APPLICATION FOR INSURANCE
Worksite Market

KANAWHA
INSURANCE COMPANY

210 South White Street, Lancaster, SC 29720
Mail: Post Office Box 7777, Lancaster, SC 29721-7777

HOME OFFICE USE ONLY
POLICY NUMBER:

Proposed Insured (Please Print)

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

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Address (Street or R.R.) | Marital Status ○ Married ○ Single ○ Divorced ○ Widowed

City | State | Zip Code | Home Telephone

Employer Name - Location | Date of Employment (MM/DD/YYYY)

Occupation (Exact duties and job title)

Gross Earnings (not including variable compensation)

$, . Per ○ Hour ○ Week ○ Month ○ Annual

Spouse

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

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Child One

Child 1 (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Child Two

Child 2 (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

Child Three

Child 3 (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) | Height (Ft-In) | Weight | Social Security Number | Gender ○ Male ○ Female

	Proposed Insured	Spouse	Dependent Children
1. Have you missed 3 or more consecutive days of work in the past 6 months for any injury or illness other than cold, flu or maternity?	○ Yes ○ No		
2. Has any person to be insured ever been treated or diagnosed by a member of the medical profession for AIDS or tested positive to the AIDS virus (HIV), provided the determination was diagnosed by FDA licensed tests? No test results obtained from an anonymous counseling testing site or the results of a home test kit need be disclosed. (If "Yes," provide name.) _____	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
3. Are you and your spouse (if applying for coverage) citizens of the United States of America or resident legal aliens? (If "No," provide name.) _____	○ Yes ○ No	○ Yes ○ No	
4. How many hours per week do you work?	☐☐☐		

BENEFITS SECTION:

○ **DISABILITY INCOME:** ○ Non OCC ○ 24 Hour (Occ Class: ○ AAA ○ AA ○ A ○ B)

Employee Only

Benefit Period

○ 3 Month ○ 6 Month ○ 12 Month ○ 24 Month

Elimination Period

○ 0/7 ○ 0/14 ○ 7/7 ○ 14/14 ○ 30/30 ○ 90/90 ○ 180/180

Section 125: Pre-tax? ○ Yes ○ No

Monthly Benefit $ ☐,☐☐☐

Total Modal Premium $ ☐☐☐.☐☐

Riders ○ Employee ○ Spouse ○ Child(ren)

○ Emergency Accident ○ 1 Unit ○ 2 Units

○ Hospital Indemnity ○ $40 ○ $50 ○ $60

○ Outpatient Sickness ○ $25 ○ $50

○ COBRA Rider

COBRA Rider Benefit Amount $ ☐,☐☐☐

○ **LIFE INSURANCE:** ○ Employee ○ Spouse ○ Child(ren)

	Proposed Insured	Spouse
Have any persons proposed for coverage used tobacco in any form in the past 12 months?	○ Yes ○ No	○ Yes ○ No
Answer only if applying for Accelerated Living Benefit Rider. Had a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosed prior to age 60? (If "Yes," provide name.) _____	○ Yes ○ No	○ Yes ○ No

Employee Benefit Amount $ ☐☐☐,☐☐☐

Spouse Benefit Amount $ ☐☐☐,☐☐☐

Child Benefit Amount $ ☐☐☐,☐☐☐

Total Modal Premium $ ☐☐☐.☐☐

Beneficiary Name and SSN: _____

Relationship: ○ Parent, Spouse, Child(ren) ○ Other: _____

Plan: ○ L-65 ○ L-95 ○ APL ○ AD&D

○ 5 Year Term ○ 10 Year Term ○ 15 Year Term ○ 20 Year Term ○ 30 Year Term

○ Accelerated Living Benefit Rider ○ 25% ○ 50% ○ 75% ○ 100%

○ Quality of Life Acceleration Benefit Rider

○ Increasing Death Benefit Rider ○ 5% ○ 7.5% ○ 10% ○ 16.67%

○ AD&D Rider: ☐☐☐ % Of Death Benefit

○ **HOSPITAL INDEMNITY PLUS:**

○ Employee ○ Spouse ○ Child(ren)

Total Modal Premium $ ☐☐☐.☐☐

Benefit Amount $ ☐☐☐

Section 125: Pre-tax? ○ Yes ○ No

○ AD&D: ○ $15,000 ○ $30,000

○ Emergency Accident

○ Outpatient Sickness: ○ $25 ○ $50

○ Surgical: ○ $750 ○ $1500

○ **HEALTH CARE PLUS:** ○ $250 ○ $500 ○ Employee ○ Spouse ○ Child(ren)

HI Rider ○ $40 ○ $50 ○ $60 Total Modal Premium $ ___ . ___ Section 125: Pre-tax? ○ Yes ○ No

○ **CASH CANCER:**

○ Employee ○ Spouse ○ Child(ren)

Base Benefit Amount: $ ___ , ___

Premium Payment Period: ○ 20 Years ○ Lifetime

Total Modal Premium $ ___ . ___

Section 125: Pre-tax? ○ Yes ○ No

○ **CANCER PLUS:** Travel Benefit and Wellness Benefit Riders

○ Employee ○ Spouse ○ Child(ren)

Base Benefit Amount: $ ___ , ___

○ Lump Sum Benefit (Equal to 50% of Base Benefit Amount)

○ Hospital Indemnity Rider

Total Modal Premium $ ___ . ___

Section 125: Pre-tax? ○ Yes ○ No

1. Have any persons proposed for coverage ever been diagnosed as having or been treated by a physician for internal cancer, melanoma, leukemia, Hodgkin's Disease or malignant growth? ○ Yes ○ No
2. Have any persons proposed for coverage been diagnosed or been treated by a physician for skin cancer, excluding malignant melanoma, in the past 5 years? ○ Yes ○ No

○ **ACCIDENT INCOME:** ○ Employee ○ Spouse ○ Child(ren) Total Modal Premium $ ___ . ___

○ Preferred ○ Standard

Units: ○ 1 ○ 2 ○ 3 ○ 4 Section 125: Pre-tax? ○ Yes ○ No

○ COBRA Rider COBRA Rider Benefit Amount $ ___ , ___

Beneficiary Name and SSN: _____

_____

Relationship:

○ Parent, Spouse, Child(ren)

○ Other: _____

Have any persons proposed for coverage ever been convicted of DUI, DWI or had driver's license suspended? ○ Yes ○ No

Lost eyesight in one or both eyes or lost any limb or portion of a limb? ○ Yes ○ No

5. Do you have any other similar coverage in force or an application for similar insurance pending with this or any other company? If "Yes," please provide details below..... ○ Yes ○ No

Person Covered Type of Coverage Benefit Amount

_____

_____

_____

6. Will any of the policies applied for replace any coverage currently in force? ○ Yes ○ No

If "Yes," please complete the following.

Person Covered Type of Coverage Company Policy Number Effective Date (MM/YYYY)

_____ ___ / ___

_____ ___ / ___

IF APPLICATION IS SIMPLIFIED ISSUE, COMPLETE QUESTION 7:

7. HAS ANY PERSON PROPOSED FOR COVERAGE:	Proposed Insured		Spouse		Dependent Children	
	Yes	No	Yes	No	Yes	No
(A) Had, within the past 5 years: heart attack, heart disease, heart surgery, uncontrolled high blood pressure (unstable readings or frequent medication changes), stroke, transient ischemic attack (TIA), diabetes, cancer, tumor, leukemia, Hodgkin's Disease, lymphoma, kidney disease, renal failure, blood disorder (excluding any testing for HIV antibodies), liver disease, lung disorder, emphysema, alcohol or drug abuse, multiple sclerosis, cerebral palsy, spina bifida, hepatitis, lupus, sickle cell anemia, muscle or back disorder?..... (If "Yes," provide name.) _____	○	○	○	○	○	○
(B) Been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 3 years?..... (If "Yes," provide name.) _____	○	○	○	○	○	○

Owner/Payor

Please list Life Insurance Owner/Payor's name and address, if other than the Proposed Insured:

First Name | MI | Last Name

Birthdate (MM/DD/YYYY) | Social Security Number

Address (Street or R.R.)

City | State | Zip Code

Signature of Owner, If Named: _____

AGREEMENTS

It is agreed that (a) the statements and answers given in this application are representations and not warranties, (b) this application and any Home Office Amendments attached will be the basis of any insurance issued, (c) no producer has the authority to alter any contract for Kanawha, and (d) no insurance shall take effect until the application is approved by Kanawha Insurance Company.

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.

I have read or had read to me all the questions on this application and I represent the answers given are correct and complete. I also realize that any false statement or misrepresentation may result in loss of coverage under the policy subject to the time limit on certain defenses or incontestability provisions of the policy. I acknowledge that I have been furnished:

☐ Outline of Coverage ☐ Medicare Buyer's Guide (If over age 65) ☐ Life Insurance Buyer's Guide
☐ Accelerated Life Benefits Summary and Disclosure Statement

Signed At _____ (City) (State)

_____ (Signature of Proposed Insured/Owner)

Date (MM/DD/YYYY)

PRODUCER CERTIFICATION I CERTIFY ANY INFORMATION RECORDED BY ME ON THIS APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. IF CHECKED ABOVE, I FURNISHED: OUTLINE OF COVERAGE, MEDICARE BUYER'S GUIDE, LIFE INSURANCE BUYER'S GUIDE, ACCELERATED LIFE INSURANCE BENEFITS SUMMARY AND DISCLOSURE STATEMENT.

Will any of the policies applied for replace any coverage currently in force? ○ Yes ○ No

_____ (Signature of Licensed Resident Insurance Producer)

_____ (Printed Name of Licensed Resident Insurance Producer)

_____ (Producer's License Number or Social Security Number)

1) Producer Number | % Credit | 2) Producer Number | % Credit | 3) 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