

**COMBINED INSURANCE COMPANY OF AMERICA**  
**Enrollment Form for Group Critical Illness Insurance**

Home Office: Chicago, Illinois  
**FORM #C16670-DC**

I am applying for this coverage based on the following information:

(Home Office Use)	Enrollment Date:
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**ACTION REQUESTED:**  New Certificate  Reinstatement  Conversion  Certificate Change

EMPLOYEE'S (proposed insured) NAME (First MI Last)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr	Age
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)		Work Phone No.	Social Security No.	Employee ID#
Landline Phone No.	Mobile Phone No.	Email		
EMPLOYER NAME	POLICYHOLDER NAME	Hire Date: Mo/Day/Yr	Gross Annual Income	
BENEFICIARY'S Full Name	Relationship	CONTINGENT BENEFICIARY'S Name	Relationship	

Are you actively at work at least 17½ hours each week?

Yes  No

**COVERAGE FOR:**  Employee Only  Employee & Spouse  Employee & Children  Employee, Spouse & Children  
**List all eligible persons to be covered on this plan: Employee; Spouse; and Your Children age 26 or under.**

Name(s)	DOB: Mo/Day/Yr	Relationship	Sex	Indicate if Employee or Spouse used tobacco in any form in the last 12 months
	(as above)	Self	(as above)	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Spouse	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Child 1	M <input type="checkbox"/> F <input type="checkbox"/>	
		Child 2	M <input type="checkbox"/> F <input type="checkbox"/>	
		Child 3	M <input type="checkbox"/> F <input type="checkbox"/>	
		Child 4	M <input type="checkbox"/> F <input type="checkbox"/>	

Spouse includes an Eligible Domestic Partner/Civil Union Partner who resides with and is financially interdependent with the Employee, as defined in the Certificate.

REQUESTED BENEFIT AMOUNT:	PREMIUM - Mode		
Proposed insured: _____	<input type="checkbox"/> Weekly (52)	<input type="checkbox"/> Monthly (12)	<input type="checkbox"/> Bi-Weekly (26)
Spouse: See Schedule Page	<input type="checkbox"/> Semi-Monthly (24)	<input type="checkbox"/> _____	
Child(ren): See Schedule Page			
<b>Total Premium Per Pay Period:</b>			

**IMPORTANT – READ CAREFULLY –** I represent and affirm the following:

**Express Issue (Complete as required)**

	Proposed Insured		Spouse	
	Yes	No	Yes	No
1. Has any proposed insured ever been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 10 years, have you been diagnosed or treated for any of the following: a stroke or transient ischemic attack (TIA); heart attack, or any abnormality of the heart or circulatory system; diabetes except gestational diabetes or any disease of the pancreas; Emphysema, Cystic Fibrosis, or Chronic Obstructive Pulmonary Disease (COPD); any disease or disorder of the liver; kidney failure or end stage kidney disease; Amyotrophic Lateral Sclerosis (ALS); Alzheimer's Disease; Parkinson's Disease or any other disease or disorder of the nervous system; Multiple Sclerosis; Lupus; Sickle Cell Anemia; or within the past 2 years taken 3 or more medications at the same time to control high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the last 5 years has any proposed insured been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor or found to have abnormal results on a cancer screening examination or chest x-ray? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Proposed Insured		Spouse	
	Yes	No	Yes	No
<b>Simplified Issue (Complete additional questions as required)</b>				
1. a. Have two or more members of any proposed insured's immediate family (natural parents, brothers or sisters, either living or deceased) had the same condition (cancer other than skin cancer, diabetes, heart disease or stroke) diagnosed prior to age 60?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Has any proposed insured been hospitalized or treated in the emergency room for a sickness in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past 2 years has any proposed insured been diagnosed or treated for alcohol or drug abuse or been arrested for a DUI?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of proposed insured	Height		Weight	
Employee				
Spouse				

**If proposed insured has answered "Yes" to any of the above questions:**

Question No.	Name of proposed insured/Spouse/Childr(en)	Details (include the condition/illness, dates, and doctor's name & address)

It is very important that you review your enrollment form carefully. Misstatements or omissions could cause an otherwise valid claim to be denied.

**CONFIDENTIALITY OF MEDICAL INFORMATION**

The medical information disclosed on this Enrollment Form will not be disclosed to the employer or any other person without the authorization of the proposed insured.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize Combined Insurance Company of America or its reinsurers to acquire from and authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, medically related facility, insurance company, or consumer reporting agency to release to Combined Insurance Company of America any information regarding me or my past or present health for the purpose of evaluating this Enrollment Form for insurance. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to Combined.

**I understand that any insurance will not take effect unless and until Combined Insurance Company of America approves my enrollment. If coverage cannot be issued as requested under the rules of the Company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued.** I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums).

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Enrollment Form is true and complete to the best of my knowledge and belief.

Any person who knowingly presents a false or fraudulent claim for payment of 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.

X \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Employee

I, the authorized agent, have on the date of application recorded the information as given to me by the Employee.

Signature of Licensed Agent \_\_\_\_\_ Code # \_\_\_\_\_

**REMARKS OR SPECIAL REQUESTS FOR CONVERSION OR CERTIFICATE CHANGE**