APPLICATION FOR GROUP INSURANCE TO

PEKIN LIFE INSURANCE COMPANY

Please Print in Black Ink

☐ New Applicant ☐ Change in Coverage/(requested effective) _____ ☐ Beneficiary Change
☐ Addition of Dependent/Spouse ☐ Delete Dependent/Spouse (Date of Event) _____ ☐ Address Change

EMPLOYER _____ **POLICY NO.** _____

Section 1 Employee

Name (Last First Middle) | Date of Birth M D Y | Soc. Sec. No.

Home Address | City | State | Zip Code | Marital Status

Sex | Height | Weight | Occupation Title | Hours Worked Per Week | Annual Salary (If Applicable) $ | Date Employed Full-Time

Employee Status:
☐ Active ☐ COBRA ☐ Retired
☐ Rehired ☐ Continuation ☐ Other Leave

Effective Date of COBRA/Continuation or Other Leave (Month/Day/Year):

Reason for COBRA/Continuation or Other Leave:

Marriage Date PPO Network Desired

Section 2 Type of Health Coverage

Please select the type of health insurance coverage for which you are applying:
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Dependent Child(ren) ☐ Employee,Spouse & Dependent Child(ren)

Section 3 Dependent Information

List all dependents, spouse and child(ren) applying for insurance. If you need additional space, please use a seperate sheet of paper and attach it to this application (please sign and date the additional sheet).

Name (First; M.I.; Last)	Sex	Social Security Number	Relationship	Birth Date (Mo/Day/Yr)	Height Weight	Full-Time Student (if 18 years old or older)
			Spouse			
			☐ Child ☐ Grandchild ☐ Stepchild ☐ Other			School _____ Credits/Semester _____
			☐ Child ☐ Grandchild ☐ Stepchild ☐ Other			School _____ Credits/Semester _____
			☐ Child ☐ Grandchild ☐ Stepchild ☐ Other			School _____ Credits/Semester _____

Section 4 Beneficiary

Beneficiary (full name) | Relationship

If more than one beneficiary is named, then Pekin Life shall interpret this to mean equal shares to the survivor(s) unless otherwise indicated.

If the beneficiary is a minor, provide trustee's name and trust date.

Section 5 Waiver/ Refusal of Coverage

I have been given the opportunity to apply for group coverage for myself and my dependents, and I choose to waive insurance coverage for:

☐ Myself for ☐ Health ☐ Dental
☐ My Spouse for ☐ Health ☐ Dental
☐ My Children for ☐ Health ☐ Dental

Reason for waiving coverage:

NOTICE OF SPECIAL ENROLLMENT PERIOD: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

LATE ENTRANT: I understand that if I apply for coverage as a late entrant (more than 30 days after my eligibility date or the special enrollment period), I will be subject to a pre-existing limitation period of up to 18 months.

Section 6 Coverage Replacement (Certificate of Creditable Coverage)

If this section is not completed, we will presume that there has been no health insurance on any of the above applicants during the past 12 months. If coverage has been provided during any part of the last 12 months, please provide the following:

1. Other health insurance carrier: Name | Phone #
   Address
2. List your dependents insured by other health insurance:

Please fully complete all sections of this application! Incomplete applications may result in delaying the effective date of coverage.

BELOW FOR HOME OFFICE USE ONLY

Rate Class	Dep Code	FCC	FC Date	Eff Date	GI/MU	PE	Life	W.I.	Dep Life	Dental

CONTINUATION OF APPLICATION FOR GROUP INSURANCE TO

PEKIN LIFE INSURANCE COMPANY

EMPLOYER _____ **POLICY NO.** _____

EMPLOYEE _____ **SOC. SEC. NO.** _____

Section 6 Coverage Rep. (Continued)

3. Is any other health insurance terminating? ☐ Yes ☐ No If yes, date of termination: _____
4. Reason other health insurance is terminating? _____

Verification of the above information may be necessary. Also, please provide us with a Certificate of Creditable Coverage from current or former health insurance plan.

COMPLETE FOR ALL EMPLOYEES/DEPENDENTS APPLYING AS EITHER A TIMELY OR LATE APPLICANT:

Section 7 Medical History

a. In the last five years, has any person named in Sections 1 or 3 been diagnosed or treated for:

	Yes	No		Yes	No		Yes	No
Heart/Vein Disorder	☐	☐	Mental/Nervous Disorder	☐	☐	Diabetes/Blood Disorder	☐	☐
Cancer	☐	☐	Digestive System	☐	☐	AIDS/ARC	☐	☐
Lung Disorder	☐	☐	Stroke	☐	☐	Back/Bone/Joint Disorder	☐	☐
Alcoholism/Drug Abuse	☐	☐	Urinary Tract/Pancreas/Liver Disorder	☐	☐	Reproductive Organs/Infertility	☐	☐

b. Has anyone had medical expenses exceeding $5,000 in any of the past 5 years? ..... ☐ ☐

c. Does anyone have an existing condition (including pregnancy) for which they are receiving treatment or medication, or will require follow-up testing or exams? ..... ☐ ☐

d. Is anyone currently disabled or hospitalized? ..... ☐ ☐

e. Has anyone named in this application used tobacco in any form during the past 12 months? ..... ☐ ☐

f. In the space below please list and provide the complete details if you answered "Yes" above to any of the questions or conditions contained in Section 7, a - e. (Attach additional pages as needed and sign the additional pages.)

Question Number	Name of Person	Date(s) of Treatment	Give full details for each question answered "Yes," state the condition, duration and degree of recovery	Name and address of attending physician or other health care provider

g. If anyone named in this application is taking medication or has had prescribed or recommended any medication during the period of time related to your answer, please list all those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below.
(Attach additional pages as needed and sign the additional pages.)

Name of Person	Name, dosage and frequency of medication *(include illness or health condition for which medication was prescribed)*	Date(s) medication taken *(indicate if ongoing)*	Name and address of prescribing physician or licensed health care provider and dispensing pharmacy

I declare that I have read all the statements and answers shown in this application, that they are complete and true to the best of my knowledge and belief, and correctly recorded whether written by my own hand or not. Any misstatements or omissions of information that are made on this application may be the basis for later recision of your insurance coverage. Recision voids your coverage. No payments will be made for any claims submitted, whether or not the treatment was related to the condition for which information was omitted or misstated.

AUTHORIZATION – To Physicians and Practitioners, Hospitals, Institutions, and other Insurance Support Organizations.

This form will authorize any physician, hospital, clinic or other medical or medically related facility, insurance company or its reinsurers, or other organization, institution or person, that has any records or knowledge of me, my spouse, or children and of their health, to give the PEKIN LIFE INSURANCE COMPANY or its reinsurers any such information. Records being requested may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, development disabilities, mental illness, HTLV–III testing and results and/or treatment records. This information is to be used solely in my application for life and/or health insurance. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Witnessed by _____ Signature of Applicant _____

Signature of Spouse _____ Dated _____ MONTH / DAY / YEAR

(if this application shows any medical history for Spouse) Valid for 30 months – I may receive a copy