

**Applicant Section**

Applicant's Name (First, MI, Last)		Employee <input type="checkbox"/>	Gender	Birthdate (mm/dd/yyyy)	Social Security No.
		Spouse <input type="checkbox"/>	M <input type="checkbox"/>		
		Dependent <input type="checkbox"/>	F <input type="checkbox"/>		
Home Address – Street		City	State	Zip Code	State of Birth
				Employee ID/Payroll No.	
Date Employed	Occupation/ Job Title	Hrs. Worked/ Week	Annual Base Salary	Home Phone No.	
				Business Phone No.	

**Billing Section**

Payroll Deduction Employer Name	Employer Address (Street-City-State-Zip)	Section/Dept. No.	Employee Class No.
CENTENARY COLLEGE OF LOUISIANA	2911 CENTENARY BOULEVARD LOUISIANA, LA 71104		
Payer or Owner if other than Applicant (Name, Address, Social Security No.)		<input type="checkbox"/> Payer <input type="checkbox"/> Owner <input type="checkbox"/> Both	

**Spouse and Dependent Section**

Name of Spouse (First, MI, Last)	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
Employer's Name for Spouse	Date Employed	Occupation / Job Title	Hours Worked/ Week	Annual Base Salary
1. Are there any eligible dependent children applying for coverage?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Number Deps:

**Complete Question 2 for all Products**

	Applicant	Spouse
2.A. Are you actively working?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.B. If "No", is your spouse disabled or unable to work?	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Plan Section**

Indicate Type of Change (N) New (T) Transfer or (R) Rider Addition. Indicate Tax Status (P) for pre-tax or (A) for after tax

Product	Type Coverage	Type of Change	Policy Plan Code	Units/ Amount	Rider Plan/ Units	Rider Plan/ Units	Rider Plan Code	Rider Plan Code	Tax Status	Monthly Premium
<input type="checkbox"/> Accident									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Hospital Confinement									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Cancer									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Int. Care									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Critical Illness									P <input type="checkbox"/> A <input type="checkbox"/>	
<input type="checkbox"/> Disability	Elim/Benefit period /								P <input type="checkbox"/> A <input type="checkbox"/>	
<b>Total Monthly Premium \$</b>										

**Replacement Section – Complete for all Products**

3. Will any health insurance, with this or any other company, be modified or discontinued if the coverage applied for is issued? If yes, provide details.				Yes <input type="checkbox"/> No <input type="checkbox"/>
Insured's Name	Insurance Company	Type of Coverage	Policy Number	

**AIDS Section – Complete for all Products**

	Applicant	Spouse	Dependent
4. Have you tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Simplified Issue Section – Disability and Hospital Confinement			Applicant	Spouse
5. Have you previously purchased disability coverage that will remain in force which, when combined with the coverage you are applying for, will exceed 70% of your gross annual income? This does not include employer paid group disability coverage.			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Within the past 12 months, other than colds, flu or normal pregnancy, have you been off work (vacation or sick leave) for 10 or more consecutive work days due to an illness or injury, including back, neck, knee, joint or muscle?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Within the past 12 months, have you received medical advice or sought treatment (including medication) for:				
Heart Attack (MI)	Blood Pressure Reading of 160/100 or Above	Hepatitis B, C	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Surgery	Kidney Disease except Stones	Cirrhosis	No <input type="checkbox"/>	No <input type="checkbox"/>
Congestive Heart Failure	Insulin Dependent Diabetes	Hodgkin's Disease		
Stroke	Diabetes Diagnosed Prior to age 40	Leukemia		
Transient Ischemic Attack	Cancer Other than Skin Cancer			

Dependent Health Section - Hospital Confinement			
8. Within the past 12 months, has any dependent been hospitalized for respiratory disorders, including asthma, cystic fibrosis, diabetes, heart condition, cancer (other than skin cancer) or seizures? If yes, provide details. <b>Any dependent listed will not be covered under the Hospital Confinement policy to which a copy of the application is attached.</b>			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name (First, MI, Last)	Relationship	Birthdate (mm/dd/yyyy)	Social Security No.

Simplified Issue Section - Critical Illness and Intensive Care			Applicant	Spouse	Dependent
9. Within the past 10 years, have you received medical advice or sought treatment (including medication) for:					
Heart Attack (MI)	Hepatitis B, C		Yes <input type="checkbox"/>	Yes <input type="checkbox"/>	Yes <input type="checkbox"/>
Heart Surgery	Blood Pressure Reading of 160/100 or Above		No <input type="checkbox"/>	No <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Kidney Disease except Stones				
Emphysema	Chronic Obstructive Pulmonary Disease				
Organ Transplant	Cirrhosis or Liver Disease				
Congestive Heart Failure	Transient Ischemic Attack				
Diabetes	Cancer Other than Skin Cancer				
Stroke	Abnormal Catherization				
If yes to question 9 for any dependent, please provide details. <b>Any dependent listed will not be covered under the Intensive Care or Critical Illness policy to which a copy of the application is attached.</b>					
Name (First, MI, Last)	Relationship	Birthdate (mm/dd/yyyy)	Social Security No.		
10. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery systems?			Yes <input type="checkbox"/> No <input type="checkbox"/>		

Cancer Section			Applicant	Spouse	Dependent
11. Have you ever been diagnosed with, or treated for, Cancer of any type or form? If yes, please answer questions 12 and 13.			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. In the past 5 years, have you received medical advice or sought treatment for cancer, other than skin cancer; or, in the past 12 months have you received preventive Hormonal Therapy? If yes, you are not eligible for coverage. If no, please complete the Cancer History form.			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes to question 12 for any dependent, please provide details. <b>Any dependent listed will not be covered under the Cancer policy to which a copy of the application is attached.</b>					
Name (First, MI, Last)	Relationship(s)	Birthdate (mm/dd/yyyy)	Social Security No.		
13. Within the past 5 years, have you received medical advice or sought treatment for Skin Cancer, including basal cell carcinoma, squamous cell carcinoma, or melanoma of Clark's level I or II?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

