Return to: Benefits
3500 W. Olive #1000
Burbank, CA 91505
(818) 972-8992 (fax)
cathy.marcus@warnerbros.com

CriticalAssistance® Advance Employee Application

☐ First Application ☐ Add Dependents – Certificate # ______ ☐ Increase Coverage – Certificate # ______

Group Name	Group Number	Location

Applicant (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Home phone

Email Address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No	Have you used tobacco products in the last year? ☐ No ☐ Yes

Date of hire	Avg hours worked per week	Occupation	Applicant ID	Work phone/ext.

Home address	City	State	Zip code

Full name of dependents for which coverage is being applied for.	Relationship to Applicant	Date of Birth	Social Security No.	Used tobacco products in the last year?
				☐ No ☐ Yes
				Does not apply to children

Payment Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other______

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family

Critical Illness Insurance Plan ______

	Policyholder Provided Benefit Amount*	**Applicant Purchased Benefit Amount***	**Applicant Premium Per Payment Mode***
Applicant	$	$	$
Dependents (if applicable)	$	$	

*If increasing coverage, enter the **TOTAL** Benefit Amount and Premium.

Eligibility Questions

1. Are you working on a full time basis and able to perform the regular duties of your occupation? If "No", you and your dependents are not eligible for coverage. ☐ Yes ☐ No
2. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No
   If "Yes", List name(s)______, who will be excluded from coverage.

Evidence of Insurability Questions

3. Indicate height and weight for : Applicant / Spouse /
4. Has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease (Other than HIV)? ☐ Yes ☐ No
   If "Yes", List name(s)______, who will be excluded from coverage, unless included by special endorsement.
   California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
5. To the best of your knowledge, in the five years prior to the application date, has any proposed insured been treated for or been diagnosed as having any heart (including heart attack), lung, brain, circulatory, respiratory, blood, vascular (including stroke), neurological, kidney, liver, pancreas, rheumatoid, or reproductive disorders, diabetes, optic neuritis, fibromyalgia, or chronic fatigue syndrome, been scheduled for any medical or surgical procedures (including major organ transplant) that has not yet been completed, or, in the two years prior to the application date, been treated for alcohol or drug abuse? ☐ Yes ☐ No
   If "Yes", List name(s)______, who will be excluded from coverage, unless included by special endorsement.
6. Does any proposed insured have high blood pressure that is controlled by more than two medications? ☐ Yes ☐ No
   If "Yes", List name(s)______, who will be excluded from coverage, unless included by special endorsement.

Only answer if the coverage you are applying for includes the Cancer Benefit Rider	
7. To the best of your knowledge, in the five years prior to the application date, has any proposed insured been diagnosed as having or been treated for any form of cancer, or malignancy (excluding skin cancer) which includes leukemia, Hodgkin's Disease, carcinoma, sarcoma, lymphoma, or malignant tumors? If "Yes", List name(s) ____________________, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No
8. In the past 12 months, has any proposed insured been scheduled for any medical treatment that has not yet been completed, undergone a biopsy or other diagnostic test, or is now scheduled for such to determine whether any form of cancer or malignancy exists, other than a regular Pap Smear, Mammogram, Colonoscopy, or PSA test? If "Yes", List name(s) ____________________, who will be excluded from coverage, unless included by special endorsement.	☐ Yes ☐ No

Please provide details of all "Yes" answers to questions 4, 5, 6, 7, and 8. Use additional paper if needed.
For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Question #	Name	Please list: Illness, Injury, Condition, Symptoms, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital

APPLICANT'S STATEMENTS AND AGREEMENTS:

For residents of CA, GA, MA, and MN only: Are all proposed insureds covered under major medical, hospital, or medical expense insurance, or an HMO contract? ☐ Yes ☐ No If "No", list names ____________________, who will be excluded from coverage. Coverage will not be issued to anyone who does not have comprehensive medical coverage. If applicant answers "No", no coverage will be issued.

I have read or had read to me the completed application. **I represent** that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.

I understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work on the effective date (according to the insurer's rules); and f) the first month's premium must have been received by the underwriting company at its administrative office. **I understand** that completion of this application in no way implies that I will be accepted for insurance coverage.

Signed in (City/State) ____________________ This ________ Day of (Month/Year) ____________________.

Applicant's Signature ____________________ Spouse's Signature (if applicable) ____________________

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded in this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

Licensed Representative's Name Licensed Representative's Signature Agent #