Washington National®

Enrollment forms booklet | Louisiana

GROUP SOLUTIONS

SUPPLEMENTAL HEALTH INSURANCE, GROUP COVERAGE

Group critical illness

EMPLOYEE / MEMBER ENROLLMENT FORM FOR GROUP INSURANCE
Underwritten by: Washington National Insurance Company (the "Company")
11825 N. Pennsylvania Street, Carmel, Indiana 46032

This area for Agent or Plan Administrator Use Only

Group/Union Number:	**Requested effective date of coverage: The first day of:** _____ **Month** _____ **Year**
Agent Number:	

GENERAL INFORMATION SECTION

To enroll, please type or print in dark ink and return to your Agent/ Employer/Union. Any changes must be initialed by the Employee/Member.

Last Name:	First Name:	Middle Initial:	Date of Birth: (MM/DD/YY)

State of Birth:	Gender: ☐ M ☐ F	Social Security No.:	Home Phone Number:

Home Address:

Number/Street: City: State: Zip:

Employer Name:	Work Location/Site:

Date of Hire:	Occupation:	Annual Income:

Are you Actively at Work? ☐ Yes ☐ No How many hours per week are you actively at work? _____

Complete this section if you wish to have coverage for spouse and/or child(ren).

Additional Covered Person Information
Please fill in Spouse and Child Information

Name	Product	Relationship to Employee/Member	Date of Birth
	☐ Critical Illness		
	☐ Critical Illness		
	☐ Critical Illness		
	☐ Critical Illness		
	☐ Critical Illness		

EMPLOYEE / MEMBER ENROLLMENT FORM FOR GROUP INSURANCE
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CRITICAL ILLNESS COVERAGE ☐ **Enroll or** ☐ **Decline**

☐ Employee/Member ☐ Employee/Member plus spouse

For Children to be covered under the Employee/Member or Employee/Member plus spouse critical illness coverage, please list each child's name in the General Information section. Child(ren) can be added to coverage at no additional premium.

1. Have you used any tobacco product in the last 24 months? ☐ Yes ☐ No

2. Will the coverage applied for with this enrollment form:
- a. replace any existing critical illness coverage? ☐ Yes ☐ No
- b. be in addition to any existing critical illness coverage? ☐ Yes ☐ No
- c. ☐ New ☐ Increase ☐ Decrease ☐ Existing Policy No. if Increase or Decrease: _____

3. Coverage Type	**Current Amount**	**Increase or Decrease**	**Total amount applied for**
☐ Cancer ☐ Cancer and Heart/Stroke **Must select a coverage above**		+ _____ - _____	☐ 50k ☐ 40k ☐ 30k ☐ 20k ☐ 10K ☐ 5k ☐ Other: $_____
☐ Critical Conditions Lump Sum Rider		+ _____ - _____	☐ 50k ☐ 40k ☐ 30k ☐ 20k ☐ 10K ☐ 5k ☐ Other: $_____
☐ Heart/Stroke Benefit Rider		+ _____ - _____	☐ 50k ☐ 40k ☐ 30k ☐ 20k ☐ 10K ☐ 5k ☐ Other: $_____
☐ Wellness Rider		+ _____ - _____	☐ $100 ☐ $75 ☐ $50 ☐ $25
☐ Cancer Treatment Rider			
☐ Hospital Benefit Rider			
☐ Cash Value Rider (Not Available with Section 125)			

CS-CI(1)

EMPLOYEE / MEMBER ENROLLMENT FORM FOR GROUP INSURANCE
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PREMIUM

If you enroll, you will pay all or a portion of the premium.			
	Total	**Employee/Member**	**Employer/Union**
Short Term Disability			
Critical Illness Coverage:			
Total	$_____ Payroll Mode:_____		

PREM

WASHINGTON NATIONAL INSURANCE COMPANY
EVIDENCE OF INSURABILITY

(Evidence of Insurability required when Employee/Member is applying for amounts of insurance over the guaranteed issue limit, enrolling late, increasing coverage, or enrolling again after having cancelled coverage.)

PLEASE COMPLETE EACH QUESTION APPLICABLE TO COVERAGE SELECTED.
All medical questions, except the Short Term Disability section, will need to be completed if applying for the Hospital Benefit Rider.

The below questions are to be answered for: **ALL INSURANCE APPLIED**	**Employee / Member**	**Spouse (as defined by state law)**	**Child / Children**
1. Please provide the height and weight.	Height _____Ft. _____in. Weight _____lbs.	Height _____Ft. _____in. Weight _____lbs	NOT REQUIRED
2. Has any person proposed for coverage gained or lost 10 or more pounds during the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has any person proposed for coverage ever been treated for or diagnosed by a physician as having Human Immunodeficiency Virus (HIV); Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

REMARKS – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Name of Person	Question No.	Description of illness, injury, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (*include zip code*)

EOI-ALL

WASHINGTON NATIONAL INSURANCE COMPANY
EVIDENCE OF INSURABILITY

PLEASE COMPLETE EACH QUESTION APPLICABLE TO THE CRITICAL ILLNESS COVERAGE SELECTED AND RIDER(S) SELECTED.

The below questions are to be answered for: **ALL CANCER COVERAGE APPLIED FOR**	**Employee / Member**	**Spouse (as defined by state law)**	**Child / Children**
1. Within the past 5 years, has any person proposed for coverage had: a. Blood Disorder b. Carcinoma c. Cirrhosis d. Hepatitis B or C e. Leukemia f. Malignant Tumor g. Cancer or any malignancy h. Chronic Obstructive Pulmonary Disease (COPD) i. Emphysema j. Hodgkin's Disease k. Lymphoma l. Sarcoma	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 5 years, has any person proposed for coverage been treated for or diagnosed as having a pre-malignant condition or a condition with malignant potential?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

REMARKS – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Name of Person	Question No.	Description of illness, injury, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (*include zip code*)

EOI-CN

WASHINGTON NATIONAL INSURANCE COMPANY
EVIDENCE OF INSURABILITY

The below questions are to be answered for: **ALL HEART ATTACK COVERAGE APPLIED FOR**	**Employee / Member**	**Spouse (as defined by state law)**	**Child / Children**
1. Within the past 5 years, has any person proposed for coverage had: a. Angina b. Congestive heart failure(CHF) c. Coronary artery disease(CAD) d. Heart Attack(MI) e. Heart Surgery f. Prescribed Nitroglycerin g. Transient Ischemic Attack(TIA) h. Vascular Insufficiency i. Cardiomyopathy j. Coronary angioplasty(stent) k. Coronary bypass surgery l. Heart Disease m. Peripheral Vascular Disease n. Stroke (CVA o. Uncorrected Congenital Heart Defect p. Any other abnormality of the heart	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the past 5 years, has any person proposed for coverage had or been treated for high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

REMARKS – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Name of Person	Question No.	Description of illness, injury, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (*include zip code*)

EOI-HS

EMPLOYEE / MEMBER ENROLLMENT FORM FOR GROUP INSURANCE
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I hereby certify that the statements made and all information on this Enrollment form on behalf of myself, my Spouse and my Child(ren) are complete, correct and true. I understand that my enrollment form for insurance will be accepted or declined on the basis of these statements.

I authorize the Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and the Company, and are to be paid to the Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. I understand that in order to revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions and abide by any rules specified by the employer's benefit plan and/or by law.

For ages 65 and above, I have received the booklet containing insurance advice for people eligible for Medicare. Additionally, I acknowledge that I have received an Outline of Coverage. The insurance applied for shall be in force as of the date described in the certificate provided the Company approves my enrollment form without any modifications as to the plan amount or premium. If the enrollment form is approved with any such modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me and furthermore shall not take effect if there has been a change in my health as stated since the date of enrollment.

No insurer shall, on the basis of any genetic information concerning a proposed covered person's request for or receipt of genetic services, or refusal to submit to a genetic test or make available the results of genetic test: 1. Terminate, restrict, limit or otherwise apply conditions to the coverage of a Certificateholder under the certificate, or restrict the sale of the certificate to a Certificateholder; 2. Cancel or refuse to renew coverage of a Certificateholder under the certificate; 3. Deny coverage or exclude a Certificateholder from coverage under the certificate; 4. Impose a rider that excludes coverage for certain benefits or services under the certificate; 5. Establish differentials in premium rates or cost sharing for coverage under the certificate; 6. Otherwise, discriminate against a Certificateholder in the provision of insurance.

NOTICE: For this group insurance policy to become effective, a minimum number of employees or members must apply. Your coverage will not go into effect unless the minimum participation requirement is met.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of 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.

Signature of Employee/Member: X_____

Where Signed: _____ Printed Name of Employee/Member _____
City and State

If Agent involved, this Section to be Completed by Agent: I hereby certify that I have explained to the employee/member all exceptions and limitations pertaining to the insurance applied for, including any concerning pre-existing conditions. I hereby certify that I have truthfully and accurately recorded in this application the information supplied by the employee/member. I further certify that I am a licensed agent in the state where this application is being solicited by me and signed by the employee/member.

Date:_____ Signature of Agent:_____

Agency:_____ Agent Number:_____

Agent's E-mail address:_____

Agent's Phone Number:_____

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