WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Administered by:
CORPORATE BENEFIT SERVICES OF AMERICA, INC.
Your Benefits Partner
10159 Wayzata Boulevard
Minnetonka, MN 55305-1503

Medical, Dental and Disability Insurance Underwritten by:
Unified Life Insurance Company
Overland Park, Kansas

Life and AD&D Insurance Underwritten by:
Jefferson Pilot Financial Ins. Company
Omaha, Nebraska

Employee Application for Insurance

This Section to be Completed by Your Employer

Group Name _____ Group Number _____ Division Number _____ Class _____

1. REASON FOR APPLICATION

❑ New Coverage

❑ Change in Coverage: Requested Effective Date of Change _____

❑ Add ❑ Delete Coverage for *(name)* _____

❑ Other *(Please describe)* _____

❑ Enrolling for Coverage that I Previously Waived/Declined *(Please check reason at right)*

❑ COBRA Coverage Exhausted ❑ Newborn ❑ Adoption
❑ Spouse's Employer No Longer Contributes to Premium ❑ Marriage
❑ Lost Coverage Through Spouse Date of Event _____

2. INFORMATION ABOUT YOU

Email Address _____ Height _____ Weight _____

❑ Male ❑ Female

Social Security Number _____ Occupation _____

Name _____ Birthdate _____
Last First Middle Initial

Address _____ ( ) _____
Number & Street City County State Zip *Home Phone*

Spouse Address (if different) _____ ( ) _____
Work Phone

Marital Status: ❑ Single ❑ Married; date of marriage _____ ❑ Separated; date separated _____

❑ Divorced; date of divorce _____ ❑ Widowed; date widowed _____

Hours Worked per Week _____ Date Hired/Rehired *(circle one)* to full-time _____ Monthly Earnings$ _____

Are you currently covered by Worker's Compensation? ❑ Yes ❑ No

3. INFORMATION ABOUT YOUR DEPENDENTS (complete Section 8 if waiving dependent coverage)

PLEASE PRINT NAME OF DEPENDENTS APPLYING FOR COVERAGE	SOCIAL SECURITY NUMBER	RELATIONSHIP TO APPLICANT	IF CHILD AGE 19 TO 25 INDICATE IF FULL TIME COLLEGE STUDENT	DATE OF BIRTH MO./DAY/YEAR	HEIGHT	WEIGHT
			❑ YES ❑ NO	/ /		
			❑ YES ❑ NO	/ /		
			❑ YES ❑ NO	/ /		
			❑ YES ❑ NO	/ /		
			❑ YES ❑ NO	/ /		

4. COVERAGE OPTIONS

Please check the coverage(s) you're applying for below. Availability of coverage(s) is based on your employer's selected plan of insurance.

	Medical	Dental	Disability	Life
Employee	❑	❑	❑	❑
Spouse	❑	❑	❑	❑
Child(ren)	❑	❑	❑	❑

Designate Beneficiary if Electing Life Insurance:

Name of Beneficiary _____

Relationship _____

FOR HOME OFFICE USE ONLY

❑ New ❑ Late
❑ Timely
❑ Special
❑ 24 Hr. Cov. +
look.date _____

❑ Previously Insured _____
❑ Employee ❑ Medical ❑ Dental
❑ Spouse ❑ Medical ❑ Dental
❑ Children ❑ Medical ❑ Dental

❑ APS attached (confidential) on _____
❑ Questionnaire attached on _____
❑ PVS attached

Effective Date _____

5. OTHER COVERAGE INFORMATION

This information you provide about other coverage (either prior or current) is necessary to determine whether you will have any waiting periods for pre-existing conditions. It will also help us to coordinate benefits with any other group health plan you may have. **To ensure proper credit towards the pre-existing clause of the policy, attach a Certificate of Creditable Coverage.**

1. Have you or your dependents had health insurance coverage with another carrier(s) at anytime during the last 12 months?
❑ Yes ❑ No If yes, answer the following:

****Provide information (below) about all the health insurance coverage you have had during the previous 12 months****

Name of Policyholder _____ SS# of Policyholder _____

Effective date of policy ____/____/____ Termination date of policy ____/____/____
mo day year *mo day year*

Reason coverage ended: _____

Type of Plan: ❑ Group ❑ Individual ❑ Other Persons covered: ❑ Self ❑ Spouse ❑ Child/ren

Name of insurance company _____ Telephone number _____

Was this a group policy offered through an employer? ❑ Yes ❑ No If yes, provide the following:

Name of employer _____ Telephone number ( ) _____

2. Will you or your dependents continue to be covered under another health insurance plan while you are covered under this Unified Life Insurance Company plan? ❑ Yes ❑ No If yes, answer the following:

Who will continue to be covered: ❑ Self ❑ Spouse ❑ Child/ren

Effective date of policy ____/____/____ Type of plan: ❑ Group ❑ Individual ❑ Other
mo day year

Name of insurance company _____ Telephone number ( ) _____

Is this plan through your spouse's employer? ❑ Yes ❑ No If yes, provide the following;

Name of employer _____ Telephone number ( ) _____

3. Do you or your dependents currently have **Medicare** coverage? ❑ Yes ❑ No If yes, answer the following:

Name of person covered by Medicare _____ Medicare claim number _____

Is Medicare eligibility due to? ❑ Over age 65 ❑ End-stage renal disease ❑ Total disability

Part A effective date ____/____/____ Part B effective date ____/____/____
mo day year *mo day year*

4. Are you or your dependents currently insured by **Unified Life Insurance Company?** ❑ Yes ❑ No

Were you or your dependents previously insured by **Unified Life Insurance Company?** ❑ Yes ❑ No

6. HEALTH INFORMATION

IMPORTANT NOTICE: Any omissions or misstatements in this application may void your coverage or cause an otherwise valid claim to be denied.

1. Is anyone named in this application
   - **a.** currently pregnant? *(If yes, expected due date _____)* ..... ❑ Yes ❑ No
   - **b.** currently taking any medications prescribed by a physician? *(If yes, please list all medications below)* ..... ❑ Yes ❑ No
   - **c.** now disabled or unable to perform normal work- or age-related activities? ..... ❑ Yes ❑ No

   (If yes, please identify names, conditions and dates of disability below.)
2. Has anyone named in this application had a professional medical diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? *(We are not seeking the results of HIV Antibody Test)* ..... ❑ Yes ❑ No
3. Within the last five years, has anyone named in this application been advised or scheduled to have surgery or tests not yet completed? ..... ❑ Yes ❑ No
4. Within the last 10 years, has anyone named in this application been seen, counseled, consulted, or treated for:

Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease/Disorder, Stroke, Circulatory Disorder, or High Blood Pressure	❑	❑	Cancer, Tumor or Abnormal Growth	❑	❑	Menstrual or Gynecological Disorder, or Infertility
❑	❑	Diabetes or Connective Tissue Disorder	❑	❑	Nervous Disorder (including Attention Deficit and Psychological Disorders)	❑	❑	Anemia or Blood Disorder
❑	❑	Allergies, Asthma, Emphysema, Sinus, Nasal or Lung Disease or Disorder	❑	❑	Headaches	❑	❑	The Use of Alcohol, Chemicals, or Other Drugs (Been Advised to Cease or Decrease Use of)
❑	❑	Ulcers, Stomach or Intestinal Disorder	❑	❑	Seizures, Epilepsy	❑	❑	Ear, Skin, or Eye Disorder
			❑	❑	Liver Disorder	❑	❑	Hernia, Rectal Disorder
			❑	❑	Arthritis, Back, Joint or Muscle Disorder	❑	❑	Thyroid, Adrenal Disorder, or Enlargement of the Lymph-nodes
			❑	❑	Kidney, Bladder or Prostate Disorder			

5. Within the last five years, has anyone named in this application had any mental or physical disorders, examination, hospitalization, treatment, medical advice or surgery not mentioned above? ..... ❑ Yes ❑ No

IN THE SPACES BELOW, PLEASE LIST MEDICATIONS AND PROVIDE FULL DETAILS TO QUESTIONS FOR WHICH YOU ANSWERED "YES" ABOVE. IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

QUESTION NO.	FAMILY MEMBER	DATES OF TREATMENT	DATE OF FULL RECOVERY	IDENTIFY THE CONDITION AND TYPE OF TREATMENT RECEIVED	NAME/ADDRESS OF ATTENDING PHYSICIAN/HOSPITAL

7. DISCLOSURES, AUTHORIZATION AND SIGNATURE

The medical policy excludes coverage for health care services relating to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within six months prior to your enrollment date. This waiting period for pre-existing conditions complies with state and federal law and will not exceed a period of 12 months from your enrollment date if you enroll when you're initially eligible or during a special enrollment period, or a period of 18 months if you're a late enrollee. The policy's waiting period for pre-existing conditions will be shortened if you had prior qualifying coverage and had no lapse in coverage of 63 days or more (not including probationary periods). Prior qualifying coverage may be demonstrated by providing the Administrator with a Certificate of Creditable Coverage from your prior plan or health insurance carrier. If you don't have a Certificate of Creditable Coverage, contact your prior plan or carrier. Federal law requires your prior plan to provide you with such a Certificate if you send them a written request within 24 months of the date your coverage ended. If you aren't able to obtain a Certificate of Creditable Coverage after requesting one in writing, the Administrator will assist you in obtaining the necessary information to demonstrate prior qualifying coverage.

If applicable, I authorize my employer to make deductions from my earnings for my share of the cost of the coverage to which I am entitled.

I have answered the above questions to the best of my knowledge and belief. I understand and agree that no coverage shall be in force until: subscription to the Trust has been accomplished, the Administrator approves this application, eligibility requirements have been met, and certificate of insurance is issued, which shall not be valid unless the first period cost is paid. I further understand that this application will become a part of my certificate and any coverage afforded will be in consideration of the answers being true and complete and the premium paid. I also understand that any misstatements or failure to provide sought for information may be used as the basis for rescission of my insurance.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, government agency, insurance company or other organization or person, that has any records or knowledge of me or any family member for whom insurance is requested, to give to the National Health Care Trust, CBSA, Unified Life Insurance Company, Jefferson Pilot Financial or their representative(s) any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Applicant _____ **Date Signed** _____

IMPORTANT: If you're waiving coverage, please complete section 8

8. WAIVER OF INSURANCE

If you wish to waive coverage for yourself and/or your dependents, please complete this section and sign below.

Employee Name _____ **SS #** _____ **Date of Birth** _____

#1 Employee's Refusal of:

- ❑ **Group Medical Insurance**
- ❑ **Dental Insurance**
- ❑ **Life Insurance**

for: ❑ **myself** ❑ **my spouse** ❑ **my child/ren**

#2 Reason for Refusal:

- ❑ **Insured under spouse's plan**
- ❑ **Insured under another plan**
- ❑ **Contribution required**
- ❑ **Other (list explanation)** _____

_____

I hereby certify that I have been given an opportunity to apply for insurance under the Group Insurance policy or policies provided by my employer, and that I have declined to do so.

I understand that by not applying for such insurance, I will not become insured under said policy or policies and will not be entitled to any benefits thereunder.

I further understand that if I and/or my dependents desire to apply for such insurance at a later date, coverage may possibly not be available or I may be required to provide health status information for purposes of group rate setting. Depending on applicable law, coverage may possibly not be issued or penalties such as deferred effective dates or pre-existing limitations may be imposed.

Signature of Applicant _____ Date Signed _____

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents are waiving medical coverage, the following special enrollment periods may be available.

- If you and/or your eligible dependents (including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose eligibility for that other health plan (this includes COBRA coverage), then you and/or your eligible dependents may be able to enroll in this plan within 30 days of the other coverage ending.

- If you and/or your eligible dependents (including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose the employer contribution for that other plan, then you and/or your eligible dependents may be able to enroll in this plan within 30 days of the loss of the employer contribution for the other coverage.

- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the event.

Failure to specify that you are declining coverage because you have other coverage may waive your special enrollment rights as described above.