

If you want Cancer Coverage fill out this section of questions.

**Cancer Coverage – Insured \$ _____ Insured & Child(ren) \$ _____
Insured & Spouse (with or w/o dependent children) \$ _____ Premium \$ _____**

- Any eligible children applying for coverage? **Yes** ____ **No** ____ **Number of eligible children** _____
- Within past 10 years, have you tested positive for HIV, sought treatment for AIDS or ARC? **Yes** ____ **No** ____ **Dependents** **Y** ____ **No** ____
- Within past 10 years have you been diagnosed with or treated for CANCER of any type? **Yes** ____ **No** ____ **Dependents** **Yes** ____ **No** ____
- In the last 5 years, have you or any person applying for coverage received medical advice or sought treatment for Skin Cancer, including basal cell carcinoma, squamous cell carcinoma or melanoma of Clark's level 1 or 2? **Yes** ____ **No** ____ (if yes complete a skin cancer rider)
- In the past 5 years, have you or any person applying for coverage received advice or sought treatment for cancer, other than skin cancer; or, in the past 12 months have you or others received preventive Hormonal Therapy? **Yes** ____ **No** ____ **Dependents** **Yes** ____ **No** ____

If you want Term Life Insurance fill out this section of questions.

Term Life Insurance – Face Amount \$ _____ Term _____ Riders _____ Premium \$ _____

Spouse name _____ State of Birth _____ DOB _____ Age _____

- Has the applicant been diagnosed, received treatment from a physician for HIV, AIDS and/or ARC? **Yes** ____ **No** ____ **Spouse?** **Yes** ____ **No** ____ **Dependents?** **Yes** ____ **No** ____

-In the past 12 months have you used tobacco in any form? **Yes** ____ **No** ____ **Spouse?** **Yes** ____ **No** ____ **Dependents?** **Yes** ____ **No** ____

-In the past 24 months have you used any illicit drugs or controlled substance not prescribed for you or have you sought treatment for drug or alcohol abuse?
Yes ____ **No** ____ **Spouse?** **Yes** ____ **No** ____ **Dependents?** **Yes** ____ **No** ____

- In the past 24 months have you been charged with operating a motor vehicle under the influence of drugs, alcohol, plead guilty, no contest, been convicted or have a charge pending for any felony or misdemeanor? **Yes** ____ **No** ____ **Spouse** **Yes** ____ **No** ____ **Dependents?** **Yes** ____ **No** ____

Within the past 24 months have you been prescribed 3 or more medications for high blood pressure or been prescribed medication for high blood pressure **AND** cholesterol?
..... **Yes** ____ **No** ____ **Spouse?** **Yes** ____ **No** ____ **Dependents?** **Yes** ____ **No** ____

- In the past 10 years have you received advice, treatment for internal cancer including leukemia, melanoma of Clark's level III or higher? **Yes** ____ **No** ____
Spouse? **Yes** ____ **No** ____ **Dependents?** **Yes** ____ **No** ____

- Have you ever received medical advice or treatment fro: heart attack/angina – cardiac/circulatory surgery – peripheral vascular disease – stroke – chronic kidney(renal) failure – systemic lupus disease – congestive heart failure – emphysema – bipolar disorder – insulin dependent diabetes – diabetes diagnosed prior to age 40 – COPD – schizophrenia – multiple sclerosis – paralysis – chronic hepatitis – hepatitis(except A)? **Yes** ____ **No** ____ **Spouse?** **Yes** ____ **No** ____ **Dependents?** **Yes** ____ **No** ____

Height _____ **Weight** _____ **Spouse Height** _____ **Weight** _____ **Dependent height** _____ **weight** _____ **Additional dependents**

Additional beneficiaries: (continued from first page of information)

Name _____ Age _____ DOB _____ Relationship _____

Name _____ Age _____ DOB _____ Relationship _____

_____ **Disability**

_____ **Accident**

_____ **Cancer**

Effective Date _____

_____ **Life**

_____ **.58** _____ **First Net Fee**

_____ **Deduction Total**

By signing below, I authorize my employer to deduct from my payroll the appropriate amount of my benefit coverage. I acknowledge and understand that the benefits are voluntary and my responsibility for payment of the premium(s) if out of work. I also understand that any changes I make to this benefit after the enrollment period may be subject to additional requirements.

Employee signature to accept _____ **Date** _____

This form may be faxed to the office at **770-914-1306**. Please be sure to fill in the box of each product you are requesting. Remember to sign and date.