JOHN ALDEN HEALTH EMPLOYEE ENROLLMENT FORM

TO AVOID DELAYS IN PROCESSING, ALL AREAS MUST BE COMPLETED IN INK BY EMPLOYEE.

This enrollment is for: **Group No.** ____________

❑ New Group ❑ Adding Spouse
❑ New Enrollee ❑ Adding Dependent Coverage No. of Children ________
❑ Coverage Change Main Location City: ____________ State: ________
Requested Effective Date: Month: ____________ ❑ First or ❑ Fifteenth

Company name		Your work address	
Employee's name: last: first: MI:		Social Security No.:	
Employee's address		County	City
State	Zip	Home phone ( )	Work phone ( )
❑ Single	❑ Married: date of legal marriage	❑ Divorced: date of legal divorce	
Date of birth	State of birth	Height: ft in	Weight / Sex
Date employed full-time	Occupation	Hours worked per week for this company	
Current monthly income from this company $		Current status ❑ At work ❑ COBRA ❑ Disability ❑ Retired	

Selected Coverage **If waiving any coverages, complete the waiver section of this form.**

1. ❑ All coverages provided by employer ❑ Life & AD&D (no medical) ❑ Dental Only ❑ Life, AD&D & Dental (no medical)
   ❑ Life amount $ ____________ ❑ Disability amount $ ____________
2. Life Insurance beneficiary's name ____________ Age ________ Relationship ____________
   Address ____________
   If no beneficiary is designated, benefits will be paid according to the terms of the Certificate of Group Insurance.
3. For Employee Choice and/or Dental Choice Plans: Indicate plan selection(s) from employer's billing statement and quote
   ____
   Dental Choice: ❑ PPO ❑ Indemnity

Eligible Dependents To Be Enrolled

Are you enrolling every eligible dependent? ❑ Yes ❑ No Complete the waiver section for any family members that are not to be insured.

Name (Last, First, M.I.)	Sex	Birth Date	State of Birth	Social Security No.	Height	Weight
Legal Spouse				- -	ft in	
Child				- -	ft in	
Child				- -	ft in	
Child				- -	ft in	

Please explain if any child listed above is (a) not your natural child, legally adopted child, or stepchild, (b) not solely supported by you, or (c) not permanently residing in your household. ____________

Required Information About Other Coverage and Prior Coverage

Important: This section must be completed to establish your eligibility for credit to waive all or part of a preexisting condition limitation period. You may be asked to provide a certificate of creditable coverage and/or a copy of both sides of your ID card from your prior carrier(s).

1. Have you and all dependents you are enrolling been covered by this employer's major medical plan(s) for the past 12 months? ❑ Yes ❑ No
2. Have you or your dependents been covered under any major medical plan or plans at any time in the past 12 months? ❑ Yes ❑ No
   a. If yes, who was covered? ❑ Employee ❑ Spouse ❑ Children b. Name of carrier: ____________
   c. Phone number: ( ) ____________ d. Policy/ID Number: ____________ e. Effective date: ____________
   f. Termination date: ____________ Reason: ❑ Left employment ❑ Employer canceled ❑ Nonpayment of premium ❑ Divorce ❑ Other: ____________
   g. Dental coverage included? ❑ Yes ❑ No Ortho coverage included? ❑ Yes ❑ No
   Major Services (i.e. root canal, periodontics, etc.) covered? ❑ Yes ❑ No
3. Do you or your dependents have any other health insurance coverage that will remain in force after you are covered by this plan? ❑ Yes ❑ No. a. If yes, name of carrier: ____________ b. Phone number: ( ) ____________
   c. Name of covered person(s): ____________ d. Type of coverage: ____________
4. Are you or your dependents on ❑ COBRA ❑ Continuation ❑ Medicare? If so, name: ____________
   Effective date: ____________ Reason: ____________

Health History **Please explain all yes and circled answers in the space after question 6.**

1. Have you or any person you are enrolling ever had, been medically advised they had, been treated for, or been referred for counseling for any of the following? **Please circle all that apply:**
   a. Cancer, leukemia, diabetes, paralysis, stroke, or disorder of the heart, muscles, kidneys, liver (including hepatitis) or colon? ❑ Yes ❑ No
   b. Immune disorders, AIDS, sexually transmitted diseases, chronic lung disorders, Kaposi's sarcoma or a positive test for HIV? ❑ Yes ❑ No
   c. Any nervous, mental or behavioral disorder, alcoholism, or chemical, alcohol or drug abuse or addiction, or used illegal drugs or prescription medication other than as prescribed? ❑ Yes ❑ No
2. Are you or any person you are enrolling currently taking prescribed medication, under medical treatment, or been advised of the possibility or necessity of any future treatment or testing? ❑ Yes ❑ No
3. Is any person you are enrolling totally or partially disabled? ❑ Yes ❑ No
   If yes, name____________________ Date of onset: ____________
4. Are you or any family member, enrolling or not, currently pregnant? ❑ Yes ❑ No
   If yes, name: ________________ Due date: __________ Anticipated Complications: ❑ Yes ❑ No
   Multiple Births: ❑ Yes ❑ No

Additional Health Questions

5. Have you or any person you are enrolling ever had, been medically advised they had, or been treated for any of the following? **Please circle all that apply:**
   Disease or disorder of the digestive system, seizure disorder, arthritis, back disorder, other physical disorder or deformity, or medical claims exceeding $10,000 in the last 24 months? ❑ Yes ❑ No
6. Has anyone applying for coverage smoked or used tobacco products during the past 12 months? ❑ Yes ❑ No

For all yes and circled answers above, provide the following information:

Question No. & Ltr.	Name of Patient (Maiden Name if Applicable)	Physician/Clinic (Complete Address & Tel. No.)	Dates Seen	Condition/Diagnosis, Results of Treatment, and Medication Prescribed

Authorization and Signature

I represent that all the information I have provided on this form is complete and true to the best of my knowledge and belief. I understand that John Alden Life Insurance Company will rely on all of this information in deciding whether or not to issue coverage, to determine eligibility for benefits, and that any incorrect or incomplete information may void this insurance. I hereby request to participate in my employer's group plan. All my elections and authorizations shall remain in effect until I change them in writing. I authorize deductions from my earnings of any contributions for continued participation as may be required now or later. I understand that health and disability benefits may be limited or excluded according to the preexisting conditions limitation provisions of the plan. I authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, insurance or reinsurance company, or employer having certain information about me or my dependents to give all such information to John Alden Life Insurance Company or its legal representative. I also authorize John Alden Life Insurance Company to release any information obtained to reinsurance companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required, or as I may further authorize. I agree this authorization shall be valid for two and one half years from the date shown below. I know that I may request to receive a copy of this authorization. I agree that a copy of this authorization shall be as valid as the original. I also acknowledge that I have read the Important Notices About Your Rights that appear on this form. I understand that any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I understand that the agent submitting this enrollment form represents my interests, not those of John Alden Life Insurance Company. The agent has no right to bind coverage, to alter the terms of insurance coverage or enrollment form in any manner, or to adjust any claim for benefits.

Signature of Proposed Insured Employee ____________________________ Date __________

Group Insurance Waiver

If waiving any coverages for yourself or dependents, please complete this waiver section.

All eligible employees and dependents must be listed as either enrolling or waiving coverage when first eligible. If you or any of your eligible dependents do not enroll in John Alden coverage when it is first made available and want to enroll in the future, your coverage may be postponed and/or subject to a preexisting condition exclusion for up to 18 months. This preexisting condition exclusion does not apply to maternity benefits. If you or any of your eligible dependents do not enroll in John Alden dental coverage when it's first made available and want to enroll in the future, your coverage may be subject to extended waiting periods for certain benefits. For further information on the late addition policy for group employers in your state, contact your agent or a John Alden representative.

Persons Waiving	Coverage to Be Waived	Other Coverage	Carrier Name(s)	ID No.(s)	Phone(s)	Effective Date(s)
Employee	❑ All ❑ Medical ❑ All except medical	❑ Medical ❑ Dental				
Spouse	❑ All ❑ Medical ❑ All except medical	❑ Medical ❑ Dental				
Child(ren)	❑ All ❑ Medical ❑ All except medical	❑ Medical ❑ Dental				

Please indicate the type of other coverage in effect and for whom:

❑ Spouse's employer plan	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Medicare/Medicaid	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Military	❑ Employee	❑ Spouse	❑ Child(ren)
❑ COBRA	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Individual	❑ Employee	❑ Spouse	❑ Child(ren)
❑ Other. Explain:	❑ Employee	❑ Spouse	❑ Child(ren)

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or John Alden. I and my dependents have waived such coverage of our own accord.

Print complete name: last, first, and middle initial ______ Company name ______ Date of full-time employment ______

Employee signature ______ Date ______

Detach and keep for your records

Important Notices About Your Rights

Please read these notices carefully. Detach this portion to keep with your health insurance records.

1. To properly underwrite and administer your insurance coverage, we need certain information. You are our main source of information, but we may also collect or verify information by contacting: (a) medical professionals and institutions which have provided care to you or family members proposed for coverage, (b) employers and business associates, (c) friends and neighbors, and (d) insurance companies to which you have applied for coverage or benefits. The nature of information you authorize to be disclosed includes: physical conditions, health histories, avocations, ages, occupations, personal characteristics, use of drugs, alcoholism, mental illness, and communicable diseases.

   Disclosure of personal or privileged information may be made without your authorization to third parties. For example, we may disclose such information to: (a) persons or organizations that perform professional, business or insurance functions for us, such as independent claim examiners or group plan administrators, or (b) other insurance companies to which you have applied for coverage or benefits.

   You have a right to access, correct, and amend personal information appearing in our files, including information contained in investigative consumer reports. A complete description of our information practices and your rights will be sent to you upon request.

2. Data regarding the insurability of any person proposed for coverage is confidential. We may, however, make a brief report to the Medical Information Bureau. The bureau is a nonprofit organization of life insurance companies operating an information exchange for its members.

(Continued)

JOHN ALDEN Application Instructions

Print this form, Initial items below, and Return with your application!

1. Be sure to fill out the requested policy information on page 2 at the top.
2. Each question must be answered for all family members applying for coverage.
3. Any "yes" answers must be explained in full.
4. DO NOT USE WHITE OUT. If you make a mistake, cross it out, initial the change and put the correct answer next to it.
5. Be sure to sign the application where indicated. Do Not Date The Application Until You Are Ready to Return to Us. If coverage is for a child only, the parent or legal guardian must endorse the application.
6. If you should run out of room for any "yes" answers, include a separate sheet with the additional details. All applicants must sign the additional sheets or your application may be returned.
7. Include the $20 Processing Fee with the first premium & attach a voided check if requesting bank draft.

Please initial these items and return this form along with your application.

______I have reviewed the benefit outline contained in the sales brochure describing the policy.

______I have checked each question and explained all "yes" answers.

______I have reviewed and / or have read the list of exclusions / limitations that are listed in the sales brochure.

______I have signed where indicated on the application and on any additional information sheets.

______I am enclosing a check for the first month's premium payable to the insurance company.

______If requesting a monthly payment, I have signed the Automatic Withdrawal form and enclosed a voided check for the appropriate account.

______I realize that this initial check may be cashed, but that it is fully refundable if not approved.

______I will continue my current coverage, if applicable, until the insurance company has accepted me.

______I realize that effective dates are NOT GUARANTEED and totally contingent on approval by the insurance company.

______I realize that any requests for medical records or additional information may slow the approval process.

______I also realize that any past medical history may result in a higher premium and / or restricted coverage.

______I understand that this policy is not "Guaranteed Issue" and can be declined or otherwise altered.

______I further understand that if prior medical information is knowingly excluded from the application that my future insurability could be affected.

______I am in receipt of and have read the **Privacy Notice** and the **Portability Statement**.

Please Return. *We Cannot Process Your Application Without This Form*

If you have any further questions or concerns, please call us at 623-435-8400 and we will be glad to help.