



CENTRAL RESERVE LIFE INSURANCE COMPANY
A Subsidiary of Ceres Group, Inc.
 17800 Royalton Road, Cleveland, Ohio 44136-5197
 440-572-2400 • www.centralreserve.com

ASSOCIATION INSURANCE APPLICATION

TYPE OF ACTIVITY

- | | |
|--|---|
| <input type="checkbox"/> New Enrollee/Certificate
<input type="checkbox"/> Child(ren) Only Plan (Please complete Child(ren)/
Dependent section and letter F) | <input type="checkbox"/> Change to existing policy/certificate # _____
<input type="checkbox"/> Adding Dependent <input type="checkbox"/> Reinstatement of Coverage
<input type="checkbox"/> Remove Coverage Exclusion Rider
<input type="checkbox"/> Increase Benefits to: _____ |
|--|---|

SECTION 1 PERSON(S) TO BE INSURED

Marital Status of Member: Single Legally Separated Married Divorced Spouse Deceased

Last Name	First	M.I.	SEX	AGE	BIRTHDATE Mo/Day/Yr	Social Security #	HT	WT
1. Member								
2. Spouse								
CHILD(REN)/DEPENDENT(S):							Relationship	
3.								
4.								
5.								
6.								

- A. List any other names used by any of the above: _____
- B. Are all children listed legal dependents of the Member or Spouse? Yes No Do they permanently reside with the member?
 Yes No If "NO", explain: _____
- C. List child(ren) name(s) and name(s) and address(es) of school(s) for all full-time students age 19-23 (varies by state):

C. Residence Address - Tele. No () St. or R.F.D. _____ City _____ State Zip County _____ Mailing/Billing Address: - Tele. No () St. or R.F.D. _____ City _____ State Zip County _____ D. Email Address _____	E. Present Occupation/Duties of Member _____ Present Occupation/Duties of Spouse _____ F. Complete if applying for Child-Only Coverage Child's address (if different than member) St. or R.F.D. _____ City _____ State Zip County _____
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G. Are all applicants U.S. citizens? Yes No If "No", does non-citizen have a green card? Yes No ; if green card,
 how long has the individual resided in the U.S.? _____ years _____ months

H. Group Term Life Insurance Beneficiary*	Soc. Sec. No.	Relationship
FIRST M.I. LAST		

* If a minor (under age 18) is designated as the beneficiary, provide the name of the guardian who will hold proceeds in trust for the benefit of the minor _____

(If no beneficiary is designated, benefit will be paid to the estate of the insured.)

Does Not Apply To Basic Med.

SECTION 2

PRELIMINARY HEALTH QUESTIONS

- A. Have you or any person applying for insurance ever had symptoms of, been diagnosed as having or been treated or hospitalized for:
- 1. AIDS or AIDS-related Complex (ARC), or ever tested positive for HIV? (In WV, disregard the word "symptoms" in this question) Yes No
 - 2. Congestive heart failure, coronary artery disease, stroke or coronary bypass? Yes No
 - 3. Internal cancer, leukemia, Hodgkin's or Lymphoma? Yes No
 - 4. Cirrhosis of the liver, other liver disease, Parkinson's Disease or Multiple Sclerosis? Yes No
- B. Is any person applying for insurance a diabetic or suffering from substance abuse, schizophrenia or other psychosis? Yes No
- C. Is any person applying for insurance currently pregnant or is any person pregnant by a person applying for insurance? Yes No
- D. Does any person applying for insurance exceed the company's height/weight limits? Yes No

IF "YES" TO ANY OF THE ABOVE QUESTIONS, THE SPECIFIED INDIVIDUAL WITH SUCH "YES" CONDITION IS NOT ELIGIBLE TO APPLY FOR COVERAGE (unless you are applying as a HIPAA Eligible Individual).

SECTION 3

HIPAA ELIGIBLE INDIVIDUAL DETERMINATION

- A. Have you been insured under creditable coverage for at least 18 months, the most recent being an employer-sponsored group plan, with no more than a 63-day gap? (In general, "creditable coverage" is any form of major medical health insurance.) Yes No
- B. If offered, did you elect the option of state continuation or COBRA continuation and, if so, did you complete the allowable period of coverage? Yes No
- C. Are you ineligible for a group (employer-sponsored) health plan, part A or part B of Medicare, or Medicaid? Yes No
- D. Was your most recent health insurance terminated for reasons other than nonpayment of premiums or for fraud? Yes No

If you've answered "no" to any of the above questions or have other health insurance in force, you do not qualify as an Eligible Individual. If you've answered "yes" to all of the above questions and do not have other coverage, you are an Eligible Individual.

Yes, I'm applying as an Eligible Individual and understand the rates for this plan will be substantially higher than underwritten plan rates. Please attach your certification of creditable coverage or other proof of coverage. Plan desired: _____
Coverage through CRL is not required in the States of AL, AZ, IL, IN, NE, NM, OK, PA, or SC.

No, I'm electing to be underwritten and waive my right as an Eligible Individual. I understand I will be subject to a preexisting condition exclusion.

SECTION 4

COVERAGE APPLYING FOR

A. Coverage Applying For:

- 1. Plan Name: _____
- 2. Coinsurance: _____
- 3. Deductible: _____
- 4. If PPO, list Network: _____
- 5. Optional Benefits:
 - Name of Benefit: _____ Amount of Coverage: _____
 - Name of Benefit: _____ Amount of Coverage: _____
 - Name of Benefit: _____ Amount of Coverage: _____

PLEASE ATTACH A COPY OF THE PROPOSAL TO THIS APPLICATION.

- Mode of Premium Payment: Electronic Funds Transfer (Fill out section 7 on page 7)
- Monthly Quarterly Semi-annually
- List Bill: Billing Name: _____
Billing Address: _____

B. If paying by check, please make payable to Central Reserve Life, equal to the initial insurance premium; Administration charge and Association Dues are required. (In South Carolina, include the member's check made payable to the Eagle Consumer Association.) Agent's checks will not be accepted.

C. REQUESTED EFFECTIVE DATE: _____ If approved, the actual effective date will be determined by CRL's Home Office and may differ from the requested effective date.

D. Will this plan be replacing group coverage, any other health insurance plan with similar benefits, other coverage or no coverage?

If replacing existing coverage – Effective date of current coverage: _____
 Expected termination date or paid-to-date of current coverage: _____
 Name and address of current carrier: _____ Phone No. _____
 Reason for replacing coverage: _____

If no coverage – Termination date of last coverage: _____
 Reason for not having health insurance coverage in the preceding 12 months: _____
 Reason for seeking coverage: _____

SECTION 5

MEDICAL QUESTIONS

Note: For each "Yes" response, please mark the number of the person (from page 1) to the right of the "Yes" box and supply information in the "Additional Medical Details" section.

In the past 5 years, has anyone applying for insurance:

- A. Been declined, received an exclusion rider or a rating when applying for health or life insurance through another company? Yes ____ No
- B. Had a medical claim denied due to a pre-existing condition? Yes ____ No
- C. Participated on a regular or routine basis in any hazardous sports or hobbies such as automobile, motorcycle or powerboat racing; aerosports; rock or mountain climbing? Yes ____ No
- D. Been cited for driving while intoxicated or had 2 or more moving violations in the past 2 years? Yes ____ No
If "Yes", indicate type of violation(s) and the date(s). _____
- E. Had any diagnostic testing, medical treatment, surgery or hospitalization recommended that has not been performed? Yes ____ No
- F. HAVE YOU OR ANYONE APPLYING FOR INSURANCE EVER HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR OR CONSULTED (Pennsylvania residents should disregard the word "consulted") WITH A PHYSICIAN CONCERNING:
1. The **LUNGS OR RESPIRATORY SYSTEM** including, but not limited to: hayfever or other allergies, sinus infections, asthma, bronchitis, tuberculosis, pneumonia or Chronic Obstructive Pulmonary Disease (COPD)? Yes ____ No
 2. The **NERVOUS SYSTEM** including, but not limited to: epilepsy, seizures, unconsciousness, convulsions, vertigo, headaches, paralysis, multiple sclerosis, cerebral palsy, Parkinson's Disease, Alzheimer's Disease, other dementia, stroke or TIA? Yes ____ No
 3. The **HEART OR CIRCULATORY SYSTEM** including, but not limited to: high blood pressure, heart attack, heart murmur, chest pain, angina, coronary artery disease, coronary bypass, irregular heart beat, varicose veins, phlebitis, blood clots, heart valve disorder, abnormal heartbeat, congestive heart failure, elevated cholesterol or triglycerides? Yes ____ No
If "Yes," provide last blood pressure reading, cholesterol or triglyceride level, date taken on page 4.
 4. The **DIGESTIVE SYSTEM** including, but not limited to: ulcer, gastritis, heart burn, esophageal reflux, intestinal disorder, colitis, gallbladder, hemorrhoids, hernia, disorder of the pancreas, spleen or liver including, but not limited to, hepatitis, jaundice, cirrhosis, or bowel obstruction? Yes ____ No
 5. The **GENITOURINARY SYSTEM** including, but not limited to: any kidney disorder, kidney stones, cystitis, bladder infections, sexually transmitted disease, prostate disorder, elevated PSA, blood or protein in the urine or bladder obstruction? Yes ____ No
 6. **MENTAL DISEASE OR NERVOUS DISORDER** including, but not limited to: any emotional disorder, anxiety, depression, panic disorder or attack, attention deficit disorder, eating disorder, psychiatric treatment or counseling or any suicidal thoughts? Yes ____ No
 7. **CONGENITAL DISORDER, BIRTH DEFECTS, OR DEVELOPMENTAL DISORDERS** including, but not limited to: Down's Syndrome, mental retardation, autism, cleft palate, club foot or congenital heart defects? Yes ____ No
 8. **ENDOCRINE DISORDERS** including, but not limited to: diabetes, high or low blood sugar, or any disorder of the thyroid gland or other glandular disorder? Yes ____ No
 9. **MUSCULAR, SKELETAL OR CONNECTIVE TISSUE DISORDER** including, but not limited to: arthritis, lupus (SLE), autoimmune diseases, rheumatic illness, temporomandibular joint (TMJ) disease, amputations, treatment of any muscular or neuromuscular disorder or any manipulation therapy? Yes ____ No
 10. **CARPAL TUNNEL SYNDROME, ARTHRITIS, GOUT, DISORDERS OF THE BACK, NECK, SPINE, KNEES, HIPS, SHOULDERS, BONES OR JOINTS?** Yes ____ No
 11. **BLOOD OR LYMPH DISORDERS** including, but not limited to: anemia, abnormal bleeding (stomach, bowel or urinary) or lymphadenopathy (swollen lymph nodes)? Yes ____ No
 12. **CANCER OR PRE-CANCEROUS CONDITIONS?** Yes ____ No
Provide location, exact diagnosis, and type of cancer and treatment received: _____
- a. Provide date of last pap and results: _____
- b. Have you been instructed to have a repeat pap smear, follow-up treatment or tests as a result of your last pap smear? Yes ____ No
13. **TUMOR, CYST, POLYPS OR GROWTH OF ANY KIND** including, but not limited to: breast lumps, abnormal mammograms or breast biopsies? Yes ____ No
Provide location and state if treated or removed and date: _____
14. **ANY DISORDER OF THE EYES, EARS** (including ear infections and ear tubes), nose or throat, tonsils or adenoids, labyrinthitis, Meniere's Disease, or any speech or hearing impairment or sleep disorders? . Yes ____ No
15. **ANY DISORDER OF THE REPRODUCTIVE ORGANS** including, but not limited to: disorders of the penis, testes, vagina, ovaries, cervix or uterus, infertility or irregular menstruation? Yes ____ No
16. **COMPLICATIONS OF PREGNANCY** including, but not limited to: cesarean section or miscarriage? Yes ____ No

17. Experienced any of the following: signs or symptoms of an immune deficiency disorder including lymphadenopathy, loss of appetite, weight loss, chronic fatigue, fever, oral thrush, skin rashes, chronic diarrhea, unexplained infections with no known cause? Yes ___ No
18. Does any person have any fixation/prosthetic devices present including, but not limited to, plates, screws, pins, implants (including breast implants), shunts, pacemakers or valve replacements? Yes ___ No
19. Been a member of Alcoholics Anonymous, had any treatment, including but not limited to, counseling for alcoholism or alcohol abuse, or been advised by a physician to discontinue or decrease alcohol consumption? Yes ___ No
20. Used sedatives, tranquilizers, cocaine, or other hallucinogenic or narcotic drugs or received treatment for drug abuse or chemical dependency? Yes ___ No
- G. Have you or anyone proposed for coverage had or been recommended to have a blood test in the past 2 years? Yes ___ No

If yes, indicate which applicant and why: _____
Provide results and follow-up recommendations or treatment below.

- H. When was the last time you or anyone proposed for insurance smoked or used tobacco or any other form of nicotine? Name of person(s) _____ Date Last Used _____ Never Used
- I. How often and how much do you or anyone proposed for coverage consume alcoholic beverages? _____
- J. Have you or anyone proposed for coverage been to an emergency room as a patient in the last 12 months? Yes ___ No
 If "Yes", why? _____
- K. Have you or anyone proposed for coverage ever had or been recommended to have any of the following:
1. Stress or treadmill EKG or ECG Yes ___ No
 2. Echocardiogram, Cardiac catheterization or Angiogram Yes ___ No
 3. SPECT or Thallium scan of the heart Yes ___ No
 4. Carotid or other blood vessel doppler flow study Yes ___ No

L. Does any person proposed for coverage have any mental or physical disease or disorder not indicated above or ever had symptoms of ill health, or been told they had, or received advice, consultation (Pennsylvania residents should disregard the word "consultation") or treatment for physical conditions or injuries? Yes ___ No

ONLY ANSWER THE FOLLOWING TWO QUESTIONS IF APPLYING FOR CRITICAL PAYMENT BENEFIT:

1. Has anyone to be insured had more than two immediate family members who have been diagnosed with the same condition before the age of 55 with heart disease, heart attack, stroke, kidney disorder, insulin dependent diabetes, internal cancer, leukemia, or Hodgkin's Disease? (an immediate family member is a father, mother, brother or sister) Yes ___ No
2. In the past 10 years, have you or any of your dependents been diagnosed as having or been treated for Alzheimer's Disease; or pre-cancerous, pre-leukemic or pre-malignant condition? Yes ___ No

ADDITIONAL MEDICAL DETAILS:

(Attach a separate sheet if additional space is needed. Applicant must date and sign any additional sheet(s).)

		Provide dates, type of treatment, and results	Name of Doctor or Hospital and Complete Address and Phone Number
Person	Question No.		
Condition			
Person	Question No.		
Condition			
Person	Question No.		
Condition			
Person	Question No.		
Condition			
Person	Question No.		
Condition			

Below, please list any prescription drugs you (or anyone proposed for insurance) have taken in the last five years.

Name	Medication	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Regular Physician:

Regular physician or medical practitioner for each proposed insured: (If none, provide last doctor seen, date, reason & results)

Primary Proposed Insured's Physician: _____

Address: _____ Phone No. _____

Date last seen: _____ Reason & Results: _____

Spouse's Physician: _____

Address: _____ Phone No. _____

Date last seen: _____ Reason & Results: _____

Child's Name: _____ Physician: _____

Address: _____ Phone No. _____

Date last seen: _____ Reason & Results: _____

Child's Name: _____ Physician: _____

Address: _____ Phone No. _____

Date last seen: _____ Reason & Results: _____

Child's Name: _____ Physician: _____

Address: _____ Phone No. _____

Date last seen: _____ Reason & Results: _____

SECTION 6

- A. **Accurate, complete and true answers.** I represent that all answers given in this application are accurate, complete and true. *I understand that if my answers on this application are incorrect, incomplete or untrue, Central Reserve Life Insurance Company (CRL) has the right to deny benefits or rescind my certificate in accordance with the provisions of the certificate for which I am applying. I understand the agent has no authority to alter or waive this, or any other, condition of coverage.*
I have not disclosed to the agent any health information which is not disclosed on this application. I understand that any incomplete, incorrect or misleading answers may void any insurance provided to me and my dependents.
- B. **Age requirements.** I understand that I must be an active, dues-paying member of the Association and that my spouse and I must both be between the ages of 16 and 64½ to apply for insurance.
- C. **Preexisting conditions.** I understand that limitations exist on coverage of Preexisting Conditions.
- D. **Precertification of care.** I understand precertification of certain outpatient procedures and tests, as well as pre-admission certification of all hospital admissions (both emergency and non-emergency), is required; otherwise, any benefits which may be payable will be reduced according to the terms of the policy.
- E. **When insurance begins.** *I understand no insurance exists unless and until I receive approval in writing from CRL's Home Office indicating coverage for me and my dependents and the effective date, and that Association dues are required to purchase and continue insurance. If at any time prior to such notification or prior to the actual effective date of coverage, whichever is later, anyone applying for coverage (including myself, spouse, and dependents) consults a doctor, is hospitalized, or has any change in health, I agree to inform CRL's Home Office immediately (Pennsylvania residents should disregard the words "consults a doctor"). If the insurance applied for does not become approved, CRL's only obligation will be to refund the insurance premium paid.*
- F. **No agent waiver.** *I understand that the agent does not have the authority to vary or waive any of the provisions of this application, nor any of the provisions, terms or conditions of any other forms or materials supplied by CRL nor to bind CRL to any promise of coverage.*
- G. **I understand that I must tell CRL if my health condition or if the health condition of any of my dependents changes between the date this application is signed and the actual effective date of coverage, if approved.**
- H. **Verification telephone call.** I, the undersigned, understand that CRL will confirm the information on my application for insurance with a verification telephone call. It is my understanding that this verification call takes approximately ten (10) minutes and is a routine process for those applying for coverage with CRL and that this telephone call will be tape recorded. I also understand that my application will not be considered if verification is not completed.
I (or my spouse, if applicable) may be contacted at the telephone numbers listed below. [If I cannot be contacted, I will call Central Reserve Life at 1-800-253-4651.]
Member () Spouse () Telephone No. () _____ Time ____ a.m./p.m. Work () Home () Other ()
Member () Spouse () Telephone No. () _____ Time ____ a.m./p.m. Work () Home () Other ()

I. By signing below, I acknowledge that:

- (i) I understand that the opportunity to apply for group insurance is contingent upon membership in the association and that, if I am not already a member, by signing this application, I am applying for membership in the association and authorizing CRL to collect any membership dues and remit them to the association on my behalf (In the state of Missouri, this application cannot be used to apply for membership in the association. A separate application must be submitted); and
- (ii) I have read this application, the plan brochure, including any state-specific inserts and have had an opportunity to read and review a sample certificate booklet, and that I understand and accept the terms and conditions provided in all of these materials, including, but not limited to, the plan benefits, exclusions, and limitations; and
- (iii) Any disputes arising under the Policy/Certificate are subject to an appeals procedure, including arbitration, which will be binding, unless binding arbitration is prohibited by the law of my state of residence. If binding arbitration is prohibited in my state, I understand that any disputes are subject to non-binding arbitration or non-binding mediation or voluntary arbitration.

Notice to Virginia Insureds about Coordination of Benefits (COB): If you are covered under other group accident and sickness coverage, the other plan may have primary responsibility for covered expenses of other family members who are covered under this plan. Dependent children will receive primary coverage from plans that do not have a COB provision. If a plan does contain a COB provision, primary responsibility for coverage of dependent children is determined either by the month in which each parent's birthday falls, or by gender, depending upon the terms of each plan. Insured persons are required to furnish CRL with information concerning all active plans and the benefits payable from those plans. Upon receipt of this information, CRL will be able to answer questions regarding primary and secondary coverage. For details regarding COB, refer to the certificate booklet for each plan.

NOTICE: For New Mexico residents only: We are required by New Mexico law to inform you of the following: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

NOTICE: For Kentucky and Ohio residents only: We are required by Kentucky and Ohio law to inform you of the following: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

NOTICE: For Oklahoma residents only: We are required by Oklahoma law to inform you of the following: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

NOTICE: For Pennsylvania residents only: We are required by Pennsylvania law to inform you of the following: "Any person who knowingly and with intent to defraud any insurance company or other person, files an application of 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 subjects such person to criminal and civil penalties."

NOTICE: For Tennessee residents only: We are required by Tennessee law to inform you of the following: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

NOTICE: For Virginia residents only: We are required by Virginia law to inform you of the following: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits."

My authorization to obtain records and information. I hereby authorize any physician, practitioner, pharmacy, hospital, or medically-related facility, insurance company, employer or other organization, institution or person that has my records or knowledge of me or any member of my family to give to CRL, or its authorized representative, any such records or information. Records or information shall include, but are not limited to, medical records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used to determine eligibility for the insurance applied for and possible future investigative needs. I also authorize CRL to provide such information to its reinsurer(s), pre-certification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including but not limited to, the writing agent and general agent or as lawfully required. CRL reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties. I have the right to request access to all personal information collected and, upon written request, I may ask CRL to correct, amend or delete any incorrect personal information. A copy of the company privacy and insurance information practices is available upon request.

This authorization shall be valid from the date signed for a period of two (2) years from the date signed. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time upon written notice to the person holding the authorization, subject to the rights of anyone who acted in reliance on the authorization prior to notice of its revocation.

X _____ Signed in the State of _____
 Signature of Member (signature of Parent or Legal Guardian
 required if child is under age 18) Date Signed

X _____ Date Signed
 Signature of Spouse (if applying for coverage)

X _____ Date Signed
 Signature of Dependent (if age 18 or older)

(THE MEMBER MUST SIGN ABOVE IN ORDER FOR ANY COVERAGE TO BE CONSIDERED.)

SECTION 7 BANK AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER

If you want to pay your premiums by electronic funds transfer:

- Attach a voided check from the account you wish to use.
- Sign below.

Authorization to honor checks drawn by
Central Reserve Life Insurance Company (CRL)

(In the state of South Carolina, all references to "CRL" are replaced with "the Association")

I authorize you to pay and charge to my account checks drawn by CRL to its own order. I agree that this authorization in no way affects the terms of this insurance coverage and I understand that if any such withdrawal is not paid to you for any reason, with or without cause or whether such non-payment is intentional, inadvertent or otherwise, you shall be under no liability whatsoever, even though such non-payment results in the forfeiture of insurance. This authorization is to remain in full force and effect until written notification from me of its termination. Notice must be received at least ten (10) days prior to the scheduled withdrawal date to afford the Insurance Company and the depository an opportunity to act on the request.

_____ Date

_____ (Signature of bank depositor – as shown on bank records for the account to which this authorization is applicable)

INDEMNIFICATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

TO: The Bank named on voided check:

In consideration of your participation in a plan which Central Reserve Life Insurance Company (CRL) has put into effect by which amounts for premiums due on certificates of insurance are collected by drafts drawn by CRL on accounts of persons who have made themselves responsible for these payments, CRL does hereby agree that subject to the terms and provisions of such insurance policies without varying, extending or altering the terms thereof:

- (1) It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any check drawn by CRL on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such checks drawn by CRL, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a certificate of insurance, the premium on which is sought to be collected by CRL by any such check; and
- (2) It will refund to you any amount erroneously paid by you on any such check of claim for the amount of such erroneous payment is made by you within a reasonable time from the date of the check on which such erroneous payment was made.

 **TEAR OFF SECTION BELOW PERFORATION AND LEAVE WITH APPLICANT** 

NOTICE TO PERSONS PROPOSED FOR INSURANCE

As part of our normal procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained as to the character, general reputation, personal characteristics and mode of living of persons proposed for insurance in this application. Personal interviews with friends, neighbors and associates may be used to develop this report. (In WV, no information collected concerning the sexual orientation of the proposed insured will be used to determine his or her eligibility for insurance.) Within a reasonable time after receipt of this Notice, you have the right to make a written request of this Company to receive additional detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. We or our reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information in its file.

SECTION 8**CERTIFICATION OF SOLICITING INSURANCE AGENT****TO CRL:**

As the soliciting insurance agent, I certify that I have fully explained to this Member all insurance benefits, limitations, exclusions and conditions as set forth in the sales brochure for the selected insurance plan and in soliciting this business I have fully complied with the CRL Agent Code of Ethics and Procedures, form S911.

I have advised the Member not to cancel any existing coverage unless and until the Member receives an approval letter from CRL's Home Office stating the effective date of coverage.

I certify that I am not aware of any information which might have an adverse effect on the insurability of any person here proposed for insurance.

I further certify that I have reviewed this application, and that it has been completed in full for submission to CRL.

Signed at _____, on this _____ day of _____, 20_____

Signature of Soliciting Insurance Agent

Agent S.S. # (Required)

Agent Code

Print or Type Name of Agent

Agent Address

Agent Phone

Agent Email Address

Application taken: In Person By Phone By Mail

**TO BE
COMPLETED BY GA/MGA**

GA/MGA

GA/MGA Code



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NOTICE TO PERSONS PROPOSED FOR INSURANCE (continued)

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We, or our reinsurers, may also release information in our file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

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