



CENTRAL RESERVE LIFE INSURANCE COMPANY

17800 Royalton Road • Cleveland, OH 44136-5197 • 440-572-2400 • www.centralreserve.com

GROUP INSURANCE ENROLLMENT APPLICATION

TYPE OF APPLICATION
[] NEW GROUP
[] ADDITION TO ACCOUNT #
[] ADDING DEPENDENT COVERAGE - ACCOUNT #
[] OTHER

EMPLOYEE OPTIONS
[] Supplemental Life Amount (Not including base amount) \$
[] Life Only (No Medical) Reason:
[] Medical Only (No Life) Available in Arizona and Nevada.
[] Dental Coverage
[] No Dental Coverage (waiver)

Employee Name: Last, Maiden Name (if applicable), First, Middle Initial, Date of Birth: Month, Day, Year, Sex: [] Male, [] Female, Ht.: Ft./In., Wt.: Lbs.

Home Address: Street, Apt.#, City, County, State, ZIP Code, Home Phone #: () , Social Security #

Employer (Exact Name), Employer Phone #: () , Occupations & Duties, Monthly salary/wage amount, Class of Life/STD

Group Term Life Insurance Beneficiary*: Last, First, Middle Initial, Social Security Number, Relationship, Hours worked by Employee per week for participating employer, Is this Seasonal? [] YES, [] NO, Employee's Date Employed Full Time With Company

*If a minor (under age 18) is designated as the beneficiary, provide the name of the guardian who will hold proceeds in trust for the benefit of the minor until minor reaches age 18: (If no beneficiary is designated, benefit will be paid to the estate of the insured.)

[] Single [] Married [] Separated [] Divorced [] Spouse Deceased, Are all Dependents (spouse and/or children) to be insured? [] YES [] NO, Number of Dependents (Spouse and/or children) to be insured:

Spouse's Full Name: Include Maiden Name (if applicable), Social Security #, Date of Birth: Month, Day, Year, Sex: [] Male, [] Female, Ht.: Ft./In., Wt.: Lbs.

Dependent's Name if to be insured, Relationship, Social Security #, Date of Birth: Month, Day, Year, Sex (M/F), Does the Dependent Reside with the Employee?

The soliciting agent has no authority to waive the requirement of full disclosure of health history on this application. You must check each answer to make sure it is correct and complete before you sign. Do not sign a blank application.

- 1. In the past ten years (5 years in IN), have you or any of your dependents been diagnosed as having or been examined, medically advised, or treated in any way for:
a. Heart problem/condition, any circulatory disorder, cancer (malignancy), any precancerous, or pre-leukemic condition, skin cancer, stroke, any birth defect/disorder, blood disorder, anemia, diabetes, respiratory disorder, digestive/intestinal disorder, urinary system disorder, liver disorder, Multiple Sclerosis, Cerebral Palsy, or Alzheimer's disease, history of premature birth or infertility, had any history of complications of pregnancy or high-risk pregnancy?
b. Any nervous, mental, epilepsy or other seizure disorder, paralysis or amputation of any limb, behavioral disorder, or chemical, alcohol or drug abuse or addiction, been arrested for driving under the influence of alcohol or drugs, used illegal drugs, or used prescription medication other than prescribed?
2. In the past ten years, have you or any of your dependents proposed for coverage been treated or diagnosed by a physician or a licensed medical professional as having AIDS or ARC (AIDS-Related Complex) or tested positive for the AIDS (HIV) virus?
3. During the past five years, have you or any of your dependents been examined or treated by a doctor or other health care practitioner or been hospitalized or operated on for any condition not listed above?
4. Are you or any of your dependents currently under a doctor's care, taking medication, contemplating medical/surgical care or treatment in the future, or currently pregnant?

If the answer is "YES" to any of the above questions, provide full details below and address(es) of doctor(s)/hospital(s) and complete the appropriate section(s) of a Health History Questionnaire.

Table with 5 columns: Person w/ condition, Medical condition/diagnosis, Date of onset, Type, frequency, and dates of treatment including medication, Any malignancy

Table with 4 columns: Name of all tests performed, dates and results, If high blood pressure or diabetes, provide three recent blood pressure and/or blood sugar readings and dates, Date of last occurrence, Degree of recovery

Name, Name of Doctor/Hospital/Clinic, Address, Reason Seen/Diagnosis

5. Have you or any of your dependents ever used tobacco in any form? Yes No
 If "YES", indicate the name of user, the kind of tobacco used, how long it has been used, the amount used each day, and date of last use: _____
6. A dependent child age 19 or over may be eligible for coverage until age 23 (maximum age may vary by state law). Are any of the above listed dependent children enrolled as a full-time student (12 credit hours) in an accredited college or university and primarily dependent upon the employee for support? Yes No
 If "YES", provide name(s) of child(ren) and the name(s) and address(es) of school(s) _____
7. If your application is approved, will CRL's plan be replacing other coverage? Yes No
 If "YES," please attach copies of your Certification of Creditable Coverage for you and your dependents. If a Certification of Creditable Coverage is not available, provide the following information:
 Effective date of current coverage: _____ Expected termination date or paid-to-date of current coverage: _____
 Name and address of current carrier: _____
 Are there any dependents listed on this application who are not covered under the policy that is being replaced? Yes No
 If "Yes", please list: _____
 Current Carrier Policy Number: _____ Phone Number: _____

IMPORTANT INFORMATION – PLEASE READ CAREFULLY BEFORE SIGNING APPLICATION

I represent that all answers given in this application are accurate, complete and true. I understand Central Reserve Life Insurance Company (CRL) is relying on my answers in deciding whether to approve this application and that the requested health information must be fully and completely disclosed on this application. I understand the agent has no authority to alter or waive this, or any other, condition of coverage.

I have not disclosed to the agent any health information which is not disclosed on this application. I understand that this application, if accepted, shall become a part of the policy(ies) and any incomplete, incorrect or misleading answers may operate to void any insurance provided to me and my dependents, as stated in CRL's Right to Cancel or Rescind Policy Provision. I understand that any Health History Questionnaire, if completed by me, becomes a part of this application.

I understand that limitations exist on coverage of Preexisting Illnesses. Unless varied by state, Preexisting Illness is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or Treatment was recommended or received during a period of no more than six (6) months prior to the Enrollment Date. Pregnancy, or any condition relating to pregnancy, shall not be considered a Preexisting Illness.

In applying any Preexisting exclusion, CRL will credit the period of time an individual was covered under "Creditable Coverage." Each Insured Person, at the time of termination, is entitled to receive information which provides the period of Creditable Coverage under the plan. CRL must receive a copy of the Certification of Creditable Coverage or other acceptable evidence, for you and your dependents in order for CRL to give proper Preexisting credit. If you have difficulty obtaining coverage information from your prior carrier, CRL will assist you in the process. CRL will accept information regarding Creditable Coverage from another carrier through means other than a written certification (e.g., by telephone). Authorization is hereby granted to request a Certificate of Creditable Coverage for myself or any of my dependents (or any other information required to confirm prior Creditable Coverage) on behalf of myself or my dependents who are applying now or at any time in the future.

I declare that I am working on a full-time basis at least 30 hours per week (24 hours in Oklahoma; 25 hours in Ohio; 17½ hours in Alabama; as defined by the employer in Arizona), and receiving a wage and that I authorize deductions from my earnings of the required contributions, if any, toward the cost of the insurance.

I understand no insurance exists unless and until my employer or I receive notification of approval in writing from CRL's Home Office indicating coverage for me and my dependents and the effective date. If at any time prior to such notification, anyone applying for coverage (including myself, spouse, and dependents), is hospitalized, or has any change in health from what is stated in the application, I agree to inform CRL's Home Office immediately.

I understand that the agent does not have the authority to vary or waive any of the provisions of this application, nor any of the provisions, terms or conditions of any other forms or materials supplied by CRL nor to bind CRL to any promise of coverage.

I, the undersigned, understand that CRL will confirm the information on my application for insurance with a verification telephone call. It is my understanding that this verification call takes approximately ten (10) minutes and is a routine process for those applying for coverage with CRL and that this telephone call will be tape recorded. I understand that I must tell CRL if my health condition or if the health condition of any of my dependents, as stated on the application, changes between the date this application is signed and the date I receive written notification of approval, providing coverage is approved, from CRL's Home Office.

I or my spouse (if applicable) may be contacted at the telephone numbers listed below. [If you cannot be contacted, please call Central Reserve Life at 1-800-253-4651.]

Applicant () Spouse () Telephone No. () _____ Time _____ a.m. / p.m. Work () Home () Other ()
 Applicant () Spouse () Telephone No. () _____ Time _____ a.m. / p.m. Work () Home () Other ()

Notice to VA Insureds about Coordination of Benefits (COB): If you are covered under other group accident and sickness coverage, this other plan may have primary responsibility for covered expenses of other family members who are covered under this plan. Dependent children will receive primary coverage from plans that do not have a COB provision. If a plan does contain a COB provision, primary responsibility for coverage of dependent children is determined either by the month in which each parent's birthday falls, or by gender, depending upon the terms of each plan. Insured persons are required to furnish CRL with information concerning all active plans and the benefits payable from those plans. Upon receipt of this information, CRL will be able to answer questions regarding primary and secondary coverage. For details regarding COB, refer to the certificate booklet for each plan.

Any disputes arising under the Policy are subject to an appeals procedure and arbitration, which may be binding, depending on state law.

Application Authorization

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, employer, or, except in AZ, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to CRL, or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. CRL may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. CRL reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask CRL to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed to determine eligibility for insurance. For determination of benefits, the authorization shall be valid for either the term of coverage of the policy for health insurance products or for the duration of the claim for all other insurance products. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

NOTICE: For New Mexico residents only: We are required by New Mexico law to inform you of the following: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

NOTICE: For Ohio residents only: We are required by Ohio law to inform you of the following: "Any person who, with 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 is guilty of insurance fraud."

NOTICE: For Oklahoma residents only: We are required by Oklahoma law to inform you of the following: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

NOTICE: For Tennessee residents only: We are required by Tennessee law to inform you of the following: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

Signature of Applicant: _____
Date:

Signature of Spouse: _____
(If applying for coverage) Date:

Signature of Adult Child: _____
(If applying for coverage) Date:

Signature of Adult Child: _____
(If applying for coverage) Date:

Signature of Authorized Representative: _____
Relationship/
Authority to Represent: Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

(EMPLOYER GROUPS: Signature of spouse not required when initial group includes ten (10) or more employees applying for medical coverage.)

THE EMPLOYEE MUST SIGN ABOVE IN ORDER FOR ANY COVERAGE TO BE CONSIDERED

