ENROLLMENT FORM FOR GROUP CRITICAL ILLNESS POLICY (#P-LSPGRP 11/05)

5990 Greenwood Plaza Blvd., Suite 325, Greenwood Village, CO 80111 • www.cblnet.com

Name	Height	Weight	**Phone** H. ( )
Address (No. Street, City, State, Zip Code)	State of Birth	Sex	W. ( )

Soc. Sec. No.	Date of Birth	Age	Occupation

Beneficiary – Please provide as much information as possible (name, address, social security number, etc.)	Relationship

CERTIFICATE DATA

10 Year Renewable and Convertible Term Life Insurance With Critical Condition Accelerated Benefits ❑ Other Rider ❑ Family Rider

Face Amount	Premium ☐ M ☐ W ☐ B ☐ Q	Cash Paid at Enrollment	Annual Salary
$	$	$	$

Premiums Payable
- ❑ Bank Draft
- ❑ Govt. Allotment
- ❑ Payroll Deduction
- ❑ Other _____

PERSONS TO BE COVERED UNDER FAMILY RIDER

	SEX	DATE OF BIRTH		SEX	DATE OF BIRTH
Spouse		/ /	Insured Child		/ /
Insured Child		/ /	Insured Child		/ /

NON-MEDICAL (Please furnish <u>your personal physician's name and address even if you answer "No"</u> to all questions and details to all "Yes" answers.)

Yes	No		
		1.	Have you or any family member to be covered ever had, been told you had or been treated for any of the following: (Check all that apply and give details below.)
❑	❑		a. Cancer, tumor, ulcer, neurological disorder or related disease or disease of the breast or reproductive organs?
❑	❑		b. Heart attack, angina pectoris, chest pain, stroke, high blood pressure or any other disease of the heart or blood vessels?
❑	❑		c. Disease of the kidney, urinary bladder, stomach, intestines, liver, gall bladder, lungs or respiratory system, nervous or mental disorder?
❑	❑		d. Diabetes, chronic hepatitis, leukemia, internal organ transplant, cirrhosis of the liver, or paralysis?
❑	❑	2.	Have you ever been diagnosed or been treated for or been told you will require treatment for a disorder of the Immune System including Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other AIDS-related condition, or had a positive test for the AIDS virus (HIV)?
❑	❑	3.	Have you ever had or been treated for alcohol or drug abuse or addiction? (If yes, give full details below.)
❑	❑	4.	Have you been hospitalized, consulted a physician, or received treatment for any illness or injury in the past 5 years, other than as stated above?
❑	❑	5.	Have you smoked cigarettes or used tobacco products in the past 12 months?
❑	❑	6.	Have you missed more than 5 consecutive days of work due to accident or sickness in the past 12 months?
❑	❑	7.	Have you ever been declined or rated-up for life or health insurance? (Provide dates and details below.)
❑	❑	8.	Within the past 2 years have you been advised to have any diagnostic test, hospitalization, surgical procedure or treatment that has not been done?
❑	❑	9.	Have you had a parent, brother or sister who prior to age 60 suffered from cancer, diabetes, stroke, heart attack (myocardial infarction), heart disease, kidney disease, or mental illness?
❑	❑	10.	Do you currently have any growth, cyst or lump or any new pigmented area of skin that has not been evaluated by a physician?
❑	❑	11.	Within the past 5 years have you had any symptoms for which future medical assessment is planned, contemplated, or for which you have not yet consulted your physician?
❑	❑	12.	Are you currently taking or been advised to take prescription drugs? Indicate drugs and prescribing physician below.
❑	❑	13.	Is this insurance intended to replace any existing life insurance, health insurance or annuity policy? (If yes, include existing policy details below.)

Provide Personal Physician's Name and Address

Question #	**DETAILS of "YES" Answers: Please include dates, duration, attending physicians or hospital name, address and phone number. Attach additional sheets if necessary.**

Insurance will take effect at 12:01 A.M. on the date of approval by the Insurer, however, it is understood that the Company will incur no liability because of this enrollment unless and until it is approved by the Company and the first premium is paid or an authorization for payroll deduction has been signed by the enrollee while the health and other conditions affecting the insurability of the Proposed Insured are as described in this enrollment form. No change in amount, classification, plan of insurance, age at issue, or benefits will be effective unless agreed to in writing by the Proposed Insured. I hereby acknowledge receipt of the disclosure statement required by the Fair Credit Reporting Act.

I hereby authorize any physician, medical practitioner, hospital, clinic, Health Maintenance Organization, including Mayo, Kaiser Foundation, Veterans Administration, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institute, or person that has any records or knowledge of me or my family, or our health, medical history or physical condition, to give to Colorado Bankers Life Insurance Company or its reinsurers any such information including psychiatric histories and to testify as to such information.

This authorization is valid for thirty (30) months after the date it was signed. A photostatic copy of this authorization will be as valid as the original.

The statements on this enrollment form are true to the best of my (our) knowledge and belief. I (we) understand that this certificate will be effective on the date it is issued by the Company.

DATED AT _____ THIS _____ DAY OF _____ , 20 _____ .
CITY STATE

_____ _____
OWNER'S SIGNATURE AND SOCIAL SECURITY NUMBER (If different than Proposed Insured) PROPOSED INSURED'S SIGNATURE

To the best of my knowledge and belief the insurance applied for herein ❑ is not ❑ is intended to replace or change any existing life insurance, health insurance or annuity coverage. I asked and correctly recorded all information on this enrollment form in the presence of the Proposed Insured.

_____ _____
AGENT'S SIGNATURE AGENT'S NAME (Printed)

DISCLOSURE STATEMENT

Information regarding your insurability will be treated as confidential. Colorado Bankers Life Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Colorado Bankers Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

As a part of our normal procedure for processing your enrollment form for insurance an investigative consumer report may be obtained which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates. You are entitled to receive a copy of the investigative report, if any.

Upon written request to the Underwriting Department, further information on the nature and scope of the report will be provided.

Enrollee may request to be interviewed in connection with the preparation of the investigative consumer report. Enrollee is entitled to receive a copy of the investigative consumer report.

THIS PRE-WRITTEN NOTICE MUST BE DETACHED AND LEFT WITH THE PROPOSED INSURED.

Colorado Bankers Life Insurance Company
5990 Greenwood Plaza Boulevard • Greenwood Village, Colorado 80111 • (303) 220-8500