COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202
ENROLLMENT FORM - GROUP TERM LIFE INSURANCE

Application Type: ☑ Initial Request ☐ Late Applicant ☐ Rehire
☐ Annual Enrollment ☐ Change in Status ☐ Increase

Note: If you DO NOT ENROLL for coverage for you or your dependent(s) during the initial enrollment period, and / or you apply for coverage over any Guaranteed Issue amount, you will need to complete the Evidence of Insurability form.

SECTION 1: EMPLOYEE (APPLICANT) INFORMATION – Always complete

Proposed Insured Name (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.

Home Address – Street	City	State	Zip Code	Employee ID/Payroll No.

Email Address	Home Phone No. Business Phone No.

Date Employed	Occupation/Job Title	Annual Base Salary	Hrs. Worked/ Week	Employee Class
			40	-na-

Employer Name	Employer Address (Street-City-State-Zip)	Section/Dept. No.
Police Assoc. Prince Wm E5593819	PO BOX 7402 WOODBRIDGE, VA 22195	-na-

SECTION 2: COVERAGE INFORMATION – Always complete

Coverage Elections	**Plan Code**	**Face Amount**	**Monthly Premium**
☑ **Employee** If multiple of salary, indicate multiple selected _____	8BZU	45,000.00	$6.57
☐ **Spouse**	na	na	
☐ **Dependent Children**	na	na	
Is a suite being applied for? ☑ Yes ☐ No Rider Plan Code: ESZM			$3.15
		Total Premium	$9.72

SECTION 3: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage

Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
na	M ☐ F ☐			
na	M ☐ F ☐			
na	M ☐ F ☐			
na	M ☐ F ☐			
na	M ☐ F ☐			

SECTION 4: BENEFICIARY INFORMATION – Employee only

Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

SECTION 5: ELIGIBILITY INFORMATION – Required for Guaranteed Issue and all levels of underwriting		
	Proposed Insured	**Your Spouse**
1. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	Yes ☐ No ☐	
2. Are you actively working? If "No", are you disabled or unable to work?	Yes ☑ No ☐ Yes ☐ No ☐	
3. Is your spouse (if applying for coverage) disabled or unable to work?		Yes ☐ No ☐

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I confirm I have read and understand the Fraud Statement attached. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the policy or certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy or certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the application.

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City_____ State VA Date _____
mm/dd/yyyy

(x)_____
Signature of Proposed Insured

AGENT SECTION

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

Date_____ (x) Greg Woolley
mm/dd/yyyy Signature of Licensed Agent (if applicable)

Agent Name Greg Woolley License No. 531916 Code No. 669905

Example to show results of exercising the Accelerated Death Benefit on a $100,000 life coverage face amount.

1.	Death Benefit of certificate before Death Benefit is advanced	
	Life Coverage Face Amount	$100,000
2.	Benefit Calculation based upon application for this benefit:	
	Amount of Face Amount requested to be advanced	$75,000
	Less adjustments:	
	any due but unpaid premiums	($ 0)
	administrative fee	($200)
	Net benefit prior to discounting	$74,800
	Interest rate used to discount accelerated payment*	6.00%
	Discount factor	0.943397
	Amount of Accelerated Death Benefit	$70,566
3.	Status of benefits on the Date of Payment of Accelerated Death Benefit:	
	Remaining Death Benefit	$25,000

*Will vary based on current yield on 90-day treasury bills.

Signature of Named Insured

Greg Woolley
Signature of Agent

Date signed (MM/DD/YYYY)

Named Insured Social Security Number

Fraud Warning Notice

For all states except those listed below:	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Arizona	For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana and West Virginia	Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
District of Columbia	**WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.
Florida	**All statements and information found in the application are deemed representations and not warranties. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree**.
Kentucky, Kansas and North Carolina	Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.
Maine and Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
Oklahoma	WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon and Texas	Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. If coverage is contested, the company's only obligation will be to refund all premiums paid.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
Virginia	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

COLONIAL LIFE & ACCIDENT INSURANCE COMPANY

REQUIRED DISCLOSURE FORM FOR ACCELERATED DEATH BENEFIT

Consequences of This Benefit:

Receipt of accelerated death benefits MAY AFFECT MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that you have life coverage and own a certificate with an accelerated death benefit may affect your eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

Medical condition allowing the Accelerated Death Benefit	An Accelerated Death Benefit is a benefit that allows you, the named insured, to be advanced a portion of the death benefit if the covered person is diagnosed with a terminal illness after the coverage effective date. *Terminal Illness* means an injury or sickness which results in the covered person having a life expectancy of 12 months or less and from which there is no reasonable prospect for recovery. This Disclosure Form highlights some of the information in Policy Form Group Term Life 1.0. It is not an insurance contract. If there are any inconsistencies between this disclosure form and the policy, then the terms and conditions of the actual policy will control.
Benefit Amount	You may request an amount of up to 75% of the certificate life coverage face amount, but not greater than $150,000. The minimum Accelerated Death Benefit payment is $5,000. The certificate must be in force on the date of payment and must have a life coverage face amount of at least $10,000. The Accelerated Death Benefit amount payable to you is reduced: • first by any due but unpaid premiums; then • by the administrative fee charged by us for Accelerated Death Benefit payments, in the amount in effect at the time of payment, not to exceed $200; then • the remaining sum is discounted for a time period of one year using an interest rate no greater than the greater of: (a) the current yield on 90 day treasury bills; or (b) the current maximum statutory adjustable policy loan interest rate.
To File a Claim	The Accelerated Death Benefit will be paid to you during the covered person's lifetime while the certificate is in force, upon receipt of all of the following: 1. a completed Accelerated Death Benefit request form: and 2. proof that the covered person has been diagnosed with a terminal illness. Such proof will include a statement from the covered person's licensed physician, and any other medical information we deem necessary to confirm the covered person's health status; and 3. written consent of any irrevocable beneficiary or any assignee, if applicable, agreeing that you may elect the death benefit advance.
Benefit Payment	We will pay the Accelerated Death Benefit in a lump sum. Upon payment of the Accelerated Death Benefit, the life coverage face amount of the certificate will be reduced by the amount of Accelerated Death Benefit requested by you.
Taxability of Benefits	The amount paid under this benefit may be taxable. We are not responsible for any tax on or other effects of any benefit paid. As with all tax matters, consult your personal tax advisor to assess the impact of this benefit.
Effect on Benefits	The death benefit will be reduced if you file for and receive an Accelerated Death Benefit. If an Accelerated Death Benefit is paid, the certificate may not be converted and no new coverage can be added to the certificate.