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

Applicant Section					
Applicant's Name (First, MI, Last)	Employee ☐ Spouse ☐ Dependent ☐	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.	
Home Address – Street City State Zip Code			State of Birth	Employee ID/Payroll No.	
Date Employed	Occupation/ Job Title	Hrs. Worked/ Week	Annual Base Salary	Home Phone No. Business Phone No.	

Billing Section			
Payroll Deduction Employer Name	Employer Address (Street-City-State-Zip)	Section/Dept. No.	Employee Class
Payer or Owner if other than Applicant (Name, Address, Social Security No.)		☐Payer ☐Owner ☐Both	

Spouse and Dependent Section				
Name of Spouse (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
Employer's Name for Spouse	Date Employed	Occupation / Job Title	Hours Worked/ Week	Annual Base Salary
1. Are there any eligible dependent children applying for coverage?			Yes ☐ No ☐	Number Deps:

Complete Question 2 for all Products	**Applicant**	**Spouse**
2.A. Are you actively working?	Yes ☐ No ☐	Yes ☐ No ☐
2.B. If "No", is your spouse disabled or unable to work?		Yes ☐ No ☐

Plan Section

Indicate Type of Change (N) New **(T)** Transfer or **(R)** Rider Addition. **Indicate Tax Status (P)** for pre-tax or **(A)** for after tax

Product	**Type Coverage**	**Type of Change**	**Policy Plan Code**	**Units/ Amount**	**Rider Plan/ Units**	**Rider Plan/ Units**	**Rider Plan Code**	**Rider Plan Code**	**Tax Status**	**Monthly Premium**
☐**Accident**									**P** ☐ **A** ☐	
☐**Hospital Confinement**									**P** ☐ **A** ☐	
☐**Cancer**									**P** ☐ **A** ☐	
☐**Int. Care**									**P** ☐ **A** ☐	
☐**Critical Illness**									**P** ☐ **A** ☐	
☐**Disability**	Elim/Benefit period _____/_____								**P** ☐ **A** ☐	
									Total Monthly Premium $	

Replacement Section – Complete for all Products

3. Will any health insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued? If yes, provide details. Yes ☐ No ☐

Insured's Name	Insurance Company	Type of Coverage	Policy Number

AIDS Section – Complete for all Products	**Applicant**	**Spouse**	**Dependent**
4. 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)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue Section – Disability and Hospital Confinement	**Applicant**	**Spouse**
5. 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 ☐
6. Within the past 12 months**,** other than colds, flu or normal pregnancy, have you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle?	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue Section – Disability and Hospital Confinement - continued			Applicant	Spouse
7. Within the past 12 months**,** have you received medical advice or sought treatment (including medication) for:				
Heart Attack (MI)	Blood Pressure Reading of 160/100 or Above	Hepatitis B, C	Yes ☐	Yes ☐
Heart Surgery	Kidney Disease except Stones	Cirrhosis		
Congestive Heart Failure	Insulin Dependent Diabetes	Hodgkin's Disease	No ☐	No ☐
Stroke	Diabetes Diagnosed Prior to age 40	Leukemia		
Transient Ischemic Attack	Cancer Other than Skin Cancer			

Dependent Health Section - Hospital Confinement	
8. Within the past 12 months**,** has any dependent been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer) or seizures? If yes, provide details. **Any dependent listed will not be covered under the Hospital Confinement policy to which a copy of the application is attached.**	Yes ☐ No ☐

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

Simplified Issue Section - Critical Illness and Intensive Care		Applicant	Spouse	Dependent
9. Within the past 10 years, have you received medical advice or sought treatment (including medication) for:				
Heart Attack (MI)	Hepatitis B, C	Yes ☐	Yes ☐	Yes ☐
Heart Surgery	Blood Pressure Reading of 160/100 or Above			
Heart Disease	Kidney Disease except Stones	No ☐	No ☐	No ☐
Emphysema	Chronic Obstructive Pulmonary Disease			
Organ Transplant	Cirrhosis or Liver Disease			
Congestive Heart Failure	Transient Ischemic Attack			
Diabetes	Cancer Other than Skin Cancer			
Stroke	Abnormal Catherization			

If yes to question 9 for any dependent, please provide details.
Any dependent listed will not be covered under the Intensive Care or Critical Illness policy to which a copy of the application is attached.

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

10. Within the past 12 months**,** have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery systems?	Yes ☐ No ☐	

Cancer Section	Applicant	Spouse	Dependent
11. Have you ever been diagnosed with, or treated for, Cancer of any type or form? If yes, please answer questions 12 and 13.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
12. In the past 5 years, have you received medical advice or sought treatment for cancer, other than skin cancer; or, in the past 12 months have you received preventive Hormonal Therapy? If yes, you are not eligible for coverage. If no, please complete the Cancer History form.	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

If yes to question 12 for any dependent, please provide details.
Any dependent listed will not be covered under the Cancer policy to which a copy of the application is attached.

Name (First, MI, Last)	Relationship(s)	Birthdate (mm/dd/yyyy)	Social Security No.

13. Within the past 5 years**,** have you 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?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Other Section – Complete for all Products except Disability	
14. Are you Medicare eligible?	Yes ☐ No ☐
15. Has the Important Notice to Persons on Medicare been provided?	Yes ☐ No ☐

Applicant's Beneficiary Information – Complete for all Products					
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Applicant	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Applicant	Social Security No.

Height and Weight Section – Complete for all products at Simplified Issue Level 1 amounts
Indicate Applicant's Current: Height_____ **Weight**_____ **Indicate Spouse's Current: Height**_____ **Weight**_____

Medication Section - Complete for all products at Simplified Issue Level 1 amounts	Applicant	Spouse
M1. Are you currently prescribed any medication? If yes, provide details in the Health Details Section.	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue Level 1 Section – Disability	Applicant
D1. Within the past 5 years**,** have you received medical advice or sought treatment for any cancer, other than skin cancer?	Yes ☐ No ☐
D2. Within the past 5 years, have you received medical advice or sought treatment (including medication) for: Heart Attack (MI), Heart Surgery, Heart Disease, Congestive Heart Failure, Stroke, Transient Ischemic Attack, End Stage Kidney (Renal) Disease, Emphysema, Cirrhosis or Liver Disease, Chronic Obstructive Pulmonary Disease, Multiple Sclerosis, Neurological Disorder, Chronic Fatigue Syndrome, Fibromyalgia	Yes ☐ No ☐
D3. Within the past 5 years, have you received medical advice or sought treatment (including medication) for: If yes, provide details in the Health Details Section. Back Injury or Illness, Knee Injury or Illness, Neck Injury or Illness, Joint Injury or Illness, Muscular Injury or Illness, Carpal Tunnel Syndrome, Diabetes, Hepatitis B, C, Blood Pressure Reading of 140/90 or Above	Yes ☐ No ☐
D4. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application? If yes, provide details in the Health Details Section.	Yes ☐ No ☐
D5. Do you have any individual or group disability insurance now in force with any company, including Colonial Life & Accident Insurance Company? If yes, provide details.	Yes ☐ No ☐

Insurance Company	Monthly Disability Amount	Elimination Period/Benefit	Policy Number

Simplified Issue Level 1 Section - Hospital Confinement	Applicant	Spouse
H1. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease, mental or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application? If yes, provide details in the Health Details Section.	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue Level 1 Section - Critical Illness	Applicant
C1. Within the past 5 years, have you received medical advice, sought treatment, or had surgery or an abnormal diagnostic test for any disease or physical disorder (other than lacerations or broken bones not related to a health condition) not listed on this application? If yes, provide details in the Health Details Section.	Yes ☐ No ☐
C2. Have you ever received medical advice or sought treatment for: Heart Disease, Lung Disease, Kidney Disease, Cirrhosis or Liver Disease, Hepatitis B, C, Circulatory Disease, Respiratory Disease, Blood Pressure Reading of 140/90 or Above If yes, provide details in the Health Details Section.	Yes ☐ No ☐

Health Details Section

For yes answer, provide details below.
For prescribed medication**,** indicate the condition it was prescribed for, medication name, dosage and date of onset.

Condition Name	Medication Name/ Dosage	Date of Onset and Recovery	Doctor/Hospital Name, Address & Phone #	Date of Treatment	Type Treatment Received

Additional Data Section

Agreement Section

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 now have or have had in the past.

THE APPLICANT AGREES AS FOLLOWS:

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. To the best of my knowledge and belief, the answers and statements above are true and complete. 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 is paid. 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, if applicable. I understand that any untrue statement or material misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER. I certify that no person to be covered for specified diseases is also covered by any Title XIX program (Medicare, Medicaid or any similar name.) 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.

Yes ☐ No ☐

REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the Policy indicated. I hereby request cancellation

- ☐ of my Colonial Policy Number(s)_____Transfer or cancellation of the base plan will also mean cancellation of all attached riders.
- ☐ of my rider only_____as of the effective date and hour of my new coverage.

If, for any reason the policy applied for above is not issued, this request for cancellation shall be null and void.

Signed at: (City)_____(State)_____(Date)_____
mm/dd/yyyy

_____ _____

Signature of Applicant Signature of Employee/Payer

Agent Section

Agent's Name (If Present) _____
(please print)

Do you have knowledge or reason to believe that the Applicant is intending to replace any existing insurance?

Yes ☐ No ☐

I have explained to the Applicant all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to pre-existing conditions, if applicable. I hereby certify that I know nothing affecting the insurability of the Applicant, which is not fully set forth in this application. I have not made, nor agreed to make, any rebate of premium for insurance. I further certify that I am a licensed agent in the state where this application is being taken.

Date_____ (x)_____ License No._____ Code No._____
mm/dd/yyyy Signature of Licensed Agent

DETACH AND LEAVE WITH APPLICANT

Notice of Insurance Information Practices

We collect Non Public Information (NPI) about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) will affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Our affiliated companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs. This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

If you believe NPI we have about you is incorrect, please write us. You letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

If we decide not issued coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

To receive our complete privacy notice, including more information about our information-sharing, access and correction practices, write to our parent company: Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122. For additional information about our commitment to privacy, visit www.coloniallife.com.
NIP

DETACH AND LEAVE WITH APPLICANT.

DISCLOSURE NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU.

Information regarding your insurability will be treated as confidential. Colonial or its reinsurer(s) 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. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (617) 426-3660.

Colonial or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

MIB