☐ New Contract
☐ Contract Change For #_____
☐ Reinstatement For #_____

Group Enrollment Form
Combined Insurance Company of America ("The Company")
Administrative Office: P.O. Box 506, Keene, N.H. 03431-0506

COMBINED INSURANCE®

I. Employee Information:

Group Name _____ Location/Dept. _____
Name _____ Date of Hire _____ Home Phone _____
Legal Address _____ Email _____
Street City State Zip
Annual Salary _____ Social Security _____ Employee ID _____

Is the employee actively at work performing the regular duties of the job in the usual manner and at the usual place of employment? ☐ Yes ☐ No

If applying for coverage, is your Spouse currently hospitalized, receiving home health care or receiving or applying to receive disability benefits? ☐ Yes ☐ No

II. Proposed Insured Information:

	Name	Gender	Birth Date	Age	Tobacco or Nicotine Products in Last 12 Months
1. Employee:		☐ M ☐ F			☐ Yes ☐ No
2. Spouse:		☐ M ☐ F			☐ Yes ☐ No

III. Coverage Information: Planned Premium Mode: ☐Weekly ☐Bi-Weekly ☐Monthly ☐Semi-Monthly ☐Other_____

Base Plan: Lifetime Benefit Term (LBT)

Employee: Face _____ Premium $_____

Riders:

- ☐ Acceleration for LTC Rider
- ☐ Extension for LTC Rider
- ☐ Restoration Rider
- ☐ Dependent Child Rider: _____Units Premium $_____
- ☐ Accidental Death Benefit Rider Premium $_____
- ☐ Waiver of Premium Rider Premium $_____
- ☐ Guaranteed Insurance Rider ☐ $1/5 yrs ☐ $2/5 yrs ☐ $1/10 yrs
- ☐ Level Term Rider (LTR)
  - 1. Employee: Face _____ Premium $_____
  - 2. Spouse: Face _____ Premium $_____
- ☐ Other _____ Premium $_____

Total Planned Premium $_____

Base Plan: Lifetime Benefit Term (LBT)

☐Spouse Face _____ Premium $_____

Riders:

- ☐ Acceleration for LTC Rider
- ☐ Extension for LTC Rider
- ☐ Restoration Rider
- ☐ Dependent Child Rider: _____Units Premium $_____
- ☐ Accidental Death Benefit Rider Premium $_____
- ☐ Payor Waiver Rider Premium $_____
- ☐ Guaranteed Insurance Rider ☐ $1/3 yrs ☐ $2/3 yrs ☐ $1/5 yrs
- ☐ Level Term Rider (LTR)
  - 1. Employee: Face _____ Premium $_____
  - 2. Spouse: Face _____ Premium $_____
- ☐ Other _____ Premium $_____

Total Planned Premium $_____

IV. Beneficiary:

Insured: _____ Beneficiary: _____ Relationship: _____
Insured: _____ Beneficiary: _____ Relationship: _____

V. Certificateholder:

The Employee will be the Certificateholder unless another is subsequently designated.

VI. Conditional Issue Questions:

Complete as required for any person proposed for Coverage. If any question is answered "Yes", please answer all of the Simplified Issue Eligibility questions on Page 2 for that person.

Proposed Insured Person:	Employee Yes	Employee No	Spouse Yes	Spouse No
a. Has the Employee missed more than 5 consecutive days of active work due to an illness or injury in the past 3 months?	☐	☐	N/A	
b. Has any proposed Insured been treated in a medical facility, hospitalized or disabled in the past 6 months, excluding flu or cold? Hospitalized means in-patient or outpatient, whether or not confined. Treated in a medical facility does NOT include a regular physician's office visit.	☐	☐	☐	☐
c. Has any Proposed Insured, within the last 10 years, been diagnosed as having or been treated by a physician for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐
d. Has any person/Spouse proposed for coverage been seen or treated by a licensed physician or other medical practitioner within the past 6 months, excluding flu, cold or routine physical?	☐	☐	☐	☐

VII. Other Coverage:

Does any Person proposed for coverage have any life insurance in force or is any application for life insurance or reinstatement now pending? ☐ Yes ☐ No If Yes, complete the following:

Insured	Name of Company	Face Amount	Month/Year Issued	To be Replaced?
				☐ Yes ☐ No
				☐ Yes ☐ No

VIII. Additional Question: Complete as required

To the best of your knowledge and belief, has any proposed insured, in the past 5 years:	Employee Yes	Employee No	Spouse Yes	Spouse No
a. Been confined in a long term care facility, currently receive home heath or adult day care, or has the proposed insured been advised by a physician to receive such confinement or care?	☐	☐	☐	☐
b. Required assistance for a period longer than 4 weeks to perform any of the following daily activities: bathing, continence, dressing, eating, toileting, getting up and down from bed or chair?	☐	☐	☐	☐

IX. Simplified Issue Questions: Complete as required

1. Employee Height: _____Ft. _____In. Weight:_____ 2. Spouse Height: _____Ft. _____In. Weight:_____

Within the past 5 years, has any proposed Insured been admitted or advised to be admitted to a hospital or received medical advice or treatment for:	Proposed Insured Person: Employee Yes	Employee No	Spouse Yes	Spouse No
a. Any chest pain, heart disease, stroke or paralysis, lung or respiratory disease, blood disease or high blood pressure? If yes, provide most recent blood pressure reading and date;	☐	☐	☐	☐
b. Any cancer, tumor, disorder of the kidney, liver disease or hepatitis;	☐	☐	☐	☐
c. Any mental or psychiatric disorder, stomach or intestinal disorder or reproductive organ disorder;	☐	☐	☐	☐
d. Received or been advised to have, counseling or treatment for the use of alcohol, drugs, illegal drugs, or used any illegal drug or controlled substance;	☐	☐	☐	☐
e. Taken any prescription medication in the past 6 months (If "Yes", state name of medication, reason for taking, frequency and dosage);	☐	☐	☐	☐
f. Had or been advised to have an electrocardiogram, x-ray, blood study, urinalysis, or any other diagnostic study, operation or treatment;	☐	☐	☐	☐
g. Other than stated above, within the past 5 years, had any other illness, operation or treatment?	☐	☐	☐	☐

Details: Provide full details of "yes" answers on Page 1 and 2. Include the diagnoses, date, duration, and names and address of all attending physicians and medical facilities.

Proposed Insured	Question #	Describe Injury, Illness, Disorder, Symptoms and Medication (include Dosage and frequency)	Date Diagnosed	Length of Treatment	Current Health Status	Name & Address of Doctor or Hospital

If more space is needed to provide details, attach a signed and dated additional sheet of paper.

Declaration, Agreement and Authorization To Release Information: I/We declare that each answer given to the questions contained in this enrollment form is complete and true to the best of our knowledge and belief. I understand and agree that the company will rely on these answers, and the answers and statements I may give in any other form taken as part of this Group Enrollment Form. I also understand that The Company reserves the right to accept or deny this coverage after taking into account whatever information may be available to it.

The insurance being applied for will be effective as of the Date of Issue, provided the person(s) to be insured is (are) found acceptable for such insurance as applied for.

I/We authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, MIB, Inc. or employer to give to Combined Insurance Company of America any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition as applicable. To facilitate the rapid transmissions of such information, I authorize all said sources, except MIB, Inc., to give such records or knowledge to any agency employed by The Company to collect and transmit such information. I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my request for insurance or to evaluate a claim during the time that this authorization is valid. I also understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization.

I/We authorize The Company or its reinsurers to make a brief report of my protected health information to MIB, Inc.

If coverage cannot be issued as applied for under the rules of The Company, I/We authorize Combined Insurance Company of America to issue available 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 applying allows for alternate methods to pay insurance premiums).

The Certificateholder/Insured and the agent certify that no illustration conforming to the coverage applied for was provided, but that an illustration conforming to the coverage issued will be provided upon delivery.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an enrollment form for insurance may be guilty of a criminal offense under state law.

Agent: To the best of your knowledge, will the coverage applied for replace any life or annuity coverage now in force on the life of any Proposed Insured? (If Yes, complete appropriate State replacement forms)…… ☐ Yes ☐ No

SIGNED AT: (State) DATE: SIGNATURE OF LICENSED AGENT:

SIGNATURE OF CERTIFICATEHOLDER/INSURED: PRINTED NAME OF AGENT:

SIGNATURE OF SPOUSE: (if required) STATE LICENSE NUMBER: (if required by law)