



New Enrollee Coverage Change Name of Employer Judevine Center for Autism Location _____

A. Employee Information

Employee's Legal Name <small>First, Middle, Last</small>				Date of Birth <small>(MM/DD/YYYY)</small> / /	
Employee's Home Address <small>Street Address</small>				City <small>State</small> ZIP+4	
<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No.		Birth State/Country	
Date of Employment <small>(MM/DD/YYYY)</small> / /		Hours per week		Annual Salary \$	
In the past 90 days , have you been working less than 30 hours per week or unable to perform any of the duties of your primary occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If YES, please explain _____					
During the past 12 months , has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum?				Employee <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse's Legal Name <small>First, Middle, Last</small>				Date of Birth <small>(MM/DD/YYYY)</small> / /	
<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No.		Birth State/Country	

CHILD INFORMATION: If additional space is needed, please attach a separate sheet of paper.

Child's Legal Name <small>First, Middle, Last</small>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <small>(MM/DD/YYYY)</small> / /
Child's Legal Name <small>First, Middle, Last</small>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <small>(MM/DD/YYYY)</small> / /
Child's Legal Name <small>First, Middle, Last</small>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <small>(MM/DD/YYYY)</small> / /
Child's Legal Name <small>First, Middle, Last</small>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <small>(MM/DD/YYYY)</small> / /

B. Voluntary Benefit Election—Completion of a Statement of Health and/or Statement of Insurability form may be required for coverage to be approved.

Note: *Wellness benefits may be elected on only one product. Coverage not elected will be considered refused even if not specifically declined.

Accident Expense Yes No Employee Only Employee/Spouse Employee/Child Family

Critical Illness Yes No Wellness Benefit* Yes No Employee Only Employee/Spouse Employee/Child Family

Benefit \$ Spouse Benefit \$ Child Benefit \$

C. Beneficiaries—Unless shown differently below, survivors share equally. If additional space is needed, attach a separate sheet of paper.

Legal Name <small>(First, Middle, Last)</small>	Relationship	P=Primary C=Contingent	Date of Birth	Social Security No.	Share %
			/ /		
			/ /		

D. Certification and Authorization

I certify that the statements and answers provided in this application were made by me, are complete and true, and have been correctly and fully recorded. I agree that this enrollment form constitutes my application and shall form a part of the certificate if attached thereto. My statements and answers are offered as an inducement to grant insurance, and I understand that Assurity may use misstatements or misrepresentations in the application to contest the validity of any coverage provided. I further understand that the insurance applied for shall be in force as of the certificate issue date shown on the certificate schedule and not the date the application is signed. I understand that any premiums deducted before the issue date of the certificate are pre-paid premiums and will be applied to coverage beginning on the issue date. If the certificate is not issued, Assurity will refund any premium deductions it receives. I further authorize my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested *(including dependents' coverage)*.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at *(city, state)* _____ Dated ____ / ____ / ____ (MM/DD/YYYY)

Signature of Primary Proposed Insured _____

**ASSURITY® LIFE INSURANCE COMPANY**Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (866) 289-7337 • FAX (877) 864-6630**Worksite Group
Statement of Health****PLEASE PRINT WITH BLACK INK**

<i>First, Middle, Last</i>	<i>First, Middle, Last</i>
Employee's Legal Name	Spouse's Legal Name

Employer Name	Employee: Height ft. in. Weight lbs.	Spouse: Height ft. in. Weight lbs.
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GENERAL

1. In the past **10 years**, has any Proposed Insured been diagnosed or treated by a medical professional for acquired immune deficiency syndrome (*AIDS*), AIDS-related complex (*ARC*) or antibodies to human T-lymphotropic virus type III (*HTLV*); or had a positive test for human immunodeficiency virus (*HIV*) antibodies? Yes No

If **YES** to any of the above, please indicate which Proposed Insured(s) _____

CRITICAL ILLNESS

1. During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised by a medical professional to have diagnostic tests or any medical or surgical procedures that have not been completed or for which results have not been received? Yes No

2. During the past **10 years**, has any Proposed Insured had or been advised to have an organ or tissue transplant, or consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for, or had symptoms of any of the following: disease or disorder of the heart (*including heart attack, heart condition, congestive heart failure, heart valve disorder*), circulatory system (*including peripheral vascular disease, carotid artery disease*), liver, lungs (*excluding asthma but including chronic obstructive pulmonary disease (COPD) and emphysema*), kidneys or pancreas, hepatitis (*other than type A*), stroke, transient ischemic attack (*TIA*), insulin-dependent diabetes, dementia, Alzheimer's disease, paralysis, multiple sclerosis (*MS*), muscular dystrophy (*MD*) or alcohol or drug abuse? Yes No

3. During the past **6 months**, has any Proposed Insured had any blood pressure readings of 160/100 or higher? Yes No

4. During the past **10 years**, has any Proposed Insured needed assistance or personal supervision to perform any activities of daily living (*toileting, transferring, continence, eating, bathing or dressing*)? Yes No

IF APPLYING FOR EITHER CANCER RIDER, QUESTIONS 5 AND 6 MUST BE ANSWERED.

5. During the past **5 years**, has any Proposed Insured ever consulted with or been diagnosed, treated, hospitalized or prescribed medication by a medical professional for internal cancer, leukemia, lymphoma Hodgkin's lymphoma (*formerly known as Hodgkin's disease*), melanoma, malignant tumors or carcinoma in situ? Yes No

6. During the past **12 months**, has any Proposed Insured been hospitalized, disabled or advised by a medical professional to have diagnostic tests or any medical or surgical procedures that have not been completed or for which results have not been received? Yes No

If **YES** to any of the questions above, please provide complete details below. If additional space is needed, attach a separate piece of paper.

Proposed Insured's Name	Date of Condition	Details (<i>including medical care provider's name</i>)

PROPOSED INSURED'S AGREEMENT

I, the Proposed Insured, agree that all answers and statements in this application are complete and true to the best of my knowledge and belief and will be relied upon to determine insurability. I further agree that this statement of health form constitutes a part of my application and shall form a part of the certificate if attached thereto.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Signed at _____ on _____
City
State
Date (MM/DD/YYYY)

Signature of Primary Proposed Insured
Signature of Spouse (if Proposed Insured)