

TYPE:	APPLYING FOR:	WAIVING/DECLINING FOR:
VISION COVERAGE	<input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Children	<input type="checkbox"/> Employee <input type="checkbox"/> Above Dependents
GROUP TERM LIFE COVERAGE (includes AD&D if selected by your employer)	<input type="checkbox"/> Employee If voluntary, \$ _____ or _____ times salary	<input type="checkbox"/> Employee
GROUP DEPENDENT TERM LIFE COVERAGE	<input type="checkbox"/> Spouse <input type="checkbox"/> Children If voluntary, spouse \$ _____	<input type="checkbox"/> Spouse <input type="checkbox"/> Children
GROUP SUPPLEMENTAL TERM LIFE COVERAGE (includes supplemental AD&D if selected by your employer)	<input type="checkbox"/> Employee \$ _____ <input type="checkbox"/> Spouse \$ _____ <input type="checkbox"/> Children The employee must also apply for group term life and AD&D to be eligible for group supplemental term life and AD&D coverage. The employee must apply for group term life, dependent term life and supplemental group term life to be eligible for group supplemental dependent term life.	<input type="checkbox"/> Employee <input type="checkbox"/> Children <input type="checkbox"/> Spouse
GROUP SHORT TERM DISABILITY COVERAGE	<input type="checkbox"/> Employee If voluntary, \$ _____ (Can not exceed 60% of pre-disability earnings) Is anyone named on this application now disabled or unable to perform normal work- or age- related activities? <input type="checkbox"/> NO <input type="checkbox"/> YES If "yes," please identify names, conditions, dates of disability and name and address of attending physician and attach to this application.	<input type="checkbox"/> Employee

BENEFICIARY INFORMATION

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Please indicate at least one or more primary or contingent beneficiaries below if you have applied for Group Term Life Coverage, Accidental Death and Dismemberment (AD&D) Coverage or Short Term Disability Coverage (Survivor Benefit). Contingent beneficiaries are only entitled to receive a benefit if no primary beneficiary survives the employee. Attach additional sheet if necessary.

The employee is the primary beneficiary for all dependent life policies.

NAME	RELATIONSHIP	ADDRESS	PRIMARY OR CONTINGENT	ALLOCATION %	APPLIES TO:
					<input type="checkbox"/> Group Term Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental Life <input type="checkbox"/> STD Survivor Benefits
					<input type="checkbox"/> Group Term Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental Life <input type="checkbox"/> STD Survivor Benefits
					<input type="checkbox"/> Group Term Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental Life <input type="checkbox"/> STD Survivor Benefits

HEALTH QUESTIONS

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The health questions need to be answered if: (1) your amount applied for is over the guaranteed issue amount; or (2) you are not applying within 30 days of completing your New Hire Waiting Period. For any "Yes" answer in Questions 1-4, please provide details in the space provided below:

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 1. Within the last ten (10) years have you or any dependent ever had or been treated for any of the following: heart disorder, high blood pressure, back disorder, stroke, cancer, tumor, diabetes, kidney, or liver disease, an immune deficiency disorder, AIDS, AIDS-Related Complex (ARC), respiratory disorder, or any mental or nervous system disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the last seven (7) years have you or any dependent ever been treated for, arrested in connection with or been told to have counseling for the use of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the last five (5) years have you or any dependent received treatment from and/or consulted a physician, psychiatrist, psychologist or other medical practitioner or taken prescription medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you or any dependent ever had life/disability insurance rejected, rated or restricted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Employee: Height _____ Weight _____ Spouse: Height _____ Weight _____ | | |

GIVE COMPLETE DETAILS OF ANY "YES" ANSWERS FOR QUESTIONS 1 - 4
(USE SEPARATE SHEET IF NECESSARY)

QUES. NO.	NAME OF PERSON TREATED AND FULL INFORMATION AS TO NATURE OF AILMENT	DATE OF ONSET	LAST DATE SEEN FOR THIS CONDITION	DEGREE RECOVERED	TREATMENT GIVEN	COMPLETE NAME/ ADDRESS/PHONE NUMBER OF ATTENDING PHYSICIAN

I am requesting the coverage(s) I have selected above under the group policy(ies) issued by, or which may be issued by TruAssure Insurance Company ("Insurer"). I authorize my employer to deduct any required contribution to pay for the coverage(s) from my earnings. If I am absent from work due to accident or illness at the time my coverage(s) would otherwise become effective, my coverage(s) will not become effective until the day I return to active employment. If a dependent is confined or disabled on the date the coverage(s) would otherwise become effective, I understand such coverage(s) will not become effective until the confinement and/or disability ends for such dependent.

UNDERSTANDING: I understand: • the representations I make, together with any supplemental representations that I make, shall be the basis for the Insurer to issue any coverage; • that no agent has the authority to waive any answer to any questions, pass on insurability, make or alter any contract or waive or alter any of the Insurer's other rights or requirements; • that no coverage will be effective until the date specified by the Insurer after this application has been approved by the Insurer; • any misrepresentation contained herein may be used to reduce or deny a claim, void coverage or void the group contract(s) within the contestable period, if such misrepresentation materially affects the Insurer's acceptance of the risk; including approving any person for coverage; • if I decline any coverage, future changes in coverage are NOT automatic and will be subject to the Insurer's approval; • if my death occurs before TruAssure has approved in writing any TruAssure coverage, the only death benefit provided shall be the lesser of the maximum amount available without evidence of insurability or the maximum amount I am eligible for, under the coverage(s) for which I was eligible.

I understand that the Insurer has no liability for anything the agent/broker said or failed to say before, during, or after the application process, that is not subsequently confirmed in writing by an authorized officer of the Insurer; including but not limited to, answers given by the agent/broker in response to questions asked by myself, my spouse or dependent(s). Furthermore, I understand that the Insurer is not liable for any statement, representation or other information provided to myself, my spouse or my dependent(s) that is not expressly contained in a written document provided to them and signed by an authorized officer of the Insurer.

I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, U.S. Veteran's Administration facility or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., consumer reporting agency or other organization, institution or person that has any record or knowledge of me or my family members to give to the Insurer or their legal representative, reinsurers, authorized agents or designees any and all information about me or any family member to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits and mode of living, including, but not limited to, all medical and health care records.

I understand the information obtained by this authorization will be used by the Insurer to determine eligibility for benefits under my employer's group policy(ies). I further authorize the Insurer at its option to furnish and deliver to my employer or its representative(s) in accordance with the Insurer's insurance policy(ies), this information and also the cost incurred for each health care service, benefit payment made for health care service, date of such payment, recipient of such payment and such other claims, eligibility and other information requested by my employer and as deemed appropriate and necessary by the Insurer. I understand the purpose of and/or need for such disclosure is for said person(s) to conduct audits of claims, evaluations of the policy and/or transfer of claims administration and for any other valid business purpose. Other than as authorized herein, no information will be released by the Insurer to any person or organization, except to reinsuring companies, the Medical Information Bureau, Inc., persons or organizations performing business or legal services in connection with this application or claim; or upon my further authorization or as required by law. I agree this authorization shall be valid for two and one-half years from the date I signed this application.

I understand I may request a copy of this authorization; I agree a photographic copy shall be as the original.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing false deceptive statement is committing a fraudulent act which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

Has any person assisted you in the completion of this form? Yes No

If yes, please print name: _____

I have read and understand each of the questions above and affirm that the recorded answers and statements are true and complete to the best of my knowledge and belief.

Applicant's Signature _____ Date _____

Spouse's Signature* _____ Date _____

*Required only if medical questions for spouse need to be answered.