

**APPLICATION FORM FOR
ACCIDENT-ONLY INSURANCE**

TIME INSURANCE COMPANY

PLEASE PRINT IN BLACK INK

TYPE OF ACTIVITY

New Change Conversion Reinstatement Policy Number _____

PERSON(S) PROPOSED TO BE INSURED

Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Social Security #	Height	Weight
(Applicant)							
(Spouse)							

Dependents

Relationship	Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Full time student
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Resident Address _____
Street City State ZIP

Email Address _____

Home Phone () _____ Business Phone () _____ Best Time to Call _____

Name of Employer _____ Type of Business _____

Job Title _____

Job Duties _____

PROPOSED ADDITIONS TO AN EXISTING POLICY ONLY

Add Spouse named above Add Dependent(s) named above

Reason(s) for addition(s) _____

Desired effective date for addition(s): _____

Complete the POLICY INFORMATION section below to indicate the type of coverage now desired. Complete the remainder of the application respective to any coverage applicable to the proposed addition.

BILLING – to be completed by agent

Payroll Deduction

Monthly 28 day
 Other _____

Direct

Monthly Credit Card Monthly EFT (Electronic Fund Transfer)
 Annual Billing

Employee No. _____ Dept. No. _____

Billable Premium \$ _____ Premium Collected \$ _____

Sit. Code _____

POLICY INFORMATION - to be completed by agent

CHECK COVERAGE DESIRED

- Individual only Individual and Spouse
 One-Parent Family Two-Parent Family

Occupation Class _____
 Industry Code _____
 Industry Class A B C D E

	Modal Premium	If Payroll Deduction
<input type="checkbox"/> Level 1 Off the Job Accident Policy <input type="checkbox"/> Level 2 Off the Job Accident Policy <input type="checkbox"/> Level 1 24-hour Accident Policy <input type="checkbox"/> Level 2 24-hour Accident Policy	\$	<input type="checkbox"/> Pre Tax <input type="checkbox"/> After Tax

Optional Rider Coverage	Number of Units*	Disability Benefit Period	Disability Elimination Period	Modal Premium	If Payroll Deduction
<input type="checkbox"/> Off the Job Accident Disability Rider (available for Applicant only)		<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	<input type="checkbox"/> 0 days <input type="checkbox"/> 7 days	\$	After tax only
<input type="checkbox"/> On the Job Accident Disability Rider (available for Applicant only)		<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	<input type="checkbox"/> 0 days <input type="checkbox"/> 7 days	\$	
<input type="checkbox"/> Sickness Disability Rider (available for Applicant only)		<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months	14 days only	\$	
<input type="checkbox"/> Spouse Off the Job Accident Disability Rider (available for Applicant's spouse only)		6 months only	0 days only	\$	
*NOTE: Each unit is equal to a \$100 monthly benefit				\$	TOTAL PREMIUM

INSURANCE AND HEALTH HISTORY

1. Are you covered under another accident policy with
- Is this a change of that coverage?
- Time Insurance Company? No Yes, policy # _____ No Yes
 - Union Security Insurance Company? No Yes, policy # _____ No Yes
 - John Alden Life Insurance Company?..... No Yes, policy # _____ No Yes
2. Has anyone proposed to be insured been charged with driving under the influence of alcohol or any narcotic within the last 12 months or been charged two or more times within the last five years? Yes No
- If "Yes", please list the name and relationship of each person _____

**Anyone listed in response to 2 will not covered under the policy or any riders.
 If the applicant is listed, a policy will not be issued, in which case do not submit this application.**

- 3a. Has anyone proposed to be insured been diagnosed with or treated for an injury, disease, or disorder of the back, the neck, or a joint by a member of the medical profession in the last 12 months? Yes No

If you answered "Yes" to 3a, provide the details below and complete 3b.

Person's Name	Medical Conditions	Onset MM/YYYY	Surgery Performed? If "Yes", provide the type of procedure and date

For policies that provide benefits for expenses incurred for an accidental injury only

**IMPORTANT NOTICE TO PERSONS ON MEDICARE:
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE.**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplemental Insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.

These include: hospitalization; physician services; and, other approved items and services.

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

BEFORE YOU BUY THIS INSURANCE

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

FAIR CREDIT REPORTING ACT AND PRIVACY PRE-NOTIFICATION

Thank you for considering Time Insurance Company as your insurance carrier. Your enrollment form will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this application form which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

Information collected by us and used to issue an insurance policy or certificate may be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, PO Box 1739, Ft. Mill, SC 29716-1739.

FRAUD WARNING

Any person who, with intent to defraud or knowingly presents false information on an application for insurance, or files a false or fraudulent claim for payment of a loss or benefit, is guilty of insurance fraud. Any person found guilty of insurance fraud may be subject to fines and confinement in prison.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding you insurability will be treated as confidential. Time Insurance Company or its 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 a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction on 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. Time Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability or medical insurance, or to whom a claim for benefits may be submitted.

**APPLICATION FORM FOR OPTIONAL DISABILITY RIDERS
WITH THE ACCIDENT-ONLY INSURANCE**

TIME INSURANCE COMPANY

PLEASE PRINT IN BLACK INK

Last Name	First Name	M.I.	Sex	Birth date MM/DD/YYYY	Social Security #
(Applicant)					

IF APPLYING FOR ANY DISABILITY RIDER, PLEASE COMPLETE 1-7

- 1a. I certify that my gross annual income (without overtime, unless contractual, bonuses or other incentives) for my full-time job is \$ _____
Annual income must be \$10,000 or greater for coverage to be issued.
I understand this information will be verified at the time of claim.
- 1b. **If applying for the Spouse Disability Rider:**
I further certify that my spouse's gross annual income (without overtime, unless contractual, bonuses or other incentives) for his/her full-time job is \$ _____
Spouse's employer _____ Spouse's Job Title _____
2. Does anyone proposed to be insured under a disability rider have a short-term disability policy or policy rider with Time Insurance Company, Union Security Insurance Company, or John Alden Life Insurance Company? Yes No
3. If your industry is class E, have you been employed for less than 12 months with the employer listed on the front page of this application? Yes No
4. Does anyone proposed to be insured currently have disability coverage, that you purchased, which remains in force, and if combined with this applied-for coverage, exceeds 70% of their monthly gross (pre-tax) income? Yes No
5. Is anyone proposed to be insured currently on leave or not working because of sickness, maternity or injury? ... Yes No
6. Are there any material or substantial job duties that anyone proposed to be insured is unable to perform because of sickness, maternity or injury? Yes No
7. Does anyone proposed to be insured work fewer than 30 hours per week in the primary (full-time) occupation with the employer listed on the first page of the application? Yes No

If you answered "Yes" to any of 3-7, please indicate to which person any "Yes" answer applies: Applicant Spouse

The person indicated above is not eligible for disability rider coverage; therefore, no disability rider will be issued for that person.

IF APPLYING FOR THE ON-THE-JOB DISABILITY RIDER, PLEASE COMPLETE 8

8. Are you covered by worker's compensation or a similar law in your full-time job? Yes No

If you answered "Yes" you are not eligible for On-the-Job Rider coverage; therefore, this rider will not be issued.

IF APPLYING FOR THE SICKNESS DISABILITY RIDER, PLEASE COMPLETE 9-15

9. Has a member of the medical profession ever diagnosed you with or ever treated you for any of the following? Yes No
- Cardiomyopathy
 - Chronic fatigue syndrome
 - Chronic hepatitis
 - Chronic liver disease
 - Chronic obstructive pulmonary disease
 - Crohn's disease
 - Emphysema
 - Fibromyalgia
 - Heart valve replacement
 - Multiple sclerosis
 - Muscular dystrophy
 - Pulmonary fibrosis
 - Regional enteritis/ileitis
 - Rheumatoid arthritis
 - Rheumatic fever
 - Stroke or TIA (mini-stroke)
 - Systemic lupus
 - Ulcerative colitis
 - Vascular insufficiency (circulatory problems)

10. Have you ever been diagnosed with acquired immune deficiency syndrome (AIDS) by a member of the medical profession or have you ever tested positive for human immunodeficiency virus (HIV)? Yes No

Acquired Immune Deficiency (AIDS) is caused by a virus known by several names i.e. Human Immunodeficiency Virus (HIV); Human T-Lymphotropic Virus Type III (HTLV-III); Lymphadenopathy Associated Virus (LAV); and AIDS Related Virus (ARV). It may take anywhere from a few months to several years or more after initial infection with HIV for AIDS or ARC to develop. AIDS is a condition that breaks down part of the body's immune system making it difficult for the body to fight off infection and disease. AIDS Related Complex (ARC) is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorder with no known cause.

11. In the past five years, have you been diagnosed with or treated for cancer (other than nonmelanoma skin cancers)? Yes No

12. Have you ever been diagnosed with or received treatment for Type I diabetes; or Type II diabetes (1) diagnosed prior to age 30, or (2) with complications to include retinopathy, neuropathy, or nephropathy, or (3) with continued tobacco use or (4) requiring the use of insulin within the past five years? Yes No

13. In the past 24 months, has surgery been performed for any of the following or have you been diagnosed with or treated for any of the following: Yes No

- Angina (heart-related chest pains)
- Atrial fibrillation
- Carpal tunnel syndrome
- Congestive heart failure
- Coronary angioplasty (or stents)
- Coronary bypass surgery
- Drug or alcohol abuse
- Heart attack
- Kidney disease (not including kidney stones)
- Sciatica

14. In the past 12 months, have you received treatment in an emergency room or Hospital or missed ten total days of work for any of the following: Yes No

- Asthma
- Blood disorders
- Chronic bronchitis
- Diverticulitis
- Gastric bypass
- Hypertension / high blood pressure
- Joint replacement
- Pancreatitis
- Seizures
- Type II diabetes

15. Have you been advised by a Physician to be hospitalized or to have surgery that has not yet been performed (excluding routine childbirth)? Yes No

If you answered yes to any of 9-15, you are not eligible for Sickness Disability Rider coverage; therefore the rider will not be issued.

IF APPLYING FOR MORE THAN 4 UNITS OF SICKNESS DISABILITY COVERAGE – PLEASE COMPLETE 16-19

16. Have you received disability benefits or claimed workers' compensation in the last five years? Yes No

17. In the past 12 months, have you missed five consecutive days or ten total days of work because of your sickness or injury (not related to routine childbirth)? Yes No

18. In the past 12 months, has a member of the medical profession diagnosed you with or treated you for any heart disease or disorder excluding insignificant heart murmurs? Yes No

19. In the past 12 months, have you been confined to a hospital as an inpatient (not including confinement because of routine childbirth)? Yes No

If you answered "Yes" to any of Items 16-19, you must provide details below for the appropriate items and complete 20

	Medical Condition	Onset (MM/YYYY)	Surgery Performed? (If "Yes", provide the type of procedure and date)
16. <i>Detail:</i>			
17. <i>Detail:</i>			
18. <i>Detail:</i>			
19. <i>Detail:</i>			

20. Your Physician's Name _____ Phone Number _____
(if no regular physician, physician last seen)
Address _____
Street City State ZIP
Date Last Seen by Physician _____ Reason for Last Visit _____

I understand this application acts as an addendum to the application form for Accident-Only Insurance. All representations and affirmations made in the Applicant's Agreement and Agent Information and Review of the form apply equally to the information provided on this form.

Signature of Proposed Policyowner Date signed

Signature of Licensed Resident Agent Date Signed