

Application For Individual Life Insurance
Kanawha Insurance Company



Section A: Always complete this Section with Employee Information for all coverages.

Employee / Owner

Name of Employee/Owner (First Name, MI, Last Name - Please Print) Suffix

Birthdate (MM/DD/YYYY) Social Security Number

Gender Male Female

Address

City State ZIP Code Date of Employment (MM/DD/YYYY)

Employer Name and Location

P O R T A R T H U R I S D G R P 8 9 8 1 0 6

Occupation (Exact duties and job title)

Gross Earnings (not including variable compensation)

\$ _____ Per Hour Month Week Year Benefit Group (If Applicable) 1 2 3 4 5

1. Are you currently actively at work?..... Yes No

2. Have you used any form of tobacco in the past 12 months?..... Yes No

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) Social Security Number

Gender: Male Female

3. Has your spouse used any form of tobacco in the past 12 months?..... Yes No

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) Social Security Number

Gender: Male Female

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

Birthdate (MM/DD/YYYY) Social Security Number

Gender: Male Female

Child Three

Child Name (First Name, MI, Last Name)

(If proposed for coverage)

Suffix

Birthdate (MM/DD/YYYY)

Social Security Number

Gender: Male Female

Section B: Complete this Section if applying for Employee Coverage.

Life Paid Up at 99 - Employee Coverage

Automatic Benefit Increase Rider \$1/Week \$2/Week

AD&D Rider

Loss of Work Rider

Waiver of Premium Rider

Automatic Premium Loan Option

Beneficiary:

100% to my Spouse, as recorded on Page 1 of this Application

Other (List Name and relationship): _____

Employee Benefit Amount

\$ _____, _____

Total Modal Premium

\$ _____ . _____

Employee Term Rider - Benefit Amount:

\$ _____, _____

Family Term Rider

Spouse Benefit Amount

\$ _____, _____

Child Benefit Amount

\$ _____, _____

Life Paid Up at 90 - Employee Coverage

Automatic Benefit Increase Rider \$1/Week \$2/Week

AD&D Rider

Loss of Work Rider

Waiver of Premium Rider

Automatic Premium Loan Option

Beneficiary:

100% to my Spouse, as recorded on Page 1 of this Application

Other (List Name and relationship): _____

Employee Benefit Amount

\$ _____, _____

Total Modal Premium

\$ _____ . _____

Employee Term Rider - Benefit Amount:

\$ _____, _____

Family Term Rider

Spouse Benefit Amount

\$ _____, _____

Child Benefit Amount

\$ _____, _____

Life Paid Up at 65 - Employee Coverage

Automatic Benefit Increase Rider \$1/Week \$2/Week

AD&D Rider

Loss of Work Rider

Waiver of Premium Rider

Automatic Premium Loan Option

Beneficiary:

100% to my Spouse, as recorded on Page 1 of this Application

Other (List Name and relationship): _____

Employee Benefit Amount

\$ _____, _____

Total Modal Premium

\$ _____ . _____

Employee Term Rider - Benefit Amount:

\$ _____, _____

Family Term Rider

Spouse Benefit Amount

\$ _____, _____

Child Benefit Amount

\$ _____, _____

Section C: Complete this Section if applying for Spouse and/or Child(ren) Stand Alone Policy.

Spouse Stand Alone Policy - Select coverage desired:

- Life Paid up at 99 Life Paid up at 90 Life Paid up at 65

- Automatic Premium Loan Option AD&D Rider

Spouse Benefit Amount

\$,

Total Modal Premium

\$.

- Family Term Rider (Child Coverage Only)

Beneficiary: 100% to the Employee, as recorded on Page 1 of this Application

Other (List Name and relationship): _____

Child Benefit Amount

\$,

Life Paid up at 65 Child(ren) Stand Alone Policy - Select all coverages desired:

- Coverage on Child 1 Automatic Premium Loan Option

Beneficiary: 100% to the Employee, as recorded on Page 1 of this Application

Other (List Name and relationship): _____

Child 1 Benefit Amount:

\$,

Child 1 Total Modal Premium

\$.

- Coverage on Child 2 Automatic Premium Loan Option

Beneficiary: 100% to the Employee, as recorded on Page 1 of this Application

Other (List Name and relationship): _____

Child 2 Benefit Amount

\$,

Child 2 Total Modal Premium

\$.

- Coverage on Child 3 Automatic Premium Loan Option

Beneficiary: 100% to the Employee, as recorded on Page 1 of this Application

Other (List Name and relationship): _____

Child 3 Benefit Amount

\$,

Child 3 Total Modal Premium

\$.

Section D: Complete this Section if applying for Contingent Guarantee Issue.

4. Has any proposed Insured ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?.....
5. In the past 12 months, has any proposed Insured been disabled, hospitalized, treated in an emergency room, and if employed, missed 5 or more consecutive days of work due to an injury or illness other than cold, flu, back problem, strained / sprained / fractured / broken limb, or maternity?.....
(If # 5 is "Yes," complete questions 6, 7, and 8)

	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
4. Has any proposed Insured ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In the past 12 months, has any proposed Insured been disabled, hospitalized, treated in an emergency room, and if employed, missed 5 or more consecutive days of work due to an injury or illness other than cold, flu, back problem, strained / sprained / fractured / broken limb, or maternity?..... (If # 5 is "Yes," complete questions 6, 7, and 8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Section E: Complete this Section and Section D If applying for Simplified Issue. Complete question 8 if applying for coverage on Child(ren).

6. In the past 5 years has any proposed Insured been diagnosed with, sought treatment, taken medication or been hospitalized for any of the following:

Heart Attack / Heart Surgery / Heart Disease; Stroke / Transient Ischemic Attack (TIA); Cancer (except basal skin cancer); Liver Disease / Hepatitis / Cirrhosis; End Stage Renal / Kidney Disease; Neurological Disorder / Multiple Sclerosis; High Blood Pressure reading (140/90 or above); Emphysema / Lung Disease; Lupus; Blood Disorder; Epilepsy; Alcohol and / or Drug Abuse; Diabetes (Insulin Dependent).....
7. Has any proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 3 years?.....
8. Has any child proposed for coverage ever been diagnosed with or treated for Congenital Cardiac Abnormality or other abnormalities, Spina Bifida, Down's Syndrome, Cerebral Palsy, or Cystic Fibrosis?.....

	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
6. In the past 5 years has any proposed Insured been diagnosed with, sought treatment, taken medication or been hospitalized for any of the following: Heart Attack / Heart Surgery / Heart Disease; Stroke / Transient Ischemic Attack (TIA); Cancer (except basal skin cancer); Liver Disease / Hepatitis / Cirrhosis; End Stage Renal / Kidney Disease; Neurological Disorder / Multiple Sclerosis; High Blood Pressure reading (140/90 or above); Emphysema / Lung Disease; Lupus; Blood Disorder; Epilepsy; Alcohol and / or Drug Abuse; Diabetes (Insulin Dependent).....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Has any proposed Insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 3 years?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Has any child proposed for coverage ever been diagnosed with or treated for Congenital Cardiac Abnormality or other abnormalities, Spina Bifida, Down's Syndrome, Cerebral Palsy, or Cystic Fibrosis?.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

