

**Instructions:** Please complete the entire application in black ink. If you are waiving/declining coverage at this time you are still required to complete sections I., III., and V.

**I. General Information**

New Employee  Change Group Name \_\_\_\_\_

Group Number: \_\_\_\_\_ Class: \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_

Requested Action  Add Coverage  Delete Coverage  Beneficiary Change  
 Other (describe) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

Your Name \_\_\_\_\_  
Last First MI Sex Birthdate

Employee Address (Street, City, County, State, Zip) \_\_\_\_\_

Occupation Title \_\_\_\_\_ Earnings \$ \_\_\_\_\_ (Circle One: Annual, Monthly, Weekly, Hourly)

Date of Hire \_\_\_\_\_ Hrs. Worked/Week \_\_\_\_\_ Marital Status  Single  Married

Have you ever applied for, been insured by, or are you currently insured by The EPIC Life Insurance Company?  Yes  No

If yes, provide details: \_\_\_\_\_

List all family members to be insured (first and last name)	Relationship to Employee	Sex	Birth Date	Full-Time Student?
	Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**II. Beneficiary Selection**

Name of primary beneficiary (if multiple, specify allocation%) \_\_\_\_\_

Relationship \_\_\_\_\_

Address of Beneficiary \_\_\_\_\_  
Number and Street City State Zip

Name of contingent beneficiary (optional): \_\_\_\_\_ Relationship \_\_\_\_\_

**III. Coverage Selection**

Please check the coverage(s) you're applying for below. Availability of coverage(s) is based on your group's selected plan of insurance.

Type	Applying For	Waiving/Declining For
Group Term Life Coverage (Includes AD&D if selected by your employer)	<input type="checkbox"/> Myself	<input type="checkbox"/> Myself
Group Dependent Term Life Coverage	<input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Voluntary Term Life Coverage (Includes Voluntary AD&D if selected by your employer)	<input type="checkbox"/> Myself \$ _____ or multiple of salary _____ <input type="checkbox"/> My Spouse \$ _____ <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Supplemental Term Life Coverage (Includes Supplemental AD&D if selected by your employer)	<input type="checkbox"/> Myself \$ _____ <input type="checkbox"/> My Spouse \$ _____ <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Short Term Disability (STD) Coverage	<input type="checkbox"/> Myself	<input type="checkbox"/> Myself
Group Supplemental Short Term Disability (STD) Coverage	<input type="checkbox"/> Myself \$ _____ * Can't exceed 60% pre-disability Basic Weekly Earnings	<input type="checkbox"/> Myself
Group Voluntary Short Term Disability (STD) Coverage	<input type="checkbox"/> Myself \$ _____ * Can't exceed 60% pre-disability Basic Weekly Earnings	<input type="checkbox"/> Myself
Group Long Term Disability (LTD) Coverage <input type="checkbox"/> Base <input type="checkbox"/> Voluntary	<input type="checkbox"/> Myself	<input type="checkbox"/> Myself
Group Dental Coverage <input type="checkbox"/> Traditional <input type="checkbox"/> Base <input type="checkbox"/> Voluntary Traditional <input type="checkbox"/> Buy-up	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents Spousal Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
Group Dental Preferred Provider Coverage <input type="checkbox"/> Traditional PPO <input type="checkbox"/> Voluntary PPO Please provide Preferred Provider Network: _____	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents Spousal Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
Group Vision Coverage	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents Spousal Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No

For Office Use Only	GN	DIV	Class	PP	ED	CC
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## IV. Health Questions

The health questions need to be answered if: (1) your life/STD/LTD amount applied for is over the guarantee issue amount or; (2) you are not applying within 30 days of completing your probationary period.

If question 1-4 are answered "yes" please provide details in the space provided below:

Yes No

1. Within the last ten (10) years have you or any dependent ever had or been treated by a physician or a member of the medical profession for any of the following: heart disorder, high blood pressure, back disorder, stroke, cancer, tumor, diabetes, kidney or liver disease, an immune deficiency disorder, AIDS, AIDS-Related Complex (ARC), respiratory, or any mental or nervous system disorder? AIDS testing received at anonymous counseling and testing sites or through home test kits need not be revealed. We are not seeking the results of HIV antibody tests.  Yes  No
2. Within the last seven (7) years have you or any dependent ever been treated for, arrested in connection with, or been told to have counseling for the use of alcohol or drugs?  Yes  No
3. Within the last five (5) years have you or any dependent received treatment from and/or consulted a physician, psychiatrist, psychologist, or other medical practitioner or taken prescription medication?  Yes  No
4. Have you or any dependents ever had life/disability insurance rejected, rated, or restricted?  Yes  No
5. Employee: Height \_\_\_\_\_ Weight \_\_\_\_\_ Spouse: Height \_\_\_\_\_ Weight \_\_\_\_\_

GIVE COMPLETE DETAILS IF QUESTIONS 1 THROUGH 4 ARE ANSWERED "YES" (FOR ADDITIONAL SPACE, USE SEPARATE SHEET)

Ques. No.	Name of Person Treated and Full Information as to Nature of Ailment	Date Of Onset	Last Date Seen for this Condition	Degree Recovered	Treatment Given	Complete Name, Address, and Phone Number of Attending Physician

## V. Agreement Authorization

I am requesting the coverage(s) I have selected in Section III. above under the group policy(ies) issued by, or which maybe issued by, EPIC, and I authorize my employer to deduct any required contribution to pay for the coverage(s) from my earnings.

**CERTIFICATION:** I represent and certify all of the following: • I am employed by the employer named herein and am working the number of hours indicated on the front of this application; • I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; • I entered each and every answer myself in response to each request for information and/or question; • no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); • such representations are true, accurate, and complete to the best of my knowledge; • I and my spouse and dependent(s) have been given the opportunity to apply for the coverage(s) available to me (us) through my employer; • and I was not pressured nor forced by my employer, the agent or EPIC into waiving/declining any coverage as shown in Section III. above.

**UNDERSTANDING:** I understand: • the representations I make, together with any supplemental representations that I make, shall be the basis for EPIC to issue any coverage; • that no agent has the authority to waive an answer to any question, pass on insurability, make or alter any contract, or waive or alter any of the EPIC's other rights or requirements; • that no coverage will be effective unless and until the date specified by EPIC after this application has been approved by EPIC; • any misrepresentation contained herein may be used to reduce or deny a claim, void coverage, or void the group contract(s) within the contestable period, if such misrepresentation materially affects EPIC's acceptance of the risk; including approving any person for coverage; • if I decline any coverage, future changes in coverage are NOT automatic and will be subject to EPIC approval; • if my death occurs before EPIC has approved in writing any EPIC coverage, the only death benefit provided shall be the lesser of the maximum amount available without evidence of insurability or the maximum amount I am eligible for, under the coverage(s) for which I was eligible.

I understand that EPIC has no liability for anything the agent said or failed to say before, during, or after the application process, that's not subsequently confirmed in writing by an EPIC authorized officer; including, but not limited to, answers given by the agent in response to questions asked by myself, my spouse or my dependent(s). Furthermore, I understand that EPIC is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that isn't expressly contained in a written document provided to them and signed by an EPIC authorized officer.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

**AUTHORIZATION TO RELEASE MEDICAL RECORDS:** I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to EPIC or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA Privacy Regulations"), but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by EPIC to determine eligibility for coverage under my employer's group policy(ies) and that my failure to authorize the release of said information may result in a refusal to issue or provide coverage. I agree that EPIC may release said information to MIB or to EPIC's reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand I may revoke this authorization by providing advance written notice of termination to EPIC at its office in Madison, Wisconsin, and that any information released in reliance on this authorization and prior to such revocation cannot be retrieved. In such case, EPIC, its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless this authorization is revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulations and could be re-disclosed by the person or entity that receives it.

Has any person assisted you in the completion of this form?  Yes  No If yes, please print name: \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Spouse's Signature\* \_\_\_\_\_

Date Signed \_\_\_\_\_

\*Required only if medical questions for spouse need to be answered.