

Instructions

1. Please fully complete the entire enrollment form. If waiving all coverage, complete only the waiver section.
2. Please type or print in ink. Date and sign in ink. Be sure to initial any corrections you make.
3. If your employer offers multiple plans, please review dental options with your employer. Refer to your employer's billing statement for the plan description for medical to make your selection.
4. Please make a copy of the completed enrollment form to keep for your records.

Please Note:

1. John Alden is not responsible for enrollment forms not sent to us in a timely manner.
2. Effective dates will be either the 1st or 15th of the month, but not before (a) the date of enrollment, (b) the date of John Alden's receipt of this form, and (c) the end of your group's waiting period. Effective dates are subject to underwriting approval and are assigned in accordance with any applicable state mandates.



Detach and keep for your records

Important Notices About Your Rights (Continued)

The bureau, upon request, may give its members a report when an insured applies for new insurance or when an insured submits a claim. We may give a report to other insurance companies under these same conditions.

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 P. O. Box 105 Essex Station, Boston, MA 02112, telephone number 617-426-3660.

3. As part of our normal underwriting procedure, we may order an investigative consumer report. Information may be obtained through personal interviews with your neighbors, friends, or others you know. This includes information as to your character, general reputation, and personal characteristics. You have the right to: (a) request a personal interview in connection with the preparation of any such report and (b) request in writing a copy of any such report. To make such a request, please write to us:

Vice President, Underwriting Department
John Alden Life Insurance Company
P.O. Box 9398
Minneapolis, MN 55440-9398



JOHN ALDEN HEALTH
EMPLOYEE ENROLLMENT FORM

TO AVOID DELAYS IN PROCESSING, ALL AREAS MUST BE COMPLETED IN INK BY EMPLOYEE.

This enrollment is for: Group No.
New Group Adding Spouse
New Enrollee Adding Dependent Coverage No. of Children
Coverage Change Main Location City: State:
Requested Effective Date: Month: First or Fifteenth

Company name Your work address
Employee's name: last: first: MI: Social Security No.:
Employee's address County City
State Zip Home phone () Work phone ()
Single Married: date of legal marriage Divorced: date of legal divorce
Date of birth State of birth Height: ft in Weight Sex
Date employed full-time Occupation Hours worked per week for this company
Current monthly income from this company \$ Current status At work COBRA Disability Retired

Selected Coverage If waiving any coverages, complete the waiver section of this form.

1. All coverages provided by employer Life & AD&D (no medical) Dental Only Life, AD&D & Dental (no medical)
Life amount \$ Disability amount \$
2. Life Insurance beneficiary's name Age Relationship
Address
If no beneficiary is designated, benefits will be paid according to the terms of the Certificate of Group Insurance.
3. For Employee Choice and/or Dental Choice Plans: Indicate plan selection(s) from employer's billing statement and quote
Dental Choice: PPO Indemnity

Eligible Dependents To Be Enrolled

Are you enrolling every eligible dependent? Yes No Complete the waiver section for any family members that are not to be insured.

Table with 7 columns: Name (Last, First, M.I.), Sex, Birth Date, State of Birth, Social Security No., Height, Weight. Rows include Legal Spouse and Child.

Please explain if any child listed above is (a) not your natural child, legally adopted child, or stepchild, (b) not solely supported by you, or (c) not permanently residing in your household.

Required Information About Other Coverage and Prior Coverage

Important: This section must be completed to establish your eligibility for credit to waive all or part of a preexisting condition limitation period.
1. Have you and all dependents you are enrolling been covered by this employer's major medical plan(s) for the past 12 months?
2. Have you or your dependents been covered under any major medical plan or plans at any time in the past 12 months?
3. Do you or your dependents have any other health insurance coverage that will remain in force after you are covered by this plan?
4. Are you or your dependents on COBRA Continuation Medicare? If so, name: Effective date: Reason:



Health History Please explain all yes and circled answers in the space after question 6.

1. Have you or any person you are enrolling ever had, been medically advised they had, been treated for, or been referred for counseling for any of the following? **Please circle all that apply:**

a. Cancer, leukemia, diabetes, paralysis, stroke, or disorder of the heart, muscles, kidneys, liver (including hepatitis) or colon? Yes No

b. Immune disorders, AIDS, sexually transmitted diseases, chronic lung disorders, Kaposi's sarcoma or a positive test for HIV? Yes No

c. Any nervous, mental or behavioral disorder, alcoholism, or chemical, alcohol or drug abuse or addiction, or used illegal drugs or prescription medication other than as prescribed? Yes No

2. Are you or any person you are enrolling currently taking prescribed medication, under medical treatment, or been advised of the possibility or necessity of any future treatment or testing? Yes No

3. Is any person you are enrolling totally or partially disabled? Yes No
 If yes, name _____ Date of onset: _____

4. Are you or any family member, enrolling or not, currently pregnant? Yes No
 If yes, name: _____ Due date: _____ Anticipated Complications: Yes No
 Multiple Births: Yes No

Additional Health Questions

5. Have you or any person you are enrolling ever had, been medically advised they had, or been treated for any of the following? **Please circle all that apply:**
 Disease or disorder of the digestive system, seizure disorder, arthritis, back disorder, other physical disorder or deformity, or medical claims exceeding \$10,000 in the last 24 months? Yes No

6. Has anyone applying for coverage smoked or used tobacco products during the past 12 months? Yes No

For all yes and circled answers above, provide the following information:

Question No. & Ltr.	Name of Patient (Maiden Name if Applicable)	Physician/Clinic (Complete Address & Tel. No.)	Dates Seen	Condition/Diagnosis, Results of Treatment, and Medication Prescribed

Authorization and Signature

I represent that all the information I have provided on this form is complete and true to the best of my knowledge and belief. I understand that John Alden Life Insurance Company will rely on all of this information in deciding whether or not to issue coverage, to determine eligibility for benefits, and that any incorrect or incomplete information may void this insurance. I hereby request to participate in my employer's group plan. All my elections and authorizations shall remain in effect until I change them in writing. I authorize deductions from my earnings of any contributions for continued participation as may be required now or later. I understand that health and disability benefits may be limited or excluded according to the preexisting conditions limitation provisions of the plan. I authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, insurance or reinsurance company, or employer having certain information about me or my dependents to give all such information to John Alden Life Insurance Company or its legal representative. I also authorize John Alden Life Insurance Company to release any information obtained to reinsurance companies, MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required, or as I may further authorize. I agree this authorization shall be valid for two and one half years from the date shown below. I know that I may request to receive a copy of this authorization. I agree that a copy of this authorization shall be as valid as the original. I also acknowledge that I have read the Important Notices About Your Rights that appear on this form. I understand that any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I understand that the agent submitting this enrollment form represents my interests, not those of John Alden Life Insurance Company. The agent has no right to bind coverage, to alter the terms of insurance coverage or enrollment form in any manner, or to adjust any claim for benefits.

Signature of Proposed Insured Employee _____ Date _____

Group Insurance Waiver

If waiving any coverages for yourself or dependents, please complete this waiver section.

All eligible employees and dependents must be listed as either enrolling or waiving coverage when first eligible. If you or any of your eligible dependents do not enroll in John Alden coverage when it is first made available and want to enroll in the future, your coverage may be postponed and/or subject to a preexisting condition exclusion for up to 18 months. This preexisting condition exclusion does not apply to maternity benefits. If you or any of your eligible dependents do not enroll in John Alden dental coverage when it's first made available and want to enroll in the future, your coverage may be subject to extended waiting periods for certain benefits. For further information on the late addition policy for group employers in your state, contact your agent or a John Alden representative.

Persons Waiving	Coverage to Be Waived	Other Coverage	Carrier Name(s)	ID No.(s)	Phone(s)	Effective Date(s)
Employee	<input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> All except medical	<input type="checkbox"/> Medical <input type="checkbox"/> Dental				
Spouse	<input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> All except medical	<input type="checkbox"/> Medical <input type="checkbox"/> Dental				
Child(ren)	<input type="checkbox"/> All <input type="checkbox"/> Medical <input type="checkbox"/> All except medical	<input type="checkbox"/> Medical <input type="checkbox"/> Dental				

Please indicate the type of other coverage in effect and for whom:

<input type="checkbox"/> Spouse's employer plan	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Medicare/Medicaid	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Military	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> COBRA	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Individual	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
<input type="checkbox"/> Other. Explain:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or John Alden. I and my dependents have waived such coverage of our own accord.

Print complete name: last, first, and middle initial

Company name

Date of full-time employment

Employee signature

Date

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Important Notices About Your Rights

Please read these notices carefully. Detach this portion to keep with your health insurance records.

1. To properly underwrite and administer your insurance coverage, we need certain information. You are our main source of information, but we may also collect or verify information by contacting: (a) medical professionals and institutions which have provided care to you or family members proposed for coverage, (b) employers and business associates, (c) friends and neighbors, and (d) insurance companies to which you have applied for coverage or benefits. The nature of information you authorize to be disclosed includes: physical conditions, health histories, avocations, ages, occupations, personal characteristics, use of drugs, alcoholism, mental illness, and communicable diseases.

Disclosure of personal or privileged information may be made without your authorization to third parties. For example, we may disclose such information to: (a) persons or organizations that perform professional, business or insurance functions for us, such as independent claim examiners or group plan administrators, or (b) other insurance companies to which you have applied for coverage or benefits.

You have a right to access, correct, and amend personal information appearing in our files, including information contained in investigative consumer reports. A complete description of our information practices and your rights will be sent to you upon request.

2. Data regarding the insurability of any person proposed for coverage is confidential. We may, however, make a brief report to the Medical Information Bureau. The bureau is a nonprofit organization of life insurance companies operating an information exchange for its members.