

Standard Life and Accident Insurance Company

Home Office: One Moody Plaza, Galveston, Texas, 77550

Administrative Office;

5722 I-55 North Frontage Road Jackson, MS 39211

P.O. Box 14067

Jackson, Mississippi 39236 Telephone: 800-800-1397

APPLICATION FOR ENROLLMENT

Organization Name & Number: (if applicable)

Effective Date: _____

APPLICATION FOR INSURANCE

New Application Additional Insured to Certificate No. _____

| | | | | | | | |
|--|-------|--------|------|---------------------|------------|-------|-----|
| NAME | First | Middle | Last | Social Security # | Birth Date | Age | Sex |
| Primary Insured: | | | | | | | |
| Spouse: (Optional) | | | | | | | |
| Dependent Children: (Optional) | | | | | | | |
| | | | | | | | |
| Resident Address: | | | | Billing Address: | | | |
| City | | State | Zip | City | | State | Zip |
| Occupation: | | | | Employer: | | | |
| Home Telephone: () | | | | Work Telephone: () | | | |
| Payment Mode: <input type="checkbox"/> Monthly Payroll Deduction | | | | | | | |
| Beneficiary: | | | | Relationship: | | | |

HEALTH QUESTIONS. If any question is answered "Yes", list the applicable person below who is not eligible for coverage.

- | | | |
|---|-----|-----|
| 1. During the past 5 years has any person intended to be insured: (i.) had symptoms of any of the following; (ii.) consulted with any member of the medical profession about any of the following; or (iii.) been treated by any member of the medical profession for any of the following: | YES | NO |
| a.) disease or abnormalities of the brain or nervous system, including, but not limited to, stroke, epilepsy, seizure, paralysis, Alzheimer's Disease or other dementia, or any degenerative neurological disorder?..... | ___ | ___ |
| b.) diseases or abnormalities of the heart, including, but not limited to heart attack?..... | ___ | ___ |
| c.) cancer, leukemia or Hodgkin's Disease?..... | ___ | ___ |
| d.) emphysema, cystic fibrosis, chronic obstructive pulmonary disease, diabetes, cirrhosis or Crohn's Disease?..... | ___ | ___ |
| e.) During the past 10 years, has any person intended to be insured: | | |
| a.) been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV)?..... | ___ | ___ |
| b.) tested positive for the HIV Infection?..... | ___ | ___ |
| 2. During the past 6 months, has any person intended to be insured: | | |
| a.) other than for any accident, had any hospital confinement of 3 days or longer?..... | ___ | ___ |
| b.) been advised to have or contemplate having a diagnostic test or surgery which has not been completed?..... | ___ | ___ |
| 4. Is any person intended to be insured or any family member (whether or not named in this application) now pregnant?.. | ___ | ___ |
| 5. During the past 3 years, has any person intended to be insured been declined for any health or life insurance?..... | ___ | ___ |
| 6. Does any person intended to be insured, have current coverage under a Medicare Program?..... | ___ | ___ |

| SELECTION OF COVERAGE | Mode Premium* | | | | List any person(s) who answered "Yes" to any questions listed above. This person(s) is/are not eligible for coverage. |
|-----------------------|---------------|---------------------|-----------------------|-------------|--|
| | Individual | Individual & Spouse | Individual & Children | Full Family | |
| Plan Number: | \$ | \$ | \$ | \$ | _____ |
| Total Premium | \$ | \$ | \$ | \$ | _____ |

Home Office Use Only:

| List all health policies in force or applied for (if none, so state). Indicate if the policy applied for is intended to replace said existing policy | | | | | |
|---|--------------|----------|------|------------|---|
| Name of Insured | Company Name | Policy # | Type | Issue Year | Replacement Yes / No |
| | | | | | <input type="checkbox"/> <input type="checkbox"/> |
| | | | | | |
| | | | | | |

AGREEMENTS, REPRESENTATIONS AND UNDERSTANDING

I certify that I have completed the application in my own handwriting or I certify that I have read the completed application. I realize that any false statement or misrepresentation that is material to the risk or hazard assumed may result in loss of coverage under the coverage applied for, subject to the incontestable period, time limit on certain defenses and legal proceedings.

I understand that the acceptance of any certificate issued on this application shall be an acceptance and ratification by me of all corrections, additions or changes made by Standard Life and Accident Insurance Company. Any changes are shown in the space labeled "Home Office Use"; however, any change in amount, class, plan or date of birth is subject to my written consent.

I understand that coverage is effective when: a.) the certificate is issued by Standard Life and Accident Insurance Company; b.) the certificate is received and accepted by me; and c.) the full first premium is paid or an authorization for payroll deduction is received and accepted by Standard Life and Accident Insurance Company; and d.) if there has been no change in my health or occupation since the date below.

I understand that this plan will not pay benefits for preexisting conditions during the first 12 months of coverage. **I understand** that the certificate provides limited benefits, specifically only the benefits which have been selected by the Sponsoring Organization and are set forth in the certificate itself.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance company, the Medical Information Bureau, the Department of Motor Vehicle Registration and paramedical facilities, that retains public records or knowledge regarding my, or my spouse's and our children's health or wellbeing to give Standard Life and Accident Insurance Company or its reinsurers or its legal representative, any and all such information. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s) and referred to elsewhere in this application for insurance. This information will be used for the purposes of underwriting and insurability determinations. Information received regarding my insurability, that of my spouse or my children may be disclosed to the aforementioned institutions for purposes of compliance, clarification, and explanation. This authorization is valid for thirty months from the date the authorization is signed. You, or a person authorized to act on your behalf, are entitled to receive a copy of this authorization form. A picture copy of this authorization shall be as valid as the original.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signature of Proposed Insured

Date

Signature of Spouse (if proposed to be insured)

Date

Return this application to:

Agent (printed) Name

Agent Number

Street Address

Agent's State License Identification Number

City, State, Zip

Signature of Agent