CAROLINA CARE PLAN®
A MEDICAL MUTUAL OF OHIO COMPANY

Employee Application & Change Form

Individuals in Groups with 2-19 Eligible Employees

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates. The Lincoln National Life Insurance Company is an affiliate of the Lincoln National Corporation.

Order Number: Z7240 R3/11
Dept of Ins. Filing Number: Z7240 R12/10

INSURANCE WAIVER

COMPLETE THE WAIVER SECTION BELOW ONLY if you do not want any coverage or want to waive some of the coverage options.

A. Waived coverages: I do not want (Check all that apply)

☐ Self: ☐ Health ☐ Dental

☐ Dependent: ☐ Health ☐ Dental

1 ______ 2 ______ 3 ______ 4 ______ 5 ______

☐ Life/Disability

B. Please indicate reason for waiving coverage. I have: (Check one)

☐ No coverage

☐ Other coverage: ______

☐ Coverage through my spouse's employer. Company name: ______

C. Terms and Declarations:

I understand that if I check any box in Question A of this Waiver I am choosing not to have those persons covered under the health, life or disability insurance designated, and any later application for enrollment and acceptance will be subject to all underwriting requirements.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or reach the plan's lifetime benefit maximum; or (2) the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends, lifetime maximum is met, or employer's contribution ends). If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

I have read and understand the above terms:

Current Employer: ______

Print Employee Name: ______ Employee Social Security Number: ______

Print Spouse Name: ______ Spouse Social Security Number: ______

Employee Signature: ______ Date: ______

Employee Name	Group/Company #
Social Security #	Section # (required)

1. ACTION REQUESTED

☐ New Policy Application or **☐ COBRA/State Continuation**

Requested Effective Date:________ (Optional)
Select Coverage: (Check all that apply)
- ☐ HMO Product Name:________
- ☐ POS Product Name:________
- ☐ HDHP Product Name:________
- ☐ Vital Access Product Name:________
- ☐ Life Complete Life and Disability Benefit section
- ☐ Other:________

☐ Policy Change

Requested Date of Change:________ (Optional)
Action: (Check the type of change)
- ☐ Address change (Enter new address in Section 2)
- ☐ Add dependent to policy (List dependent(s) in Section 3)
- ☐ Delete dependent from policy (List dependent(s) in Section 3)
- ☐ Add spouse due to marriage. (Common Law applies) (List spouse in Section 3)
- ☐ Name change. Former Name:________
- ☐ Cancel coverage
- ☐ Other

2. EMPLOYEE INFORMATION

Last Name	First Name	MI	Social Security #	Date of Birth (MM/DD/YYYY)	Gender ☐ M ☐ F

Employment Status:
- ☐ Active, Full Time Date of (Re)Hire: ________
- ☐ Retired/Early Retiree
- ☐ COBRA, Expiration Date: ________

Marital Status: ☐ Single ☐ Married, Date Married:________ ☐ Divorced ☐ Separated ☐ Widowed

Job Title	Department #

Home Address	City	State	Zip Code

Email Address	Home Phone Number	Primary Care Physician (optional)

3. COVERED DEPENDENTS

Relationship	First Name	Last Name (if different)	Social Security #	Date of Birth	Gender	Primary Care Physician (optional)
Spouse					☐ M ☐ F	
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F	
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F	
☐ Child[1] ☐ Adopted[2] ☐ Stepchild[1] ☐ Other[2]					☐ M ☐ F	

[1] If over limiting age, Student or Disability Certification form must be attached to this application
[2] Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application

4. OTHER COVERAGE

Medicare Information: Are you or any dependent covered by Medicare? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason for Medicare
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: ________
				☐ Age ☐ End Stage Renal ☐ Disability, Indicate Reason: ________

Important Notice for Medicare Eligible Individuals: If you are entitled to Medicare and Medicare is your primary coverage, you should enroll in and maintain that coverage, because when Carolina Care Plan is the secondary payer to Medicare Part B, Carolina Care Plan's plan will coordinate benefits as if you were covered under Part B, even if you are not. This can result in you being responsible for costs that would have been paid by Medicare. Your broker can assist you with any questions.

(If you are entitled to Medicare because you are over age 65 and your employer employs fewer than 20 employees; or if you are entitled to Medicare due to disability and your employer employs fewer than 100 employees, Medicare will be the primary payer, that is, Medicare must pay benefits before the group health plans pays benefits.)

Continuing Coverage (other than Medicare): Are you or any dependent keeping other health insurance coverage? ☐ Yes ☐ No If yes, please complete the section below:

Policyholder Name	Name and Address of Insurance Co.	Policy Number	Effective Date	Coverage Type	Work Status	Policy Type
				☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

Prior or Ending Coverage: Do you or any dependent have any prior or ending health insurance? ☐ Yes ☐ No If yes, please complete the section below:

- What date did your most recent health insurance become effective? ________
- What date did/will this health insurance terminate?________
- Please indicate the carrier name for the above health insurance: ________

Do you or any dependent have prior coverage with CCP? ☐ Yes ☐ No If yes, please complete the section below:

Group Name ________ Group # ________

Employee Name	Group/Company #
Social Security #	Section # (required)

5. MEDICAL HEALTH QUESTIONNAIRE

Name	Height	Weight	Smoker	Name	Height	Weight	Smoker
Self:			☐Y ☐N	Dependent:			☐Y ☐N
Spouse:			☐Y ☐N	Dependent:			☐Y ☐N
Dependent:			☐Y ☐N	Dependent:			☐Y ☐N

A. MEDICAL CONDITIONS Have you or any listed dependent been treated for, diagnosed as having, or have been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advice for any of the following conditions? If yes, explain in 5c.

A. Cancer
Y N
1. ☐ ☐ Cancer
   Type ________________
2. ☐ ☐ Leukemia
   Type ________________
3. ☐ ☐ Lymphoma
   Type ________________
4. ☐ ☐ Chemotherapy
5. ☐ ☐ Radiation
6. ☐ ☐ Tumor/Cyst

B. Lung/Respiratory
Y N
1. ☐ ☐ Allergies
   Shots ☐Y ☐N
2. ☐ ☐ Asthma
3. ☐ ☐ Cystic Fibrosis
4. ☐ ☐ Emphysema
   Oxygen ☐Y ☐N
5. ☐ ☐ Other________________

C. Muscular/Skeletal
Y N
1. ☐ ☐ Degenerative Disc Disease
2. ☐ ☐ Fibromyalgia
3. ☐ ☐ Herniated Disc
4. ☐ ☐ Osteo Arthritis
5. ☐ ☐ Rheumatoid Arthritis
6. ☐ ☐ Joint Replacement
7. ☐ ☐ Other________________

D. Heart/Circulatory
Y N
1. ☐ ☐ Aneurysm
   Type ________________
2. ☐ ☐ CAD/Angina
3. ☐ ☐ Angioplasty
   Date ________________
4. ☐ ☐ Bypass Surgery
   Date ________________
5. ☐ ☐ Congestive Heart Failure
6. ☐ ☐ Heart Attack
   Date ________________
7. ☐ ☐ Pacemaker/ICD Implant
8. ☐ ☐ Stroke
   Date ________________
9. ☐ ☐ Blood Clot
10. ☐ ☐ Irregular Heart Beat
11. ☐ ☐ Peripheral Vascular
12. ☐ ☐ Anemia, Type ________
13. ☐ ☐ Other Blood Disorder
   Type ________________
14. ☐ ☐ Hypertension
   BP Readings
   1____ 2____ 3____
15. ☐ ☐ High Cholesterol
16. ☐ ☐ Heart Valve Disorder
17. ☐ ☐ Other ______________

E. Endocrine
Y N
1. ☐ ☐ Diabetes (Type 1-Insulin)
2. ☐ ☐ Diabetes (Type 2-Oral)
3. ☐ ☐ Diabetes (Diet/Exercise)
   BS rdgs/HGB/A1C
   1____ 2____ 3____
4. ☐ ☐ Thyroid Disorder
5. ☐ ☐ Pancreatic Disorder
6. ☐ ☐ Other________________

F. Neurological
Y N
1. ☐ ☐ Cerebral Palsy
2. ☐ ☐ Epilepsy
   ☐Grand Mal
   ☐Petit Mal
   Last Seizure Date ______
3. ☐ ☐ Multiple Sclerosis
4. ☐ ☐ Parkinson's Disease
5. ☐ ☐ Other________________

G. Psychological
Y N
1. ☐ ☐ Depression/Anxiety
2. ☐ ☐ Bipolar/Schizophrenia
3. ☐ ☐ Hospitalized
   Date ________________
4. ☐ ☐ Suicide Attempt
   Date ________________
5. ☐ ☐ Other________________

H. Urinary/Bowel/Reproductive
Y N
1. ☐ ☐ Abnormal Pap
   Date ________________
2. ☐ ☐ Normal Follow-Up Pap,
   Date ________________
3. ☐ ☐ Colon Polyps/Diverticulitis
4. ☐ ☐ Crohn's/Ulcerative Colitis
5. ☐ ☐ Gastric Reflux/Ulcer
6. ☐ ☐ Enlarged Prostate
7. ☐ ☐ Kidney Stones
8. ☐ ☐ Infertility Treatments
9. ☐ ☐ Polycystic Ovarian Syndrome
10. ☐ ☐ Endometriosis
11. ☐ ☐ Liver Disorder
12. ☐ ☐ Other ______________

I. Miscellaneous
Y N
1. ☐ ☐ End Stage Renal Failure
2. ☐ ☐ Transplant
   Type ________________
3. ☐ ☐ HIV (Tested Positive)
4. ☐ ☐ Hemophilia
5. ☐ ☐ Lupus
   Type ________________
6. ☐ ☐ Hepatitis
   Type ________________
7. ☐ ☐ Other________________

B. MEDICAL QUESTIONS

Y N
1. ☐ ☐ Have you or any dependent thought you should seek medical advice, been treated for, or told that you have any other condition/disorder/disease/symptoms not listed above? (Explain in 5c)
2. ☐ ☐ Have you or any dependent been hospitalized or operated on? (Explain in 5c)
3. ☐ ☐ Have you or any dependent been advised to have an operation and/or further treatment which has not yet been performed? (Explain in 5c)
4. ☐ ☐ Are you or any dependent currently pregnant or an expectant parent?
   If yes: Name: Due Date: Is this pregnancy considered high risk? ☐ Yes ☐ No
5. ☐ ☐ Are you or any dependent currently taking any medications? (Explain in 5c)
6. ☐ ☐ Do any of the conditions identified involve Worker's Compensation? If yes, please provide the Worker's Compensation Case Number: ____

C. EXPLANATION (Explain all *yes* responses from Medical Conditions and Medical Questions here)

Name	Diagnosis	Treatment Date (From-To)	Treatment/Medication/Dosage (Be Specific)	Recovered Y N
John Doe	Skin Cancer	10/2005-3/2007	Radiation/Medication Xxxxxxx	☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐

Attach a separate sheet if additional space is required.

Employee Name	Group/Company #
Social Security #	Section # (required)

6. PRE-EXISTING CONDITION NOTICE

The following information applies to the health insurance coverage being applied for through Carolina Care Plan, Inc.:

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within no more than a six-month "look-back" period. Generally, this look-back period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the look-back period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption. This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the maximum 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you having creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to your agent or customer service at 1-800-232-2821.

The following information applies to the disability coverage being applied for through Consumers Life Insurance Company:

If disability coverage is approved, and a pre-existing condition limitation or exclusion applies to your coverage, refer to your Certificate for specific information on the limitation or exclusion.

7. LIFE AND DISABILITY BENEFITS

A. COVERAGE SELECTION: Your group insurance program provided by Consumers Life Insurance Company may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to submit evidence of insurability.

Y	N	Basic Coverage(s)	Add/Delete	Total Amount of Coverage Applied
☐	☐	Basic Life		
☐	☐	Basic AD&D		
☐	☐	Dependent Life		
☐	☐	Participation Free Voluntary Life and AD&D* (Can be chosen in increments of $10,000, to a maximum of $50,000)		
☐	☐	Short Term Disability		
☐	☐	Participation Free Short Term Disability (Can be chosen in increments of $50, minimum of $100, to a maximum of $750, not to exceed 66-2/3% of employee's Basic Weekly Wage)		
☐	☐	Long Term Disability		
☐	☐	Supplemental Life		
☐	☐	Supplemental AD&D		

***If electing Participation Free Voluntary Life and AD&D please answer question 1-5 in Section 7C.**

B. PARTICIPATION FREE VOLUNTARY SHORT-TERM DISABILITY PRE-EXISTING CONDITION NOTICE

Consumers Life will not cover a disability which beings in the first 12 months after your effective date of coverage that is caused by, contributed to by, or results from a Pre-existing Condition.

A Pre-Existing Condition is a sickness or injury for which you, within the 12 months prior to your effective date of coverage:

1. received medical treatment, consultation, care of services, including diagnostic measures, or
2. had taken prescribed drugs or medicines.

Employee Name	Group/Company #
Social Security #	Section # (required)

C. ELIGIBILITY QUESTIONS

If electing Participation Free Voluntary Life and AD&D, please answer questions 1-5 below:

1) Have you ever been diagnosed with, treated for or prescribed medication for heart disease, coronary artery disease, stroke, diabetes, kidney disease, liver disease or any form of cancer other than basal cell carcinoma? ☐ Yes ☐ No
2) Have you ever been diagnosed with AIDS, ARC or HIV (tested positive to antibodies for the HIV virus)? ☐ Yes ☐ No
3) Have you ever been diagnosed with Lou Gehrig's Disease (ALS), Downs Syndrome, Multiple Sclerosis, Spina Bifida, Parkinson's disease, Muscular Dystrophy or Cerebral Palsy? ☐ Yes ☐ No
4) In the past two year, have you been denied life insurance by this or any other insurance company? ☐ Yes ☐ No
5) Does your weight, based on your height, fall outside of an acceptable range in the following chart? ☐ Yes ☐ No

Height	Acceptable Weight Range	Height	Acceptable Weight Range
4' 5" but less than 4'6"	72 lbs to 154 lbs	5' 9" but less than 5'10"	125 lbs to 249 lbs
4' 6" but less than 4'7"	75 lbs to 156 lbs	5' 10" but less than 5'11"	129 lbs to 257 lbs
4' 7" but less than 4'8"	79 lbs to 159 lbs	5' 11" but less than 6'0"	132 lbs to 265 lbs
4' 8" but less than 4'9"	82 lbs to 161 lbs	6' 0" but less than 6'1"	136 lbs to 272 lbs
4' 9" but less than 4'10"	85 lbs to 167 lbs	6' 1" but less than 6'2"	140 lbs to 280 lbs
4' 10" but less than 4'11"	88 lbs to 173 lbs	6' 2" but less than 6'3"	144 lbs to 288 lbs
4' 11" but less than 5'0"	91 lbs to 180 lbs	6' 3" but less than 6'4"	148 lbs to 296 lbs
5' 0" but less than 5'1"	95 lbs to 186 lbs	6' 4" but less than 6'5"	152 lbs to 305 lbs
5' 1" but less than 5'2"	98 lbs to 193 lbs	6' 5" but less than 6'6"	156 lbs to 313 lbs
5' 2" but less than 5'3"	101 lbs to 199 lbs	6' 6" but less than 6'7"	160 lbs to 321 lbs
5' 3" but less than 5'4"	104 lbs to 206 lbs	6' 7" but less than 6'8"	164 lbs to 330 lbs
5' 4" but less than 5'5"	108 lbs to 213 lbs	6' 8" but less than 6'9"	168 lbs to 339 lbs
5' 5" but less than 5'6"	111 lbs to 220 lbs	6' 9" but less than 6'10"	172 lbs to 347 lbs
5' 6" but less than 5'7"	114 lbs to 227 lbs	6' 10" but less than 6'11"	177 lbs to 356 lbs
5' 7" but less than 5'8"	118 lbs to 235 lbs	6' 11" but less than 7'0"	181 lbs to 365 lbs
5' 8" but less than 5'9"	121 lbs to 242 lbs	7' 0" but less than 7'1"	184 lbs to 369 lbs

If you have answered "NO" to all of the questions above, you are eligible for voluntary life and AD&D coverage, subject to the terms and conditions of the policy.

If you have answered "YES" to any of the questions above, you are not eligible for voluntary life and AD&D coverage.

D. CLASS AND SALARY INFORMATION

Class:	Earnings: $ ____________	☐ Weekly ☐ Monthy ☐ Annual	Occupation/JobTitle:

E. BENEFICIARY DESIGNATION: (For Employee Only: Must be completed if you have applied for Life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

Last Name	First Name	Date of Birth	Relationship	Benefit %
Primary:				
Primary:				
Contingent:				
Contingent:				

Employee Name	Group/Company #
Social Security #	Section # (required)

8. TERMS AND CONDITIONS

I hereby apply to the carrier(s) offering the coverage indicated on this Application. Carolina Care Plan, Inc. (CCP) is offering the health coverage; Consumers Life Insurance Company (CLIC) is offering the Life, AD&D, and disability coverage; and The Lincoln National Life Insurance Group (LNL) is offering the dental coverage.

I authorize: (1) payroll deduction(s) and remittance of any required contribution for coverage to CCP, CLIC, LNL and/or any affiliates or divisions of these carriers; (2) release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, government agency or person to CCP, CLIC, LNL and/or any affiliates or division of these carriers: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents as long as I am covered under the policy; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize CCP, CLIC and LNL to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two years for the purpose of collecting information regarding this Application.

By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true; and (d) I did not sign a blank or partially completed Application.

I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information CCP, CLIC or LNL requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning benefits that are inconsistent with, or different from, any written information provided by CCP, CLIC or LNL; (d) to bind CCP, CLIC or LNL in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage. All contract terms must be in writing and signed or accepted in writing by an authorized representative of CCP, CLIC or LNL to be binding on these carriers.

I understand and agree that I am responsible for disclosing all information required by this Application, including, but not limited to, all health conditions and diagnoses of which I am aware. I understand and agree that CCP, CLIC and LNL have the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this Application and that I am obligated to disclose even those condition or diagnoses that I do not believe are significant or important. I understand that I have a continuing obligation to report changes in my health status or the health status of any dependent listed on this Application after I sign this Application and before I receive written notice of approval. Changes in health status include, but are not limited to, being treated for or diagnosed as having a medical condition not listed on this Application, or having been recommended for future surgery, diagnostic testing or medical treatment.

I agree that: (a) any untrue or incomplete information, statement or answers on this Application (whether or not intentional), can result in denial of a claim or rescission of coverage and may subject me to legal action by the carrier(s), subject to the policy's incontestability provision; (b) to be eligible for health coverage, I must be an active, full-time employee as defined by the policy; (c) to be eligible for life, disability income and/or dental coverage , I must be actively at work as defined in the group policy. If I am not actively at work on the date my life and/or disability income coverage would become effective, my coverage will not begin until the day I return to work; (d) if coverage is issued, it will be based on full reliance on the information contained in this Application.

My dependents and I understand and agree that any information obtained will not be released by CCP, CLIC or LNL to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to the respective carrier's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by respective carrier's Privacy Office.

I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I have read all of the statements contained in this Application, and declare by signing this Application that I am an eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. Signature of spouse authorizes release of information described in this Application.

Employee Signature	Date	Your Spouse's Signature (If applying for coverage)	Date

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against any insurer, submits any application or files a claim containing a false or deceptive statement is guilty of insurance fraud.