EPIC | SPECIALTY BENEFITS

The EPIC Life Insurance Company
1717 W. Broadway
Madison, WI 53713

Employee's Application for Group Insurance Coverage

Instructions: Please complete the entire form in black ink. If you are waiving/declining coverage at this time you are still required to complete Sections 1.,3., and 5.

1. General Information

☐ New Employee ☐ Change

Group Name ______________________________ Group Number ______________ Requested Effective Date ______________

Requested Action ☐ Add Coverage ☐ Term Coverage ☐ Beneficiary Change ☐ Other (describe) ___________________________

Last Name ________________________________ First Name ________________________________Middle Initial ______________

Employee Address ______________________________City ______________________ County __________ State ______ Zip ________

Date of Birth _________________ Phone Number ___________________ Social Security Number _______________________________

Employee Email _____________________________ Occupational Title _________________________ Annual Earnings $ ____________

Date of Hire ______________ Hrs. Worked/Week _________ Marital Status: ☐ Single ☐ Married Sex: ☐ Male ☐ Female

Have you ever applied for, been insured by, or are currently insured by The EPIC Life Insurance Company? ☐ Yes ☐ No

If yes, provide details: ____

List all family members to be insured including first and last name (For additional space, use separate sheet)	Relationship to Employee	Sex	Birth Date

2. Beneficiary Selection

Primary Beneficiary (if multiple, specify allocation to equal 100%)

Name and Relationship	Date of Birth	Address	% of Benefit

Contingent Beneficiary (optional)

Name and Relationship	Date of Birth	Address	% of Benefit

Consent of Spouse
(To be completed in community property states when the spouse of the insured is not designated as the primary beneficiary)

I understand that by signing below, I consent to the designation of the above person(s) as Primary Beneficiary(ies) and hereby waive any rights I may have to the proceeds of such insurance benefit under applicable community property laws.

Spousal Consent Signature: ____ Date: _________________________

For Office Use Only	GN	DIV	Class	PP	ED	CC

3. Coverage Selection

Please check the coverage(s) that you are applying for below. Availability of coverage(s) is based on your group's selected plan of insurance.

Coverage Type	Applying For	Waiving/Declining
Term Life Guarantee Issue______________________________	☐ Myself	☐ Myself
Accidental Death and Dismemberment Guarantee Issue______________________________	☐ Myself	☐ Myself
Dependent Term Life	☐ My Spouse ☐ My Dependents	☐ My Spouse ☐ My Dependents
Voluntary/Supplemental Term Life Guarantee Issue______________________________	☐ Myself $___________ or _____ x your annual earnings ☐ My Spouse $__________ ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents
Voluntary/Supplemental AD&D Guarantee Issue______________________________	☐ Myself $___________ or _____ x your annual earnings ☐ My Spouse $__________	☐ Myself ☐ My Spouse
Short-Term Disability Guarantee Issue______________________________	☐ Myself	☐ Myself
Voluntary Supplemental Short-Term Disability Guarantee Issue______________________________	☐ Myself $___________ * Can't exceed 60% pre-disability Basic Weekly Earnings	☐ Myself
Long-Term Disability Guarantee Issue______________________________	☐ Myself	☐ Myself
Voluntary Long-Term Disability Guarantee Issue______________________________	☐ Myself	☐ Myself
Dental ☐ Traditional ☐ Base ☐ Voluntary Traditional ☐ Buy-up	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents ☐ Coverage through my Spouse
Dental (Preferred Provider) ☐ Traditional PPO ☐ Voluntary PPO Preferred Provider Network____________________	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents ☐ Coverage through my Spouse
Vision Plan Identifier_________________	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents ☐ Coverage through my Spouse

4. Health Questions

The health questions need to be answered if: (1) your Life/STD/LTD amount applied for is over the guarantee issue amount; or (2) you are not applying within 30 days of completing your probationary period.

1. Within the last ten (10) years, have you or any dependent ever had or been treated by a physician or a member of the medical profession for any of the following: heart disorder, high blood pressure, back disorder, stroke, cancer, tumor, diabetes, kidney or liver disease, an immune deficiency disorder, AIDS, AIDS-Related Complex (ARC), respiratory, or any mental or nervous system disorder? AIDS testing received at anonymous counseling and testing sites or through home test kids need not be revealed. We are not seeking the results of HIV antibody tests. ☐ Yes ☐ No
2. Within the last seven (7) years, have you or any dependent ever been treated for, arrested in connection with, or been told to have counseling for the use of alcohol or drugs? ☐ Yes ☐ No
3. Within the last five (5) years have you or any dependent received treatment from and/or consulted a physician, psychiatrist, psychologist, or other medical practitioner or taken prescription medication? ☐ Yes ☐ No
4. Have you or any dependents ever had life/disability insurance rejected, rated, or restricted? ☐ Yes ☐ No
5. Employee: Height __________ Weight __________ Spouse: Height ____________ Weight ____________

GIVE COMPLETE DETAILS FOR EVERY "YES" RESPONSE TO QUESTIONS 1 - 4 (For additional space, use separate sheet)

Question No.	Name of Person Treated and Full information as to Nature of Ailment	Date Of Onset	Last Date Seen for this Condition	Recovery Status	Treatment Given	Complete Name, Address, and Phone Number of Attending Physician

5. Agreement Authorization

I hereby request coverage for the group benefit(s) selected above in Section 3. I authorize my employer to take deductions from my pay if contributions are required for the coverage elected.

CERTIFICATION: I represent and certify all of the following: (1) I am employed by the employer named herein and am working the number of hours indicated in Section 1. above; (2) I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; (3) I entered each and every answer myself in response to each request for information and/or question; (4) no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); (5) such representations are true, accurate, and complete to the best of my knowledge; (6) I, and my spouse and dependent(s), have been given the opportunity to apply for the coverage(s) available to me (us) through my employer; and (7) and I was neither pressured nor forced by my employer, the agent, or EPIC into waiving/declining any coverage as shown in Section 3.

UNDERSTANDING: I understand: (1) the representations I make, together with any supplemental representations that I make, shall be the basis for EPIC to determine eligibility for issuing coverage; (2) that no person, except the President & CEO or Chief Operating Officer of EPIC, has the authority to: (a) determine whether any contract (s) of insurance shall be used on the basis of the application;(b) waive or modify any of the provisions of the application or any of EPIC's requirements or rights; (c) bind EPIC by any statement or promise pertaining to any insurance contract (s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained on the written application (3) that no coverage will be effective unless and until the date specified by EPIC after this application has been approved by EPIC; (4) any misrepresentation contained herein may be used to reduce or deny a claim, void coverage, or void the group contract(s) within the contestable period, if such misrepresentation materially affects EPIC's acceptance of the risk; including approving any person for coverage; (5) if I decline any coverage, future changes in coverage are NOT automatic and will be subject to EPIC approval; and (6) if my death occurs before EPIC has approved in writing any EPIC coverage, the only death benefit provided shall be the lesser of the maximum amount available without evidence of insurability or the maximum amount I am eligible for, under the coverage(s) for which I was eligible.

I understand that EPIC is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that is not expressly contained in a written document provided to them and signed by an EPIC authorized executive officer.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

I understand that EPIC fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, EPIC may rescind and void any coverage if it determines that the employer, a covered employee, or a covered employee's spouse or named dependent, are either listed on the SDN list or associated with an entity listed on the SDN list.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer. An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to EPIC or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA Privacy Regulations"), but excluding psychotherapy notes, if any, in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment, and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by EPIC to determine eligibility for coverage under my employer's group policy(ies) and that my failure to authorize the release of said information may result in a refusal to issue or provide coverage. I agree that EPIC may release said information to MIB or to EPIC's reinsuring companies, representative, or other person performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand I may revoke this authorization by providing advance written notice of termination to EPIC at its office in Madison, Wisconsin, and that any information released in reliance on this authorization and prior to such revocation cannot be retrieved. In such case, EPIC, its directors, officers, employees, and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless this authorization is revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulations and could be re-disclosed by the person or entity that receives it.

Has any person assisted you in the completion of this form? ☐ Yes ☐ No If yes, please print name:

Applicant's Signature ________________________________ Date Signed: _______________

Spouse's Signature* ________________________________ Date signed: ________________

* Required only if medical questions for spouse need to be answered