

MIDWEST SECURITY LIFE INSURANCE COMPANY
Enrollment Form
For 26 + medical lives

A	Last Name	First Name	M.I.	Sex	Date of Birth	
	Street Address	City	State	Zip Code	Social Security #	
	Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
		Date _____	Date _____	Date _____	Date _____	Date _____
	Hours Worked Per Week	Date Employed Full Time	Gross Monthly Salary		FOR HOME USE ONLY Effective Date _____ Individual Number _____ Occupational Code _____	
	Employer Name	Street Address				
City	State	Zip Code				

B	Coverage Selected: <input type="checkbox"/> Select Coverage <input type="checkbox"/> Select Coverage 2000	
	Deductible: _____	Coinsurance: _____
	Coinsurance Maximum: _____	
	Network: _____	
	Group Health:	<input type="checkbox"/> self only <input type="checkbox"/> self and spouse <input type="checkbox"/> self and dependent children <input type="checkbox"/> self, spouse, and dependent children
	Group Life and AD&D:	\$ _____
Dependent Life:	<input type="checkbox"/> yes <input type="checkbox"/> no	
Short Term Disability Income:	\$ _____	
Dental:	<input type="checkbox"/> self only <input type="checkbox"/> self and spouse <input type="checkbox"/> self and dependent children <input type="checkbox"/> self, spouse, and dependent children	
Complete the Waiver of Coverage section (G) only if eligible benefits are Being waived for either the employee, spouse, or dependent children.		

	Sex	Dependent's Name(s)			Date of Birth	Social Security #	Full-time Student
		(Last)	(First)	(M.I.)			
C	Spouse						
	Child						
	Child						
	Child						
	Child						
	Child						
Primary Beneficiary _____		Relationship _____					
Contingent Beneficiary _____		Relationship _____					

D	Medicare Information	
	If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).	
	Are you, your spouse or your child(ren) covered by Medicare Part A? [] Yes [] No Medicare Part B? [] Yes [] No	
	Name of person covered by Medicare: _____	
	If "Yes", reason for Medicare: [] Over Age 65 [] Disability [] End-Stage Renal Disease (ESRD) [] Disability and ESRD	
	Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____	
Medicare Part C (Medicare + Choice) Effective Date: _____		

E Portability Information: Complete to determine appropriate reduction of this plan's pre-existing condition limitation. Attach certification of creditable coverage from your prior plan if you are a new enrollee under the above employer's plan.

Prior Coverage Start Date: _____ End Date: _____

Covered Individuals: _____

Prior plan or carrier name: _____

Reason for ending prior coverage: _____

F

1. Are you or your dependents participating in other group coverage (not being replaced by this plan) or Medicare benefits? Yes No
If yes, name individuals and coverage/company. _____

2. Are you or any dependent currently disabled, pregnant, or anticipating surgery? Yes No
If pregnant, when due? _____
If disabled or anticipating surgery, list person's name, type of disability or surgery, and date of disability or anticipated surgery. _____

3. Have you or any dependent received treatment, had surgery, been hospitalized, or taken medication for any condition in the last 5 years? Yes No If yes, list the person's name, the condition, date of treatment, reason for treatment, medication taken, and degree of recovery. _____

G I have decided not to apply for coverage offered for (check those that apply):

Medical: self spouse dependent children

Dental: self spouse dependent children

Other: _____

Reason for waiving coverage: _____

H To the best of my knowledge, all statements and answers in this application are complete and true.

I authorize any physician, medical practitioner, hospital, clinic or medical related facility, insurance or reinsuring company, having information available as to diagnosis treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse, or my minor children and any other non-medical information of me, my spouse, or my minor children to give Midwest Security or their legal representative, any and all such information.

Any information obtained will not be released by Midwest Security to any person or organization except to reinsuring companies, the Plan Administrator, the Plan Sponsor, Plan consultants, insurance intermediaries, or other persons or organizations performing business or legal service in connection with my application, claim, Plan renewal or as may be otherwise lawfully required or as I may further authorize.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). I authorize deductions for this coverage from my earnings if any such deductions are required. I reserve the right to revoke this deduction authorization at any time upon written notice.

I acknowledge that I have received a copy of the Authorization to Obtain Medical Information. I agree this Authorization shall be valid for two and one half years from the date shown below and that a copy of this Authorization shall be as valid as the original.

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Date: _____ EMPLOYEE'S SIGNATURE **X** _____