Enrollment Form for Voluntary Group Critical Illness

Kanawha Insurance Company

KMG AMERICA
KANAWHA INSURANCE COMPANY

PLEASE INDICATE: ○ ENROLLMENT FOR NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE

Proposed Insured (Please Print)

Person Proposed for Coverage (First Name, MI, Last Name) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender ○ Male ○ Female

Address (Street or R.R.)

City State ZIP Code Home Telephone ( ) -

Employer Name or Group Number Date of Employment (MM/DD/YYYY) / /

How many hours per week do you work? Employee Class (If Applicable) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender ○ Male ○ Female

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender ○ Male ○ Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender ○ Male ○ Female

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender ○ Male ○ Female

[210 South White Street, Lancaster SC 29720
Mail: Post Office Box 7777, Lancaster SC 29721-7777 1-877-378-1505]
Kanawha Insurance Company is a wholly-owned subsidiary of KMG America.

CRITICAL ILLNESS INSURANCE ○ Employee ○ Spouse ○ Child(ren)

Has any Proposed Insured used any form of tobacco in the last 12 months?.....	Employee	Spouse
	○ Yes ○ No	○ Yes ○ No

Base Plan ○ Vascular ○ Cancer ○ Other Critical Illnesses

Base Benefit Benefit Amount $,000 Total Modal Premium $ .00

Optional Benefits ○ Health Screening ○ Automatic Benefit Increase

Section I: Complete this Section if applying for Guarantee Issue.	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you Actively at work?.....	○	○								
2. Will this coverage replace a critical illness policy or certificate of insurance paid for, by, or through your employer?.....	○	○								
Section II: Complete this Section and Section I if applying for Contingent Guarantee Issue.										
3. Has the Proposed Insured been performing their normal duties at work, home, or school on a full-time basis and not having missed more than 5 consecutive days in the last 12 months due to illness or injury, except for normal pregnancy?.....	○	○								
4. Is any Proposed Insured now being treated, or ever been treated or diagnosed, by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for the antigens or antibodies to an AIDS virus?.....	○	○	○	○	○	○	○	○	○	○
5. In the 6 months prior to the application date, has any Proposed Insured been hospitalized as an inpatient or outpatient, or missed more than 5 consecutive days of work due to an illness or injury, except for normal pregnancy?.....	○	○	○	○	○	○	○	○	○	○
Section III: Complete this Section, Section I and Section II if applying for Simplified Issue. In questions 6 and 7, complete items A, B and/or C as appropriate.										
6. Within the past 5 years, has any Proposed Insured been diagnosed with or treated for:										
A) **Vascular:** Heart disease, including angina; heart attack; congestive heart failure; heart bypass; cerebrovascular disease, including Transient Ischemic Attack (TIA); stroke (blockages or hemmorhage); diabetes; or blood pressure readings above the normal range which have not been controlled with medication?.....	○	○	○	○	○	○	○	○	○	○
B) **Cancer:** Cancer, including melanoma; leukemia; malignant tumors; or skin cancers?.....	○	○	○	○	○	○	○	○	○	○
C) **Other:** Drug abuse or alcohol abuse; disease of the liver, kidney or digestive system; disease or disorder of the lung; diabetes; diseases of the nervous system, including Parkinson's, MS and cerebral palsy; or any disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing, or speech?.....	○	○	○	○	○	○	○	○	○	○
7. To the best of your knowledge and belief, have any 2 of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:										
A) **Vascular:** Heart attack, heart disease or stroke?.....	○	○	○	○	○	○	○	○	○	○
B) **Cancer:** Cancer?.....	○	○	○	○	○	○	○	○	○	○
C) **Other:** Kidney disease or diabetes?.....	○	○	○	○	○	○	○	○	○	○

8. A) Proposed Insured Height (Ft-In) ___ - ___ Weight ___

B) Spouse Height (Ft-In) ___ - ___ Weight ___

C) Child One Height (Ft-In) ___ - ___ Weight ___

D) Child Two Height (Ft-In) ___ - ___ Weight ___

E) Child Three Height (Ft-In) ___ - ___ Weight ___

EMPLOYEE'S REPRESENTATION AND AGREEMENT

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that the above statements are representations and not warranties.

Signed At _____ City ___ State

_____
Signature of Proposed Insured/Owner

___ / ___ / ____
Date (MM/DD/YYYY)

INSURANCE PRODUCER'S USE

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Signature of Licensed Insurance Producer _____
(Not required)

Date (MM/DD/YYYY)
/ /

Insurance Producer Number	% Credit	Insurance Producer Number	% Credit

CARE Ancillary Product Payment Form

Insured's Name: _____

Requested Effective Date:_____ (*all actual effective dates will be determined by underwriting)

Monthly Insurance Premium (all plans selected)..… $_____
Monthly CARE Membership Fee ……..+ $ 1.00
Monthly Administration Fee ……..+ $ 4.00
Total Monthly payment ……...…...= $_____

Please Select and Check one of the Following Payment Methods

☐ VISA Monthly ☐ MasterCard Monthly

**There is a 4% service fee for this option*

1. Please complete the following account information and submit with a check for the first month's premium made payable to Greater Insurance Service
2. Premium will be charged around the 20th of each month for the next month's premium

Account # ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiration Date: ____/____/____

Name as it appears on the card: _____

Cardholders Signature: _____

☐ Personal Account Insurance Deduction (P.A.I.D.) Arranged by Greater Insurance Service Corp

Instructions for P.A.I. D.

1.-Please submit one month's premium made payable to Greater Insurance Service & voided check (no deposit slips)
2.-Premium will be deducted around the 15th of each month for the next month's premium

Please Select the Account Type for Withdrawal ☐ Checking Account ☐ Savings Account

WITHDRAWAL AUTHORIZATION

Name of Depositor _____
(Print name as shown on Financial Institution Records)

To Financial Institution _____
(Address of Institution or Branch where account is maintained)

TRANSMIT/ROUTING ABA#_____

ACCT. NO. _____

PRE-AUTHORIZED WITHDRAWAL PAYMENT METHOD

As a convenience to me, I hereby request and authorize Greater Insurance Service Corp. to pay and charge to my account, maintained at the above named financial institution, for the payment of premiums due on policies I currently have or may purchase and desire to include under the P.A.I.D. Agreement. The amounts will be drawn on my account by and payable to the order of Greater Insurance Service Corp. provided there are sufficient funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing and until Greater Insurance Service Corp. actually receives such notice. I agree that Greater Insurance Service Corp. shall be fully protected in honoring any withdrawals. I understand that if the withdrawal is presented and not honored for any reason and the amount due is not paid, Greater Insurance Service Corp. assumes no responsibility for a policy lapse or cancellation due to non-payment. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of my rights in respect to each such charge shall be the same as if they were signed personally by me. A customer has the right to stop payment of a debit entry by notification to Financial Institution prior to charging account. After account has been charged the customer has the right to have the amount of an erroneous entry immediately credited to their account by Financial Institution up to 15 days following the issuance of statement or 45 days after posting, whichever occurs first.

_____ _____
Date Signature of Depositor

Form: CARE APP 3-11