Colonial Supplemental Insurance
Sunland Group Interest Form (this is not an application for insurance)

Employee Name: _____ Social Security Number: _____-_____-_____

Date of Birth: ____/____/_____ Job Title: _____Hire Date: ____/____/_____

Mailing Address: _____ City: _____ St: _____ Zip Code: _____

Hourly or Annual Income _____ Phone: _____- _____- _____ Marital Status: Married __ Single __

Beneficiary: Name _____ Date of Birth ____/____/_____ Relationship _____

Email Address: _____ Birth State: _____

Check all boxes that apply and complete both pages. Premiums are bi-weekly (26 pay periods). If you have a question, feel free to call or email our Colonial Representative, Joseph Rosser (281-639-0564 or joseph.rosser@coloniallife.com)

Accident Benefit- __$8.77 (EE Only) __$11.84 (EE/Spouse) __$14.08 (EE/Children) __$17.16 (Family)

Cancer Benefit- ($100 Wellness Benefit and $5,000 Initial Diagnosis of Internal Cancer)

__$11.81 (EE Only) __ $18.97 (EE/SP) __$12.11 (EE/Children) __$19.27 (Family)

Hospital Confinement Benefit ($1000 per In-Hospital Confinement and $500-Tier 1/$1000-Tier 2 Out-Patient Surgery - Benefit-Maximum Out-Patient Surgery Per Year is $1500)

	Employee Only	Employee/Spouse	Employee/Children	Employee/Family
Ages 17-49	__$8.53	__$18.30	__$14.56	__$22.17
Ages 50-59	__$11.81	__$25.24	__$17.58	__$28.66
Ages 60-64	__$15.41	__$33.55	__$21.60	__$36.41
Ages 65-74	__$19.33	__$42.02	__$27.04	__$45.60

Critical Illness ($25,000 Lump Sum Benefit for Covered Sickness-Heart Attack, Stroke, Renal Failure, Major Organ Transplant)

	Non-Tobacco				**Tobacco**		
17-24	__$3.76	45-49	__$12.87	17-24	__$4.91	45-49	__$20.14
25-29	__$4.56	50-54	__$16.56	25-29	__$6.41	50-54	__$25.33
30-34	__$5.49	55-59	__$20.49	30-34	__$8.37	55-59	__$32.14
35-39	__$7.33	60-64	__$25.68	35-39	__$11.95	60-64	__$38.83
40-44	__$9.64	65-70	__$30.76	40-44	__$15.53	65-70	__$47.03

20 Year Term Life Insurance (See Attached Page for Monthly Rates by Age)

Employee:	__$10,000	__$25,000	__$50,000	__$75,000	__$100,000
Spouse:	__$10,000	__$25,000	__$50,000		

Signature: _____ Date: _____

Please Answer the Questions below as they apply to you, your spouse and/or your children:

1. Are you actively at work: Employee __ Yes __ No; Spouse __ Yes __ No

2. In the 12 months, has the employee been out of work for 10 consecutive days due to either illness or injury? __ Yes __ No If Yes, Explain: _____

3. Have you tested positive for HIV? Employee __ Yes __ No; Spouse __ Yes __ No

4. Within the past 12 months have you, your spouse or children(if applying) received Medical advice or sought treatment for Heart Attack, Stroke, Heart Surgery, High Blood Pressure, Diabetes prior to age 40, Insulin Dependent Diabetes? __ Yes __ No
   If Yes, Explain: _____

5. Within the past 5 years, have you, your spouse or children(if applying) received Medical advice or sought treatment for Skin Cancer, including basal cell carcinoma, squamous cell carcinoma, or melanoma Clark's Level I or Clark's Level II? __ Yes __ No
   If Yes, Explain: _____

6. Within the past 5 years, have you, your spouse or children (if applying) received Medical advice or sought treatment for Cancer, or in the past 12 months have you received Preventative Hormonal Therapy? __ Yes __No
   If Yes, Explain: _____

7. Are you currently taking any prescribed medications: __ Yes __ No. If so, please list the names and the reason for taking the medication. _____

Tobacco User: **Employee** __ Yes __ No **Spouse** __ Yes __ No

Height/Weight: **Employee:** **Height** ___ft. ___ in. **Weight** ____

Spouse: **Height** ___ft. ___ in. **Weight** ____

Dependent Information:

Spouse: Name _____ Date of Birth _____ Employer _____

Occupation: _____ Annual Income _____ Hire Date: _____/_____

Children:

Name: _____ Date of Birth ___/___/_____ Ht. ___ Wt. ___

Name: _____ Date of Birth ___/___/_____ Ht. ___ Wt. ___

Name: _____ Date of Birth ___/___/_____ Ht. ___ Wt. ___

Note: Any pre-existing conditions prior to 12 months of the policy effective date will not be covered for 12 months after the policy effective date. After 12 months, a pre-existing condition will be covered.

Signature: _____ Date: __/__/____