Group number: _____

Critical Illness Application Form*

Instructions: Please complete boxes outlined in **RED**

***Additional information is needed. Approval is subject to Medical Underwriting Approval. See Health Application Form on View Benefits**

A: Personal Information

Last Name: Middle Initial: First Name:
Date of Birth: __/__/____ Social Security Number:
Street Address: Apt #:
City: State: Zip Code:
Home Phone Number: E-mail Address:
Marital Status: Single Married Divorced Widowed
Gender: Male Female Tobacco Usage: Yes No
Occupation: Date of Hire: __/__/____
Hours: Salary:

B: Dependents to be Insured (FILL IN AND COMPLETE IF COVERING)

Dependent 1
Last Name: Middle Initial: First Name:
Date of Birth: _____/_____/_____ Social Security Number:
Gender: Male Female Relationship:

Dependent 2
Last Name: Middle Initial: First Name:
Date of Birth: _____/_____/_____ Social Security Number:
Gender: Male Female Relationship:

C: Health Questionnaire

General Questions

Are you actively working?
Employee: Yes No Spouse: Yes No
If "No", is your spouse disabled or unable to work? Spouse: Yes No

Replacement Section

Will any health insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued? Yes No

AIDS Section

Within the past 10 years, have you tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?
Employee: Yes No Spouse: Yes No
Dependent: Yes No

C: Health Questionnaire

Other

Are you Medicare eligible? ◯ Yes ◯ No

Has the Important Notice to Persons on Medicare been provided? ◯ Yes ◯ No

Does the Employee have comprehensive health coverage? ◯ Yes ◯ No

If **NO**, the Employee is not eligible for coverage.

Height and Weight

Indicate Employee's Current: Height: Weight:

Indicate Spouse's Current: Height: Weight:

Medication

Are you currently prescribed any medication? ◯ Yes ◯ No

D: Acknowledgement of Coverage and Signature

I understand that the policy applied for will not pay benefits for any loss incurred during the first 12 months after the issue date for a disease or physical condition that I have or have had in the past. This pre-existing statement does not apply to first diagnosis center or critical illness policies.

Name Printed:

Signature: Signature Date: ____/____/____