obstructive pulmonary disease (COPD), schizophrenia, multiple sclerosis, paralysis, chronic hepatitis, or hepatitis (except A)?	Yes ☐ No ☐	Yes ☐ No ☐
☐	Whole Life Universal Life Select SI and Simplified Issue	20. Within the past 12 months, have you or your spouse if applying for coverage been hospitalized or missed 5 or more consecutive days of work for any reason other than flu, pregnancy, accidents, allergies, back or knee disorder? **If yes, you must answer questions 21 – 23.**	Yes ☐ No ☐	Yes ☐ No ☐
☐	Whole Life and Universal Life	21. Within the past 24 months, have you or your spouse if applying for coverage: **a.)** used marijuana, cocaine, heroin or any other illicit drug or controlled substance, with the exception of those prescribed for you by a member of the medical profession; received medical advice or sought treatment by a member of the medical profession for drug and/or alcohol abuse; or been advised by a member of the medical profession to reduce your consumption of drugs or alcohol? **b.)** been convicted of operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to, or been convicted of or have a charge pending for any felony or misdemeanor or are you currently on probation or parole? **c.)** been prescribed 3 or more medications by a member of the medical profession (including diuretic) for high blood pressure; or been prescribed medication for high blood pressure and diagnosed with diabetes by a member of the medical profession?	a.) Yes ☐ No ☐ b.) Yes ☐ No ☐ c.) Yes ☐ No ☐	a.) Yes ☐ No ☐ b.) Yes ☐ No ☐ c.) Yes ☐ No ☐
☐	Whole Life and Universal Life	22. Within the past 10 years, have you or your spouse if applying for coverage received medical advice or sought treatment by a member of the medical profession for internal cancer, including leukemia or melanoma of Clark's level III or higher?	Yes ☐ No ☐	Yes ☐ No ☐
☐	Whole Life and Universal Life	23. Within the past 5 years have you or your spouse if applying for coverage ever received medical advice or sought treatment by a member of the medical profession (including medication) for: heart attack (Myocardial Infarction)/angina, cardiac/circulatory surgery, peripheral vascular disease, stroke, transient ischemic attack (TIA), chronic kidney (renal) failure, systemic lupus (SLE) disease, congestive heart failure/cardiomyopathy, emphysema, manic depressive disorder (Bipolar), diabetes(excluding diet controlled and gestational), chronic obstructive pulmonary disease (COPD), schizophrenia, multiple sclerosis, paralysis or hepatitis (except A)?	Yes ☐ No ☐	Yes ☐ No ☐
☐	Juvenile Universal Life All Ages	24. Within the past 10 years, has the juvenile received medical advice or sought treatment by a member of the medical profession for cystic fibrosis, diabetes, heart disorder, leukemia, cancer (other than skin cancer), seizures, down's syndrome, cerebral palsy or been hospitalized in the past 12 months for a respiratory illness?	Yes ☐ No ☐	
☐	Juvenile Universal Life Ages 15 – 17	25. Within the past 24 months, has the juvenile used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, with the exception of those prescribed for him by a member of the medical profession; or received medical advice or sought treatment by a member of the medical profession for drug and/or alcohol abuse?	Yes ☐ No ☐	
☐	Juvenile Universal Life Ages 15 – 17	26. Within the past 24 months, has the juvenile been convicted of operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to, or been convicted of or have a charge pending for any felony or misdemeanor?	Yes ☐ No ☐	
☐	Juvenile All Ages for amounts over $50,000 to $100,000	27. Within the past 5 years, has the juvenile been confined to a hospital or medical facility, been seen by a member of the medical profession for any reason other than stated on this application, or is he currently taking medication or receiving medical advice from a member of the medical profession ? **If yes, provide details in the Additional Data Section.**	Yes ☐ No ☐	

Additional Data Section – provide information for any data overflow

Owner Section - Complete if naming an owner other than the proposed insured or if proposed insured is a juvenile.

Owner (Name and Address)	Relationship	Social Security No.
Contingent Owner (if applicable) (Name and Address)	Relationship	Social Security No.

☐ **Agreement Section**

THE PROPOSED INSURED AGREES AS FOLLOWS:
Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. Except as otherwise provided in the Conditional Receipt bearing the same date as this application (if any),I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial) until both: 1) the policy is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. If applicable, I have received an outline of coverage for the plan(s) applied for and I have been explained all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to pre-existing conditions. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy issued by Colonial, and no information about me will be considered to have been given to Colonial unless is it stated in the application. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.
If applicable, I have received and read a copy of the Notice of Insurance Information Practices (which includes MIB, Inc. Disclosure Notice). I hereby authorize Colonial Life & Accident Insurance Company to release information to the MIB.
I acknowledge that ☐ **I have** ☐ **I have not** received a full ledger illustration according to the NAIC regulations and I understand that an illustration conforming to the policy as issued (if applicable) will be provided at the time of policy delivery. I have paid to the agent named in this application $__________ for the first premium due on this policy. This amount is to be applied in accordance with the provisions of the application and the receipt.

By applying for the coverage indicated above, do you agree to the cancellation of existing similar Colonial coverage (base plan and all applicable riders) if the coverage applied for is issued? Yes ☐ No ☐ If yes, provide existing policy number: ____________________________

Signed at: (City)____________________________________ (State) __________ (Date) ____
mm/dd/yyyy

(x)____
Signature of Proposed Insured

(x)____
Signature of Owner (if Other than Proposed Insured)

Agent Section

Agent's Name ______________________________
please print

To your knowledge is the Proposed Insured intending to replace any existing insurance? Yes ☐ No ☐

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage(s) applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable. I certify that ☐ **I have** ☐ **I have not** used a full ledger illustration according to the NAIC regulations and I understand that an illustration conforming to the policy as issued (if applicable) will be provided at the time of delivery.

Date__________________ (x)______________________________ License No.______________ Code No.____________
mm/dd/yyyy Signature of Licensed Agent