COMBINED INSURANCE COMPANY OF AMERICA
Home Office: Chicago, Illinois

Enrollment Form for Group Critical Illness Insurance
FORM # C16670-MD

I am applying for this coverage based on the following information:	(Home Office Use)	Enrollment Date:

ACTION REQUESTED: ☐ New Certificate ☐ Reinstatement ☐ Conversion ☐ Certificate Change

EMPLOYEE'S (proposed insured) NAME (First MI Last)	☐ Male ☐ Female	Birthdate: Mo/Day/Yr	Age
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)	Work Phone No.	Social Security No.	Employee ID#

Landline Phone No.	Mobile Phone No.	Email

EMPLOYER NAME	POLICYHOLDER NAME	Hire Date: Mo/Day/Yr	Gross Annual Income

BENEFICIARY'S Full Name	Relationship	CONTINGENT BENEFICIARY'S Name	Relationship

Are you actively at work at least 17½ hours each week? Yes ☐ No ☐

COVERAGE FOR: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children

List all eligible persons to be covered on this plan: Employee; Spouse; and Your Children age 26 or under.

Name(s)	DOB: Mo/Day/Yr	Relationship	Sex	Indicate if Employee or Spouse used tobacco in any form in the last 12 months
	(as above)	Self	(as above)	Yes ☐ No ☐
		Spouse	M ☐ F ☐	Yes ☐ No ☐
		Child 1	M ☐ F ☐	
		Child 2	M ☐ F ☐	
		Child 3	M ☐ F ☐	
		Child 4	M ☐ F ☐	

Spouse includes an Eligible Domestic Partner/Civil Union Partner who resides with and is financially interdependent with the Employee, as defined in the Certificate.

REQUESTED BENEFIT AMOUNT:	PREMIUM - Mode
Proposed insured: _____	☐ Weekly (52) ☐ Monthly (12) ☐ Bi-Weekly (26)
Spouse: See Certificate Schedule	☐ Semi-Monthly (24) ☐ _____
Child(ren): See Certificate Schedule	
Total Premium Per Pay Period:	

IMPORTANT – READ CAREFULLY – I represent and affirm the following:

Express Issue (Complete as required)	Proposed Insured Yes	Proposed Insured No	Spouse Yes	Spouse No
1. Within the past 7 years, has any proposed insured been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or tested positive for antigens or antibodies to an "AIDS" virus?	☐	☐	☐	☐
2. Within the past 7 years, have you been diagnosed or treated for any of the following: a stroke or transient ischemic attack (TIA); heart attack, or any abnormality of the heart or circulatory system; diabetes except gestational diabetes or any disease of the pancreas; Emphysema, Cystic Fibrosis, or Chronic Obstructive Pulmonary Disease (COPD); any disease or disorder of the liver; kidney failure or end stage kidney disease; Amyotrophic Lateral Sclerosis (ALS); Alzheimer's Disease; Parkinson's Disease or any other disease or disorder of the nervous system; Multiple Sclerosis; Lupus; Sickle Cell Anemia; or within the past 2 years taken 3 or more medications at the same time to control high blood pressure?	☐	☐	☐	☐
3. In the last 5 years has any proposed insured been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor or found to have abnormal results on a cancer screening examination or chest x-ray? Cancer does not include basal cell or squamous cell carcinoma.	☐	☐	☐	☐

	Proposed Insured		Spouse	
Simplified Issue (Complete additional questions as required)	Yes	No	Yes	No
1. Has any proposed insured been hospitalized or treated in the emergency room for a sickness in the past six months?	☐	☐	☐	☐
2. Within the past 2 years has any proposed insured been diagnosed or treated for alcohol or drug abuse or been arrested for a DUI?	☐	☐	☐	☐

Name of proposed insured	Height	Weight
Employee		
Spouse		
Child		

If proposed insured has answered "Yes" to any of the above questions:

Question No.	Name of proposed insured/Spouse/Childr(en)	Details (include the condition/illness, dates, and doctor's name & address)

It is very important that you review your enrollment form carefully. Misstatements or omissions could cause an otherwise valid claim to be denied.

CONFIDENTIALITY OF MEDICAL INFORMATION

The medical information disclosed on this Enrollment Form will not be disclosed to the employer or any other person without the authorization of the proposed insured.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, medically related facility, insurance company, or consumer reporting agency to release to Combined Insurance Company of America any information regarding me or my past or present health for the purpose of evaluating this Enrollment Form for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to Combined.

I understand that any insurance will not take effect unless and until Combined Insurance Company of America approves my enrollment. If coverage cannot be issued as requested under the rules of the Company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums).

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Enrollment Form is true and complete to the best of my knowledge and belief.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X_____ City:_____ State:_____ Date: _____

Signature of Employee

I, the authorized agent, have on the date of application recorded the information as given to me by the Employee.

Signature of Licensed Agent_____ Code #_____

REMARKS OR SPECIAL REQUESTS FOR CONVERSION OR CERTIFICATE CHANGE