

# Pan American Life Insurance Company

Employee Application - to be completed by applicant only.

New Employee Enrollment

Change for Existing Employee

GROUP # \_\_\_\_\_

Employer		Address		City		State	Zip
Employer Location					Date Employed Full Time		
Occupation		Ave. Hrs. Per Week		Basic Salary		<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly	
Applicant's Last Name			First		Initial	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Address			City		State	Zip	Phone Number (   )   (   )
Birth Date: M/D/Y	<input type="checkbox"/> Male <input type="checkbox"/> Female		Height	Weight	Social Security Number		
Beneficiary's Last Name			First		Initial	Relationship	

Dependent's First Name	Initial	Last	Relationship	Birth Date	M/F	Height	Weight

**THE FOLLOWING QUESTIONS MUST BE ANSWERED IF APPLYING FOR DEPENDENT COVERAGE**

Yes    No   I acknowledge that all dependent(s) listed above for whom coverage is requested remain principally dependent upon me and are my legal dependent(s) within the meaning of the Internal Revenue Code (IRS).

Yes    No   Do you or any dependent have other group medical/dental coverage in addition to this insurance?  
If yes, list persons covered \_\_\_\_\_

Carrier Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**Coverage Elections**

	Employee Only	Employee & One Dependent	Employee & Family	
<b>Medical</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Silver <input type="checkbox"/> Gold <input type="checkbox"/> Platinum <input type="checkbox"/> Comprehensive
<b>Surgical Rider</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Vision</b>	<input type="checkbox"/>		<input type="checkbox"/>	
<b>Dental</b>	<input type="checkbox"/>		<input type="checkbox"/>	

**Life Insurance** (including AD&D)   Amount \$ \_\_\_\_\_

**Dependent Life** (not available without dependent coverage)    one unit    two units

**Disability** \$ \_\_\_\_\_    Plan A (26)    Plan B (13)

**Change Request**

Requested Date of Change

Please select appropriate changes and indicate any new information.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Beneficiary Change             | <input type="checkbox"/> Change of Address                    | <input type="checkbox"/> Date Married _____  |
| <input type="checkbox"/> Add Dependents                 | <input type="checkbox"/> Change Life Insurance Amount         | <input type="checkbox"/> Date Divorced _____ |
| <input type="checkbox"/> Remove Dependents (list names) | <input type="checkbox"/> Employee Name Change (previous name) | <input type="checkbox"/> Other _____         |

AGENT NAME	AGENT NUMBER
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## MEDICAL QUESTIONNAIRE

**IMPORTANT: Provide details to any "Yes" answers in the space below.**  
(If more space is needed, attach additional paper, signed and dated.)

- Yes  No 1. Have you or any family member applying for coverage had more than \$5,000 in medical expenses within the last 24 months?
- Yes  No 2. Have you or any of your dependents, within the last five years, been diagnosed, examined, received medical care, been medically advised or treated in any way for cancer (malignancy), heart problem/condition, any circulatory disorder, stroke, diabetes, high blood pressure, respiratory disorder, kidney/urinary system disorder, digestive/intestinal disorder, blood disorder, multiple sclerosis, cerebral palsy, alcohol or drug abuse, mental illness, or ever tested positive for HIV (Human Immunodeficiency Virus)?
- Yes  No 3. Have you or any of your dependents consulted, been examined or treated in any way for any other condition not listed above during the last five years?
- Yes  No 4. Are you or any member of your family, whether or not named on this application, now pregnant or had a caesarean section, history of premature birth or infertility?

Question Number	Name	Condition/Diagnosis	Treatment, Medication (dosage) Recovery Status	Dates Treated	Name, Address & Phone of Physician or Hospital

List names of prescribed drugs you or your dependents are taking or have taken within the last three months.  
(If more space is needed, attach an additional sheet of paper and sign and date it.)

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### EMPLOYEE AGREEMENT

I declare that all statements contained in this Medical Questionnaire are true and correct and that no information has been withheld or omitted concerning the past or present state of health about me or my named dependents. I understand that the above answers shall be the basis for the insurer to issue a certificate of insurance. I understand and agree that the insurer is not bound by any agreement made by or to any agent unless written herein. I hereby authorize my employer to deduct from my earnings the necessary contribution toward the premium. Initial premium is a refundable deposit - acceptance does not mean coverage approval. I reserve the right to revoke the initial deduction authorization at any time within 30 days of the effective date, upon my written notice. Coverage is effective only after approval and satisfaction of the waiting period. If I have waived coverage for myself or my dependents, I understand that if I decide to apply for future coverage, I will be required to provide evidence of insurability satisfactory to the insurer before coverage is effective. I HEREBY AGREE THAT NO COVERAGE WILL BE EFFECTIVE UNTIL THE DATE SPECIFIED BY THE INSURER, PROVIDED PREMIUM IS PAID FROM SUCH DATE. I HEREBY CONFIRM AND UNDERSTAND THAT THE UNDERWRITING OF THE INDIVIDUAL APPLICATION TAKEN IN THIS CASE HAS BEEN PREDICATED UPON THE ANSWERS TO THE QUESTIONS IN SAID APPLICATION AND WHERE THERE HAS BEEN A MATERIAL MISREPRESENTATION OF FACTS, COVERAGE CAN BE RESCINDED.

### AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, substance abuse facility, psychiatric facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my dependents' health to give Pan American Life Insurance or its reinsurers any such information. I understand that the information obtained by use of this authorization will be used by Pan American Life Insurance to determine eligibility for insurance benefits. Any information obtained will not be released by the insurer to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal service in connection with my enrollment for insurance, for any claim, or as may be otherwise lawfully required or as I may further authorize. I understand that I may request a copy of this authorization at any time. I agree that a photographic copy of this authorization shall be valid as the original and that this authorization shall be valid for two and one half years from the date shown below.

**This application has been completed by the individual applying for coverage. Any alterations that may have been made to said applications are confirmed by the applicant's initial.**

EMPLOYEE SIGNATURE <b>X</b>	DATE
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### WAIVER

IF YOU DECLINE PARTICIPATION. The benefits of the plan have been thoroughly explained to me and after careful consideration, I have elected not to take this offer.

EMPLOYEE SIGNATURE <b>X</b>	DATE
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