

All applicants review the following guidelines and complete this section to request coverage.

- Amounts must be elected according to the Rate Schedule provided.
- Depending on the amount of coverage you elect, you may be required to complete the Health Questions.
- Consult your agent for details concerning maximum amounts of insurance and Evidence of Insurability requirements.

Coverage	(N)ew (I)ncrease (D)ecrease (C)ancel	Monthly Benefit Amount	If (I) Or (D), My Prior Coverage Was	Monthly Premium / Rate
Short-Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Elimination Period _____ Max. Period of Payment _____				
Long-Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Elimination Period _____ Max. Period of Payment _____				
Number of Salary Deductions/Year _____				

NOTICE REGARDING MEDICAL INFORMATION BUREAU AND INSURANCE INFORMATION PRACTICES

Information regarding your insurability will be treated as confidential. The 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 (excluding test results for exposure to the HIV infection). 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. 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 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: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone number: (866) 692-6901 (TTY 866-346-3642).

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures or personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, MO 64108-2670.

Health Questions (For Employees Applying for Amounts of Insurance over the Guaranteed Issue Limit, Enrolling Late, Increasing Coverage, or Enrolling again after having Cancelled Coverage)

Last Name	First Name	Middle Initial	Social Security No.
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Please answer the following questions.

If you answer "YES" to any questions, please provide details in REMARKS below.

Height _____ Weight _____

1. Have you gained or lost 10 or more pounds during the past 12 months? Yes No
If "YES", how much? _____

2. Have you within the past 5 years: Yes No
 - a. Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation, or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?
 - b. Used any illegal drugs? Yes No

3. In the past 5 years, have you been treated by a physician for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection? Yes No

4. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection. Yes No

5. Are you pregnant as confirmed by a physician? Yes No

6. Have you been medically diagnosed, treated or been advised to seek treatment by a physician for: Arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer (other than breast cancer, but including melanoma, leukemia or Hodgkin's disease) or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; or immune system disorder? Yes No

"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.

Name, address and telephone number of personal physician _____

REMARKS – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Question No.	First Name	Description of illness, injury, or pregnancy, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (include zip code)

If Answering Health Questions, the Employee signature is required on page 4 of this form.

