COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202
APPLICATION FOR GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE

Policyholder Section	
Policyholder Name	Billing Control Number
Policyholder Home (or Corporate) Address Street City State Zip Code	Policyholder Phone Number
Do you have eligible employees located in other states? ☐ Yes ☐ No If "Yes," please list states here:	Plan Administrator Name:
Nature of Business	Effective Date of Coverage (mm/dd/yyyy)

Enrollment Information		
Initial Enrollment Dates	Start Date (mm/dd/yyyy)	Stop Date (mm/dd/yyyy)
(Subsequent Open Enrollment Dates, if any, are subject to the agreement of the Policyholder and Colonial Life & Accident Insurance Company each year)		
Policyholder Eligibility Waiting Period Number of Days _____ *If this is different for the initial and future enrollments, please indicate:* *Initial Enrollment:* _____ *Future Enrollment:* _____		
Eligible Enrollment Period after satisfying the Policyholder Eligibility Waiting Period. Number of Days: 31		

Eligible Class

☐ All Active employees working a minimum of _____ regularly scheduled hours per week. Active employees are those who are working at the worksite for earnings that are paid regularly, and they are performing the material and substantial duties of their regular occupation. The worksite must be:

- The employer's usual place of business;
- An alternative worksite at the direction of the employer; or
- A location to which the named insured's job requires him to travel.

A minimum of 20 hours per week is required and temporary and seasonal employees are excluded.

Number of Eligible Employees	

Employer Contribution		
Is there any employer contribution? If yes, indicate appropriate percent below.	Yes ☐	No ☐
☐ 100% ☐ 75% ☐ 50% ☐ Other:_____		
Who does employer contribution apply to? ☐ Employee ☐ Employee, Spouse, Dependent Children	[redacted]	

Replacement Section	
Is this a replacement of similar coverage?	Yes ☐ No ☐
Previous Company Name	Termination Date of Prior Plan

Guaranteed Issue

- An eligible individual may enroll in coverage during the 31-day period that follows the later of the policy effective date or the date the individual first becomes a member of an eligible class.
- An eligible individual may also enroll in coverage during an open enrollment period, if we and the policyholder mutually agree that an open enrollment will be held. We and the policyholder determine when an open enrollment period, if any, begins and ends.
- An eligible individual who fails to enroll during the 31-day period or during an open enrollment period, if any, must wait until the next open enrollment period to apply for coverage.

Plan Option Applied For - choose only one plan and applicable option(s) to be included:

Base Plan	Optional Benefits	
☐ **Plan 1 (Must include one optional benefit)** Hospital Confinement Benefit _____	**Plan 1: Must include one optional benefit** Health Screening Benefit Accident Only Emergency Room Visit Benefit **** Second Day and Subsequent Day Hospital Confinement Benefit**	 Yes☐ No☐ Yes☐ No☐ Yes☐ No☐
☐ **Plan 2** Hospital Confinement Benefit _____ Outpatient Surgical Procedures Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3	Health Screening Benefit **** Second Day and Subsequent Day Hospital Confinement Benefit**	Yes☐ No☐ Yes☐ No☐
☐ **Plan 3** Hospital Confinement Benefit _____ Outpatient Surgical Procedures Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3 Diagnostic Procedure Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3 Emergency Room Benefit	Health Screening Benefit **** Second Day and Subsequent Day Hospital Confinement Benefit**	Yes☐ No☐ Yes☐ No☐
☐ **Plan 4** Hospital Confinement Benefit _____ Outpatient Surgical Procedures Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3 Doctor Office Visit Benefit	Health Screening Benefit **** Second Day and Subsequent Day Hospital Confinement Benefit**	Yes☐ No☐ Yes☐ No☐
☐ **Plan 5** Hospital Confinement Benefit _____ Outpatient Surgical Procedures Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3 Diagnostic Procedure Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3 Emergency Room Benefit Doctor Office Visit Benefit	Health Screening Benefit **** Second Day and Subsequent Day Hospital Confinement Benefit**	Yes☐ No☐ Yes☐ No☐
☐ ****Custom Plan** Hospital Confinement Benefit _____	Outpatient Surgical Procedures Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Other _____ Diagnostic Procedure Benefit ☐ Option 1 ☐ Option 2 ☐ Option 3 Inpatient Surgical Procedures Benefit _____ Accident Only Emergency Room Visit Benefit _____ Emergency Room Benefit _____ Doctor Office Visit Benefit _____ Health Screening Benefit _____ Second Day and Subsequent Day Hospital Confinement Benefit _____	Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐ Yes☐ No☐

***** Requires Home Office Underwriting Approval***

Agreement Section

With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby state the statements are true and have been completed to the best of my knowledge and belief. It is understood and agreed that this application shall be attached as a part of the Policy applied for and that no Insurance shall be effective until approved by Colonial Life & Accident Insurance Company at its Home Office.

IMPORTANT NOTICE, PLEASE READ

NOTE: This coverage is not intended to replace comprehensive major medical insurance. I understand that this coverage is not major medical coverage. The coverage provides only scheduled, limited indemnity benefits which are designed to cover a part of the cost that a covered person may incur upon the occurrence of a covered injury or sickness, such as a doctor's office visit or a hospitalization. I further agree that we will inform and educate all current and future employees regarding the maximum coverage levels afforded under the policy.

Signed at: City_____ State _____ Date _____
mm/dd/yyyy

(x)_____
(Authorized Signature/Title)

Agent Section

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance Policy in detail; and (d) to the best of my knowledge and belief the proposed Policyholder is financially sound.

(x)_____ License No._____ Code _____
Signature of Licensed Agent

Fraud Warning Notice

For all states except those listed below:	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Arkansas, Louisiana and West Virginia	Any person who knowingly presents a false or fraudulent claim for payment for 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.
Colorado	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.
District of Columbia	**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
Florida	**All statements and information found in the application are deemed representations and not warranties. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree**.
Kentucky Kansas North Carolina	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
Oklahoma	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.
Oregon and Texas	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. If coverage is contested, the company's only obligation will be to refund all premiums paid.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
Virginia	Any person who, with the 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 may have violated state law.