

INSTRUCTIONS FOR EVIDENCE OF INSURABILITY

PART I: EMPLOYER / AGENCY

PLEASE TYPE OR USE BLACK BALL POINT PEN. DO NOT USE CORRECTION FLUID. Please complete Part I in its entirety, including your group number, company name and address. If you are unsure whether or not to complete this form, please consult your Schedule of Benefits.

Evidence of Insurability is required for:

1. Late Enrollments -

A late enrollment occurs when an employee has not enrolled within 31 days of date of eligibility.

IF evidence is required for a late enrollment, please check the box and complete the Total Amount Section.

2. Amounts in excess of Non-Medical Maximums

The Non-Medical Maximum is listed on the Schedule of Benefits.

IF evidence is required due to amounts in excess of Non-Medical Maximums, please check the box and indicate the Non-Medical Maximums. Then, complete the Total Amount Section for amounts the employee would be entitled to if approved and actively at work.

Please have employee complete Parts II, III and IV, in their entirety, sign and date. Please be sure that the employee detaches the disclosure statement.

- IF you have checked **NEW GROUP**, please submit these forms along with your Application or for Group Insurance Participation Agreement to your Sales Representative or Broker.
- IF you have checked **ADDITION TO EXISTING GROUP**, please mail to CareAmerica Life Insurance Company, 50 Beale Street, San Francisco, CA 94105-1808.

NOTE: Failure to accurately complete form will result in delayed processing!

PART II - IV: EMPLOYEE

PLEASE TYPE OR USE BLACK BALL POINT PEN. DO NOT USE CORRECTION FLUID. Complete Parts II, III and IV.

Part II

Fill in only the names of individuals for which Evidence of Insurability is required. For example, if you are not applying for dependent life, you do not need to list spouse and dependent names.

Please make sure that you always complete the date and state of birth, height and weight for each individual.

Part III & IV

Answer all health questions and give details in the space provided in Part IV only for "Yes" answers. Sign and date the form (Spouse's/ Domestic Partner's signature, if applicable) and detach Pre-Notice for your records.

PRE - NOTICE

(tear off for employee's records)

Perf.....

Thank you for enrolling for Group Insurance with CareAmerica Life Insurance Company (CareAmerica Life). As a part of the normal procedure of processing the group policy, information concerning proposed insureds may be obtained relative to each person's insurability.

Information regarding your insurability will be treated as confidential. CareAmerica Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act, The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

CareAmerica Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

PART I: FORM MUST BE TYPED OR COMPLETED IN BLACK BALL POINT PEN — PLEASE PRINT AND PRESS FIRMLY

For CareAmerica Life Use Only

This enrollment form is for a(n): <input type="checkbox"/> New Group <input type="checkbox"/> Addition to Existing Group <input type="checkbox"/> _____ Group Name and Address Completed By _____ <small>Print Name & Title</small> Telephone _____ Group Number _____	TYPE OF APPLICATION (CHECK ONE): <input type="checkbox"/> INITIAL <input type="checkbox"/> INCREASE IN COVERAGE IS THIS APPLICATION DUE TO LATE ENROLLMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO CHECK APPLICABLE PRODUCT(S): <input type="checkbox"/> BASIC LIFE & AD&D <input type="checkbox"/> SUPPLEMENTAL LIFE <input type="checkbox"/> VOLUNTARY LIFE <input type="checkbox"/> SPOUSE/DOMESTIC PARTNER <input type="checkbox"/> DEPENDENTS LIFE <input type="checkbox"/> OTHER	<input type="checkbox"/> APPROVED Eff. Date _____ <input type="checkbox"/> Smoker <input type="checkbox"/> Nonsmoker <input type="checkbox"/> DECLINED Date _____ Reviewed by _____ <input type="checkbox"/> Self Administered <input type="checkbox"/> Direct Billing
		AMOUNT REQUESTED _____ _____ _____ _____ _____

PART II: TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME (Last, First, Initial)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER	PHONE NO. / HOME / WORK	OCCUPATION	BASE ANNUAL EARNINGS
HOME ADDRESS		DATE OF BIRTH	STATE OF BIRTH	HEIGHT ft. in.	WEIGHT
SPOUSE/DOMESTIC PARTNER NAME (If Applying For Dependent Coverage) (Last, First, Initial)		DATE OF BIRTH	STATE OF BIRTH	HEIGHT ft. in.	WEIGHT
UNMARRIED DEPENDENT CHILDREN (Give first name(s) & date(s) of birth.)		DATE OF BIRTH	STATE OF BIRTH	HEIGHT ft. in.	WEIGHT
UNMARRIED DEPENDENT CHILDREN (Give first name(s) & date(s) of birth.)		DATE OF BIRTH	STATE OF BIRTH	HEIGHT ft. in.	WEIGHT

PART III: HEALTH QUESTIONNAIRE — Underline condition & record details in PART IV.

If you are not sure about an answer, your physician will be able to provide you with this information

1. Have you or any of your dependents ever received diagnosis or treatment for (CIRCLE CONDITIONS ANSWERED YES and explain in Section IV.) A. Heart or artery disorder, heart attack, arthritis, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder, stomach and intestine? <input type="checkbox"/> YES <input type="checkbox"/> NO B. High blood pressure? If Yes, last 2 readings and dates: <input type="checkbox"/> <input type="checkbox"/> C. Diabetes, if diabetic, age of onset, how controlled? <input type="checkbox"/> <input type="checkbox"/> D. Cancer, Leukemia, malignant growth or any form of tumor? <input type="checkbox"/> <input type="checkbox"/> E. Epilepsy, or any Mental/Nervous disorder? <input type="checkbox"/> <input type="checkbox"/> F. Paralysis and stroke? <input type="checkbox"/> <input type="checkbox"/> G. Alcoholism, drug, or substance abuse? <input type="checkbox"/> <input type="checkbox"/> H. Have you or any person applying been treated for or diagnosed with: a) Acquired immune deficiency syndrome (AIDS)? <input type="checkbox"/> <input type="checkbox"/> b) Sexually transmitted diseases such as, hepatitis, syphilis, or gonorrhea? <input type="checkbox"/> <input type="checkbox"/> 2. Other than above, have you or any of your dependents within the past five years had any physical disorder not listed above? <input type="checkbox"/> <input type="checkbox"/>	3. Have you or any of your dependents had any physical examinations in the last five years? (If "YES", give details in Section IV below regarding reason for exam, symptoms, treatment or medication and results). <input type="checkbox"/> <input type="checkbox"/> 4. Are you or any of your dependents A. Under observation or receiving treatment? <input type="checkbox"/> <input type="checkbox"/> B. Currently taking any prescribed medication or have you taken any prescribed medication during the past twelve months? (If "YES", list below) <input type="checkbox"/> <input type="checkbox"/> 5. Have you or any of your dependents ever smoked? Packs a day? How many years? If stopped, when? <input type="checkbox"/> <input type="checkbox"/> 6. Have you or any of your dependents ever been denied Life or Health Insurance? If yes, give date and reason <input type="checkbox"/> <input type="checkbox"/> 7. Have you or any of your dependents been convicted of three or more moving violations within the past three years, or have you ever been convicted of driving under the influence of alcohol or drugs? If yes, please provide details, as well as your drivers license number and state of issue on reverse. <input type="checkbox"/> <input type="checkbox"/> 8. Have you or any of your dependents participated in any potentially hazardous sports or hobbies, such as Mountain Climbing, Scuba Diving, Sky Diving or Vehicle Racing (includes Auto, Motorcycle, Boat or other)? If yes, please provide details on reverse. <input type="checkbox"/> <input type="checkbox"/>
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PART IV: Provide details of all "YES" answers given to questions in PART III. — If additional space is required, attach a separate signed and dated sheet.

Question Number & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From	To	Full Name & Complete Address of Attending Physician or Other Practitioner

AGREEMENTS AND AUTHORIZATION: I* have read and agree that the above statements are complete, true and correctly recorded to the best of my knowledge and belief. Further, I understand that CareAmerica Life shall not be liable for any claim on account of death or disability occurring or arising prior to the date of approval of this application at the Home Office of the Company. I authorize the release to CareAmerica Life, or its representatives, of all information and records regarding any medical care, treatment, diagnosis, or advice recommended to or received by me or my dependents. This authorization shall apply broadly. It shall apply without limitation to information and records maintained by any physician, practitioner, medical group, independent practice association, hospital, health care facility, medical care institution, insurance company, broker, agent, employer, the Medical Information Bureau or investigative reporting services. It shall apply without limitation to care, treatment, diagnosis, or advice provided with regard to alcohol abuse, substance abuse, emotional or mental disorders, AIDS (acquired immune deficiency syndrome), or ARC (AIDS related complex). This authorization is valid for 30 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received this Pre-Notice, and understand that coverage will not become effective until date of approval, provided I am actively at work on that day. The applicant's failure to completely and correctly disclose his or her medical history, or the medical history of their dependents, will result in the applicant's coverage being voided from the approval date of said coverage.

***I includes any adult over age 18 applying for coverage.**

Dated at _____, on _____, (CITY, STATE) _____ (MONTH, DAY) _____ (YEAR)

Signature of Employee _____ Spouse/Domestic Partner (if applicable) _____