ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (866) 289-7337 • FAX (877) 864-6630

Worksite Group HEALTH ENROLLMENT FORM

PLEASE PRINT WITH BLACK INK

Entire application form must be completed for new applications and for additions or increases to existing coverage; please check the appropriate box.

Name of Group Employer _____

☐ New application ☐ Addition or increase to existing coverage; Certificate No. _____

1. PRIMARY PROPOSED INSURED

First	*Middle*	*Last*	*MM/DD/YYYY*
Legal Name			Date of Birth / /

Social Security No.	☐ Male ☐ Female	Email	Age

Street Address	*City*	*State*	*ZIP+4*
Home Address			

Personal Phone No. ( )	Birth State/Country	Height ft. in.	Weight lbs.

Primary Employer	Gross monthly income $	*MM/DD/YYYY* Full-time Hire Date / /
Title/Occupation	No. of hours worked per week	☐ Active ☐ Disabled ☐ Retired

Duties

2. OTHER PROPOSED INSURED—**SPOUSE**

First	*Middle*	*Last*	*MM/DD/YYYY*
Legal Name			Date of Birth / /

Personal Phone No. ( )	☐ Male ☐ Female	Age	Height ft. in.	Weight lbs.

3. OTHER PROPOSED INSURED—CHILD(REN) (If additional space is needed, attach a separate sheet of paper.)

Legal Name *(First, Middle, Last)*	Gender	Age	Date of Birth
	☐ Male ☐ Female		/ /
	☐ Male ☐ Female		/ /
	☐ Male ☐ Female		/ /
	☐ Male ☐ Female		/ /

4. BENEFICIARIES (If additional space is needed, attach a separate sheet of paper.)

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Date of Birth	Share %
		/ /	
		/ /	
		/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Date of Birth**	**Share %**
		/ /	
		/ /	
		/ /	

5. FOR ALL COVERAGES, please answer the following questions.

1. In the past **90 days**, have you been working less than 30 hours per week or unable to perform any of the duties of your primary occupation? ..... ☐ Yes ☐ No

   If YES, please explain _____

2. Has any Proposed Insured **ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)*, AIDS-related complex *(ARC)* or antibodies to human T-lymphotropic virus type III *(HTLV)*; or had a positive test for human immunodeficiency virus *(HIV)* antibodies? ..... ☐ Yes ☐ No

   If YES, provide name(s) of person(s) _____

Primary Proposed Insured's Name _____

ACCIDENT EXPENSE

Plans	Insured Options	Benefit Options	Riders	Premium Amt.
☐ 24-hour Accident Expense ☐ Off-the-job Accident Expense	☐ Employee ☐ Employee/Spouse ☐ Employee/Child ☐ Family	☐ 1 unit ☐ 2 units	☐ Accident-only Disability Income Rider Benefit Period: ☐ 6-month ☐ 12-month Benefit Amount: ☐ $600 ☐ $1,200 ☐ Wellness Benefit Rider ☐ Other *(specify)* _____	

HEALTH SECTION

Please answer the following question if applying for Accident-only Disability Income Rider.

1. During the past 6 months, has any Proposed Insured missed work for more than 5 consecutive days due to personal injury or illness *(except pregnancy)*? ..... ☐ Yes ☐ No

Primary Proposed Insured's Name _____

DISABILITY INCOME

Plans	Industry Class	Benefit Options	Riders	Premium Amt.
☐ Off-the-job Accident-only Disability Income ☐ Off-the-job Accident and Sickness Disability Income	☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4	Monthly Benefit Amt. $ _____ Benefit Period: ☐ 3 months ☐ 6 months ☐ 12 months ☐ 24 months	☐ Emergency Accident Rider ☐ $100 ☐ $150 ☐ $200 ☐ On-the-job Disability Income Rider ☐ Retroactive Injury Benefit Rider ☐ Spouse Accident-only Disability Income Rider ☐ $600 ☐ $1,200 ☐ Other *(specify)* _____	

Accident-only Elimination: ☐ 0 days ☐ 7 days ☐ 14 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Accident/Sickness Elimination: ☐ 0/7 days ☐ 7/7 days ☐ 0/14 days ☐ 14/14 days ☐ 30/30 days ☐ 60/60 days ☐ 90/90 days ☐ 180/180 days

HEALTH SECTION

Please answer the following questions.

1. During the past **6 months**, has any Proposed Insured missed work for more than 5 consecutive days due to personal injury or illness *(except pregnancy)*? ☐ Yes ☐ No

2. During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? **If YES, please provide complete details in #5 below.** ☐ Yes ☐ No

3. During the past **5 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: disease or disorder of the heart *(including heart attack, heart condition, heart valve disorder)*, circulatory system, liver, lungs *(including chronic obstructive pulmonary disease (COPD) and emphysema)* or kidneys; high blood pressure with reading of 160/100 or higher; hepatitis *(other than type A)*; stroke; transient ischemic attack *(TIA)*; insulin dependent diabetes; cancer *(excluding skin)*; Hodgkin's disease; leukemia; dementia; multiple sclerosis; muscular dystrophy; or alcohol or drug abuse? **If YES, please provide complete details in #5 below.** ☐ Yes ☐ No

4. During the past **5 years**, has any Proposed Insured consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: disease or disorder of the back, neck knees, shoulder or joints; carpal tunnel syndrome; chronic fatigue, fibromyalgia; lupus; or asthma *(requiring steroids)*? **If YES, please provide complete details in #5 below.** ☐ Yes ☐ No

5. **DETAILS:** Enter complete details from questions1-4 below. If additional space is needed, attach a separate sheet of paper.

Question No.	Name *(First, Middle, Last)*	Relationship to Insured	Date(s) of Condition *(MM/DD/YYYY)*	Health Condition and Details	Medical Care Provider's Name/Address/Phone

Primary Proposed Insured's Name _____

CRITICAL ILLNESS

During the past **12 months**, has any Proposed Insured used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... Employee: ☐ Yes ☐ No
Spouse: ☐ Yes ☐ No

Insured Options	Benefit Options	Riders	Premium Amt.
☐ Employee ☐ Spouse ☐ Child	Employee Benefit Amt. $ _____ Spouse Benefit Amt. $ _____ Child Benefit Amt. ☐ $5,000 ☐ $10,000	☐ Cancer Benefit Rider ☐ Cancer Benefit Rider with Recurrence Benefit ☐ Health Screening Benefit Rider ☐ Recurrence Benefit Rider ☐ Other *(specify)* _____	

HEALTH SECTION

1. During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? **If YES, please provide complete details in #7 below.** ..... ☐ Yes ☐ No

2. During the past **10 years**, has any Proposed Insured had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: disease or disorder of the heart *(including heart attack, heart condition, congestive heart failure, heart valve disorder)*, circulatory system *(including peripheral vascular disease, carotid artery disease)*, liver, lungs *(excluding asthma but including chronic obstructive pulmonary disease (COPD) and emphysema)*, kidneys or pancreas, hepatitis *(other than type A)*, stroke, transient ischemic attack *(TIA)*, insulin-dependent diabetes, dementia, Alzheimer's disease, paralysis, multiple sclerosis *(MS)*, muscular dystrophy *(MD)* or alcohol or drug abuse? **If YES, please provide complete details in #7 below.** ..... ☐ Yes ☐ No

3. During the past **6 months**, has any Proposed Insured had any blood pressure readings of 160/100 or higher? **If YES, please provide complete details in #7 below.** ..... ☐ Yes ☐ No

4. During the past **10 years**, has any Proposed Insured needed assistance or personal supervision to perform any activities of daily living *(toileting, transferring, continence, eating, bathing or dressing)*? **If YES, please provide complete details in #7 below.** ..... ☐ Yes ☐ No

5. **If applying for either Cancer Rider:** During the past **5 years**, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for internal cancer, leukemia, lymphoma, Hodgkin's disease, melanoma, malignant tumors or carcinoma in situ? **If YES, please provide complete details in #7 below.** ..... ☐ Yes ☐ No

6. **If applying for either Cancer Rider:** During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised to have diagnostic tests or any medical or surgical procedures by a medical professional that have not been completed or for which results have not been received? **If YES, please provide complete details in #7 below.** ..... ☐ Yes ☐ No

7. DETAILS: Enter complete details from questions1-6 below. If additional space is needed, attach a separate sheet of paper.

Question No.	Name *(First, Middle, Last)*	Relationship to Insured	Date(s) of Condition *(MM/DD/YYYY)*	Health Condition and Details	Medical Care Provider's Name/Address/Phone

Primary Proposed Insured's Name _____

HOSPITAL INDEMNITY

Plan	Insured Options	Benefit Options	Premium Amount
☐ Hospital Indemnity	☐ Employee ☐ Employee/Spouse ☐ Family ☐ Employee/Child	Amount $_____ Period: ☐ 180 days ☐ 365 days Sickness Elimination: ☐ 0 days ☐ 7 days	

Riders

☐ AD&D Rider
Employee $ _____

☐ Diagnostic Rider

☐ Wellness Rider

☐ Critical Illness Rider
☐ $5,000 ☐ $10,000

☐ Emergency Accident Rider
☐ $100 ☐ $150 ☐ $200

☐ Outpatient Sickness Rider
☐ $25 ☐ $50 ☐ $75 ☐ $100

☐ Initial Hospitalization Lump Sum Rider $_____

☐ First Hospital Admission Rider

☐ Intensive Care Unit Rider $ _____

☐ Private Duty Nurse Rider

☐ Surgical/Anesthesia Rider $ _____

☐ Other *(specify)* _____

HEALTH SECTION

Please answer the following questions.

1. Currently or during the past **12 months**, has any Proposed Insured: been hospitalized two or more times, or been hospitalized for five or more days; been advised by a medical professional to be hospitalized or to have any medical or surgical procedures or diagnostic tests performed that have not been completed or for which results have not been received; or undergone evaluation following abnormal test results? ..... ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

2. During the past **12 months**, has any Proposed Insured been hospitalized or received emergency treatment for any of the following: asthma, chronic obstructive pulmonary disease *(COPD)* or emphysema; liver disease or disorder *(excluding hepatitis A)*; Parkinson's disease; anemia; or alcohol or drug abuse?..... ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

3. During the past **3 years**, has any Proposed Insured been hospitalized or received emergency treatment for any of the following: angina *(heart-related chest pain)*, heart attack, heart surgery, arrhythmia with pacemaker or congestive heart failure; cerebral vascular insufficiency, peripheral vascular disease, stroke or transient ischemic attack *(TIA/mini-stroke)*; Crohn's disease or ulcerative colitis; or multiple sclerosis?..... ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

4. During the past **5 years**, has any Proposed Insured been diagnosed with or treated for internal cancer or any malignancy, including but not limited to, carcinoma in situ, sarcoma, malignant melanoma, Hodgkin's disease, leukemia, lymphoma or a malignant tumor? *(For this question only, cancer does not include basal cell or squamous cell carcinoma.)*..... ☐ Yes ☐ No

   If YES, please indicate which Proposed Insured(s) _____

5. Has any Proposed Insured **ever** been diagnosed with or received treatment by a medical professional for any of the following: kidney disease*(excluding kidney stones or urinary tract disorders)*; uncorrected congenital heart defect *(excluding mitral valve prolapse)*;cystic fibrosis or muscular dystrophy; systemic lupus or any other autoimmune disease; insulin-dependent diabetes diagnosed prior to age 30 or diabetes with complications, including but not limited to, retinopathy, neuropathy or nephropathy; senile dementia or Alzheimer's disease; or an organ transplant or the potential need for an organ transplant? ..... ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

If any items in question 1-5 are answered YES, the indicated Proposed Insured will not be covered under this policy or any rider.

Question 6 MUST be answered in all cases if applying for the Critical Illness Rider.

6. **If applying for the Critical Illness Rider:** During the past **10 years**, has any Proposed Insured been diagnosed, treated, hospitalized or prescribed medication by a medical professional for any of the following: disease or disorder of the heart (including heart attack, heart condition, heart valve disorder, congestive heart failure) or circulatory system; stroke or transient ischemic attack (TIA); peripheral vascular disease; carotid artery disease; insulin dependent diabetes; internal cancer; leukemia; lymphoma; Hodgkin's disease; melanoma; malignant tumors or carcinoma in situ? ..... ☐ Yes ☐ No

   If YES to any of the above, please indicate which Proposed Insured(s) _____

Primary Proposed Insured's Name _____

PRIMARY PROPOSED INSURED'S AGREEMENT

I *(We)* agree that:

a. I *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the certificate if attached thereto.

b. No agent is authorized or has power to change or waive any term, provision or condition of this application, or the certificate applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

c. The insurance applied for shall be in force as of the certificate issue date as shown on the certificate schedule and not the date the application is signed. I understand that any premiums deducted before the issue date of the certificate(s) are pre-paid premiums and will be applied to coverage beginning on the issue date. If the certificate(s) is(are) not issued, Assurity will refund any premium deductions it receives.

d. If no certificate is issued and delivered and no benefit is paid, all premiums paid will be returned. If the certificate is issued as applied for or a certificate amendment is accepted by the proposed owner, premium paid will be applied to that certificate.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Issue Date ____/____/____ *MM/DD/YYYY*

Signed at _____ on ____/____/____
City *State* *Date (MM/DD/YYYY)*

_____
Signature of Primary Proposed Insured

AGENT'S STATEMENT AND AGREEMENT

I hereby certify that I have accurately recorded in this application all information supplied by the Primary Proposed Insured. The Primary Proposed Insured has read the completed application, or has had the completed application read to them.

_____ ____/____/____ (____)_____/(____)_____
Signature of Licensed Agent *Date (MM/DD/YYYY)* *Business Phone No. and Fax No.*

_____ _____ _____
Agent's Printed Name *Agent No.* *Group No.*