

Union Benefit Services – Colonial Life

724 Forestglen Dr. McDonough, GA 30252

770-320-8008 office

770-914-1306 fax 678-469-8107 cell

Open Enrollment

This is a voluntary enrollment period and premiums will be set up to be taken out of your paycheck by direct deposit. If you are interested in meeting with a benefit specialist to enroll, please fill out the following information to save time with paperwork. Keep in mind that the disability coverage is being offered on a **Guaranteed Issue** basis only during this enrollment period.

Social Security # _____ Name _____

Address _____
First M. Last
City St Zip

Gender _____ Date of Birth _____ Marital Status _____ Hire Date _____ Annual Gross Pay _____

Job Title _____ Home Phone _____ Cell Phone _____

Email address _____ Employee _____ Local _____

Beneficiary _____ DOB _____ Age _____ Relationship _____

Additional beneficiaries may be added on reverse side of form or separate sheet of paper.

If you want Disability coverage fill out this section of questions.

Disability Coverage Requested – Monthly benefit \$ _____ Elimination _____

Benefit period _____ Premium Amount \$ _____

- Actively working? Yes ___ No ___ Have you tested positive for HIV/Aids?..... Yes ___ No ___

-In the past 12 months have you been off work 10 or more consecutive days due to illness or injury? Yes ___ No ___

-In the past 12 months have you receiver medical treatment, advice or medication for: heart surgery, heart attack, congestive heart failure, blood pressure or 160/100 or above, TIA, kidney disease(except stones), insulin dependent diabetes, diabetes diagnosed prior to age 40, cancer, hepatitis B/C, cirrhosis, Hodgkin's disease or leukemia? Yes ___ No ___

If you want Accident Care coverage fill out this section of questions.

Accident Care Coverage – Insured \$ _____ Insured & Spouse \$ _____ Parent Family \$ _____

2 Parent Family \$ _____ Number of Eligible Children _____

RIDERS...Sickness Hospital Confinement \$ _____ Health Screening \$ _____ Premium \$ _____

-Have you tested positive for HIV/Aids? Yes ___ No ___ Spouse? Yes ___ No ___ Children? Yes ___ No ___

-In the past 12 months have you been off work 10 or more consecutive days due to illness or injury? ...Yes ___ No ___ Spouse Y ___ N ___

-In the past 12 months have you receiver medical treatment, advice or medication for: heart surgery, heart attack, congestive heart failure, blood pressure or 160/100 or above, TIA, kidney disease(except stones), insulin dependent diabetes, diabetes diagnosed prior to age 40, cancer, hepatitis B/C, cirrhosis, Hodgkin's disease or leukemia? Yes ___ No ___ Spouse Yes ___ No ___ Dependents Yes ___ No ___

-Emp actively working? Yes ___ No ___ Spouse actively working? Yes ___ No ___ If no, is spouse disabled/unable to work? Yes ___ No ___

-Within the past 12 months has any dependent been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer(other than skin) or seizures?.....Yes ___ No ___

-Insured - Height _____ Weight _____ Spouse – Height _____ Weight _____

Spouse Name _____ DOB _____ Age _____

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.