

**GROUP ACCIDENT INSURANCE ENROLLMENT FORM**

Enrollment Type:  Initial Enrollment  New Hire  
 Qualifying Event: Date \_\_\_\_\_ Event: \_\_\_\_\_

|   |                      |  |  |                                      |                         |
|---|----------------------|--|--|--------------------------------------|-------------------------|
| <b>Proposed Insured Section – Always complete</b> |                      |  |  |                                      |                         |
| Proposed Insured (First, MI, Last)                |                      |  | Gender<br>M <input type="checkbox"/><br>F <input type="checkbox"/> | Birthdate (mm/dd/yyyy)               | Social Security No.     |
| Home Address – Street                             |                      | City   | State  | Zip Code                             | Employee ID/Payroll No. |
| Email Address                                     |                      |  |  | Home Phone No.<br>Business Phone No. |                         |
| Date Employed                                     | Occupation/Job Title |  | Annual Income  | Hrs. Worked/Week                     | Employee Class          |
| Policyholder Name                                 |                      | Policyholder Address (Street-City-State-Zip) |  |                                      | Section/Dept. No.       |

|  |  |
|--|--|
| <b>Eligibility Information – Always complete</b> |  |
| Are you actively working?                        | Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |  |                        |              |  |
|--|--|------------------------|--------------|--|
| <b>Spouse/Dependent Section – Always complete</b>                                    |  |                        |              |  |
| Is your spouse applying for coverage? If yes, provide identifying information below. |  |                        |              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Name of Spouse (First, MI, Last)   | Gender<br>M <input type="checkbox"/><br>F <input type="checkbox"/> | Birthdate (mm/dd/yyyy) | Relationship | Social Security No.                                      |
| Are there any eligible dependents applying for coverage?                             |  |                        |              | Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |   |     |           |                                  |                     |
|--|---|-----|-----------|----------------------------------|---------------------|
| <b>Beneficiary Information – Employee only</b> |   |     |           |                                  |                     |
| Beneficiary's Name (First, MI, Last)           | Primary <input type="checkbox"/><br>Contingent <input type="checkbox"/> | Age | Benefit % | Relationship to Proposed Insured | Social Security No. |
| Beneficiary's Name (First, MI, Last)           | Primary <input type="checkbox"/><br>Contingent <input type="checkbox"/> | Age | Benefit % | Relationship to Proposed Insured | Social Security No. |

|  |  |           |                              |                 |
|--|--|-----------|------------------------------|-----------------|
| <b>Plan Section</b>                                |  |           |                              |                 |
| Type of Coverage                                   |  | Plan Code | P = Pre-Tax<br>A = After-Tax | Monthly Premium |
| <input type="checkbox"/> Proposed Insured          | <input type="checkbox"/> One Parent Family |           | P <input type="checkbox"/>   |                 |
| <input type="checkbox"/> Proposed Insured & Spouse | <input type="checkbox"/> Two Parent Family |           | A <input type="checkbox"/>   |                 |

**Agreement Section**

I understand that if sickness hospital confinement coverage is applied for, 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 6 months will not be paid. By applying for the coverage indicated above, I am requesting cancellation of existing Accident Insurance with Colonial Life & Accident Insurance Company (base plan and all applicable riders) if the coverage applied for is issued. If for any reason the coverage applied for is not issued, this request for cancellation shall be null and void. With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby certify the statements are true and have been completed to the best of my knowledge and belief.

Signed at: City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

(x) \_\_\_\_\_  
Signature of Named Insured (if applicable)

**Agent Section**

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

(x) \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Licensed Agent (if applicable) mm/dd/yyyy

Agent Name \_\_\_\_\_ License No. \_\_\_\_\_ Code No. \_\_\_\_\_