

A: Personal Information

Group number: _	

Whole Life Application Form*

Instructions: Please complete boxes outlined in RED

*Additional information may be needed. Approval is subject to Medical Underwriting Approval

Last Name: Middle Initial: First Name: Date of Birth:/ Social Security Number: Street Address:	_
B: Coverage Amount	
Voluntary Employee Whole Life & AD&D Amount of Coverage:	
Voluntary Spouse Whole Life & AD&D Amount of Coverage:	
Voluntary Child Whole Life Amount of Coverage:	
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	ne
AIDS Section Within the past 10 years, have you tested positive for the Human Immunodeficiency Virus (antibodies, or received medical advice or sought treatment for Acquired Immune Deficience Syndrome (AIDS) or AIDS-related complex (ARC)?	•
Employee: Yes No Spouse: Yes No Dependent: Yes No)

C: Health Questionnaire [Continued]		
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: Indicate Spouse's Current: Height: Weight:		
Medication Are you currently prescribed any medication? Yes No		
D: Beneficiary Information		
Primary Beneficiary		
Last Name: Middle Initial: First Name: Percentage of Benefit: Social Security Number: Gender: Male Female Relationship: Last Name: Middle Initial: First Name: Percentage of Benefit: Social Security Number: Gender: Male Female Relationship:		
Last Name: Middle Initial: First Name: Percentage of Benefit: Social Security Number: Gender: Male Female Relationship: Last Name: Middle Initial: First Name: Percentage of Benefit: Social Security Number: Gender: Male Female Relationship:		
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 cancer or critical illness policies.		
Name Printed:		
Signature: Signature Date:/		