Enrollment Form for Voluntary Group Critical Illness
Kanawha Insurance Company

KMG AMERICA
KANAWHA INSURANCE COMPANY

PLEASE INDICATE: ● ENROLLMENT FOR NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE

Proposed Insured (Please Print)

Person Proposed for Coverage (First Name, MI, Last Name) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Address (Street or R.R.)

City | State | ZIP Code | Home Telephone ( ) -

Employer Name or Group Number | Date of Employment (MM/DD/YYYY) / /

How many hours per week do you work? | Employee Class (If Applicable) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender ○ Male ○ Female

[210 South White Street, Lancaster SC 29720
Mail: Post Office Box 7777, Lancaster SC 29721-7777 1-877-378-1505]
Kanawha Insurance Company is a wholly-owned subsidiary of KMG America.

CRITICAL ILLNESS INSURANCE ○ Employee ○ Spouse ○ Child(ren)

Has any Proposed Insured used any form of tobacco in the last 12 months?.....	Employee	Spouse
	○ Yes ○ No	○ Yes ○ No

Base Plan ● Vascular ○ Cancer ● Other Critical Illnesses

Base Benefit Benefit Amount $ ___,___ Total Modal Premium $ ___.__

Optional Benefits ● Health Screening

	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you Actively at work?.....	○	○								
2. Will this coverage replace a critical illness policy or certificate of insurance paid for, by, or through your employer?.....	○	○								
Evidence of Insurability: Complete Only if Proposed Insured is a Late Enrollee										
3. Has the Proposed Insured been performing their normal duties at work, home, or school on a full-time basis and not having missed more than 5 consecutive days in the last 12 months due to illness or injury, except for normal pregnancy?.....	○	○								
4. Has any Proposed Insured tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?.....	○	○	○	○	○	○	○	○	○	○
5. In the 6 months prior to the application date, has any Proposed Insured been hospitalized as an inpatient or outpatient, or missed more than 5 consecutive days of work due to an illness or injury, except for normal pregnancy?.....	○	○	○	○	○	○	○	○	○	○
6. Within the past 5 years, has any Proposed Insured been diagnosed with or treated for:										
A) **Vascular:** Heart disease, including angina; heart attack; congestive heart failure; heart bypass; cerebrovascular disease, including Transient Ischemic Attack (TIA); stroke (blockages or hemmorhage); diabetes; or blood pressure readings above the normal range which have not been controlled with medication?.....	○	○	○	○	○	○	○	○	○	○
B) **Cancer:** Cancer, including melanoma; leukemia; malignant tumors; or skin cancers?.....	○	○	○	○	○	○	○	○	○	○
C) **Other:** Drug abuse or alcohol abuse; disease of the liver, kidney or digestive system; disease or disorder of the lung; diabetes; diseases of the nervous system, including Parkinson's, MS and cerebral palsy; or any disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing, or speech?.....	○	○	○	○	○	○	○	○	○	○
7. To the best of your knowledge and belief, have any 2 of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:										
A) **Vascular:** Heart attack, heart disease or stroke?.....	○	○	○	○	○	○	○	○	○	○
B) **Cancer:** Cancer?.....	○	○	○	○	○	○	○	○	○	○
C) **Other:** Kidney disease or diabetes?.....	○	○	○	○	○	○	○	○	○	○

8. A) Proposed Insured Height (Ft-In) Weight

B) Spouse Height (Ft-In) Weight

C) Child One Height (Ft-In) Weight

D) Child Two Height (Ft-In) Weight

E) Child Three Height (Ft-In) Weight

EMPLOYEE'S REPRESENTATION AND AGREEMENT

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that the above statements are representations and not warranties.

Signed At _____ City State

_____ Signature of Proposed Insured/Owner

/ / Date (MM/DD/YYYY)

Payroll Deduction Authorization
For
Capital Insurance Agency, Inc.

Department of _____ _____
Location

_____ _____
Employee Name Social Security #

_____
People First Employee ID #

You are hereby requested and authorized to deduct the amount of the premium from my wage each pay period and to transmit it to Capital Insurance Agency, Tallahassee, Florida, in payment of the premium under the policy(ies).

Said deduction shall commence as of _____ and continue each pay period thereafter until (A) termination of my employment, or (B) completion of the premium paying period as provided in the policy, or (C) written notice by me of the cancellation of this order stating when thereafter cancellation shall be effective, or (D) termination of this salary savings system.

I understand that amounts to be deducted may be subject to change without written authorization from me. In the event that my policy involves renewable term insurance, I understand that my premiums may increase on the policy anniversary date and will be changed without written authorization from me. _____ (initials)

Signature of Employee _____ SIGN HERE

Date _____ Witness _____

Policy Register

Policy No.	Effective Date	Description	Monthly / Biweekly Premium	

For Official Use Only

Dist No.	Dept. / Div. Code	Eff. Date of Deduction	Deduction Code	Total Monthly / Biweekly Deduction	Action Processed Date / Initial
			285	0.00	

Updated: 7/1/2007