



**CRITICAL ILLNESS INSURANCE**

Employee  Spouse  Child(ren)

Has any Proposed Insured used any form of tobacco in the last 12 months?.....	Employee		Spouse	
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

**Base Plan**  Vascular  Cancer  Other Critical Illnesses

**Base Benefit** Benefit Amount \$    ,    Total Modal Premium \$    .

**Optional Benefits**  Health Screening

	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you Actively at work?.....	<input type="radio"/>	<input type="radio"/>								
2. Will this coverage replace a critical illness policy or certificate of insurance paid for, by, or through your employer?.....	<input type="radio"/>	<input type="radio"/>								

**Evidence of Insurability: Complete Only if Proposed Insured is a Late Enrollee**

3. Has the Proposed Insured been performing their normal duties at work, home, or school on a full-time basis and not having missed more than 5 consecutive days in the last 12 months due to illness or injury, except for normal pregnancy?.....	<input type="radio"/>	<input type="radio"/>								
4. Has any Proposed Insured tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In the 6 months prior to the application date, has any Proposed Insured been hospitalized as an inpatient or outpatient, or missed more than 5 consecutive days of work due to an illness or injury, except for normal pregnancy?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Within the past 5 years, has any Proposed Insured been diagnosed with or treated for:										
A) <b>Vascular:</b> Heart disease, including angina; heart attack; congestive heart failure; heart bypass; cerebrovascular disease, including Transient Ischemic Attack (TIA); stroke (blockages or hemorrhage); diabetes; or blood pressure readings above the normal range which have not been controlled with medication?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) <b>Cancer:</b> Cancer, including melanoma; leukemia; malignant tumors; or skin cancers?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) <b>Other:</b> Drug abuse or alcohol abuse; disease of the liver, kidney or digestive system; disease or disorder of the lung; diabetes; diseases of the nervous system, including Parkinson's, MS and cerebral palsy; or any disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing, or speech?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. To the best of your knowledge and belief, have any 2 of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:										
A) <b>Vascular:</b> Heart attack, heart disease or stroke?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) <b>Cancer:</b> Cancer?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) <b>Other:</b> Kidney disease or diabetes?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





# Payroll Deduction Authorization For

# Capital Insurance Agency, Inc.

Department of \_\_\_\_\_

Location \_\_\_\_\_

Employee Name \_\_\_\_\_

Social Security # \_\_\_\_\_

People First Employee ID # \_\_\_\_\_

You are hereby requested and authorized to deduct the amount of the premium from my wage each pay period and to transmit it to Capital Insurance Agency, Tallahassee, Florida, in payment of the premium under the policy(ies).

Said deduction shall commence as of \_\_\_\_\_ and continue each pay period thereafter until (A) termination of my employment, or (B) completion of the premium paying period as provided in the policy, or (C) written notice by me of the cancellation of this order stating when thereafter cancellation shall be effective, or (D) termination of this salary savings system.

I understand that amounts to be deducted may be subject to change without written authorization from me. In the event that my policy involves renewable term insurance, I understand that my premiums may increase on the policy anniversary date and will be changed without written authorization from me. \_\_\_\_\_ (initials)

Signature of Employee \_\_\_\_\_



Date \_\_\_\_\_

Witness \_\_\_\_\_

### Policy Register

Policy No.	Effective Date	Description	Monthly / Biweekly Premium	

### For Official Use Only

Dist No.	Dept. / Div. Code	Eff. Date of Deduction	Deduction Code	Total Monthly / Biweekly Deduction	Action Processed Date / Initial
			285		