MARCONE SERVICERS ASSOCIATION

# 2017 APPLICATION
## FOR USA MEMBERS.

PLEASE FILL OUT THE FORM BELOW  ** = FIELDS MUST BE COMPLETED*

* COMPANY _____

* NAME _____

* MARCONE ACCOUNT _____

* ADDRESS _____

* CITY, STATE, ZIP _____

* PHONE _____

FAX _____

* EMAIL _____

LIFE INSURANCE INFORMATION. PLEASE COMPLETE THE FORM BELOW AND THE FORM ON THE OPPOSTIE SIDE FOR COVERAGE. MEMBERS QUALIFY FOR A $5,000 (ASSOCIATE) OR $10,000 (PLUS) POLICY

INSURER'S FULL NAME _____

INSURER'S DATE OF BIRTH _____

INSURER'S PHONE NUMBER _____

BENEFICIARY FULL NAME _____

## 3 WAYS TO REGISTER

1. **ONLINE** at www.msaworld.com
2. **FAX** this completed form to Member Services at 888.760.4264
3. **MAIL** to:
   Marcone Servicers Association
   One City Place Drive, Suite 400
   St. Louis, MO 63141

☐ **ASSOCIATE MEMBERSHIP $192/YR***

☐ **PLUS MEMBERSHIP $396/YR***

*Memberships are automatically renewed each year.

**TYPE OF PAYMENT:**

☐ CONTACT ME FOR PAYMENT

☐ MARCONE ACCOUNT

NAME ON ACCOUNT _____

ACCOUNT NUMBER _____

## TAKE FULL ADVANTAGE OF YOUR MEMBERSHIP

MSA is commited to providing the resources you want and need to successfully manage and grow your service company. This handbook will help you understand your benefits and help you utilize them for their greatest advantage to you.

**COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365 COLUMBIA, SC 29202**
**ENROLLMENT FORM - GROUP TERM LIFE INSURANCE**

**Application Type:** ☑ Initial Request ☐ Late Applicant ☐ Rehire
☐ Annual Enrollment ☐ Change in Status ☐ Increase

**Note:** If you DO NOT ENROLL for coverage for you or your dependent(s) during the initial enrollment period, and / or you apply for coverage over any Guaranteed Issue amount, you will need to complete the Evidence of Insurability form.

**SECTION 1: EMPLOYEE (APPLICANT) INFORMATION – Always complete**

| Proposed Insured Name (First, MI, Last) | Gender M ☐ F ☐ | Birthdate (mm/dd/yyyy) | Social Security No. |
|---|---|---|---|
| | | | |

| Home Address – Street | City | State | Zip Code | Employee ID/Payroll No. |
|---|---|---|---|---|
| | | | | |

| Email Address | Home Phone No.<br>Business Phone No. |
|---|---|
| | |

| Date Employed | Occupation/Job Title | Annual Base Salary | Hrs. Worked/ Week | Employee Class |
|---|---|---|---|---|
| | | | | |

| Employer Name | Employer Address (Street-City-State-Zip) | Section/Dept. No. |
|---|---|---|
| | | |

**SECTION 2: COVERAGE INFORMATION – Always complete**

| **Coverage Elections** | **Plan Code** | **Face Amount** | **Monthly Premium** |
|---|---|---|---|
| ☑ **Employee** If multiple of salary, indicate multiple selected _____ | 8BNU | $10,000 | |
| ☐ **Spouse** | | | |
| ☐ **Dependent Children** | | | |
| Is a suite being applied for? ☐ Yes ☑ No Rider Plan Code: _____ | | | |
| | | **Total Premium** | |

**SECTION 3: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage**

| Name (First, MI, Last) | Gender | Birthdate (mm/dd/yyyy) | Relationship | Social Security No. |
|---|---|---|---|---|
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |

**SECTION 4: BENEFICIARY INFORMATION – Employee only**

| Beneficiary's Name (First, MI, Last) | Primary ☐ Contingent ☐ | Age | Benefit % | Relationship to Proposed Insured | Social Security No. |
|---|---|---|---|---|---|
| | | | | | |
| Beneficiary's Name (First, MI, Last) | Primary ☐ Contingent ☐ | Age | Benefit % | Relationship to Proposed Insured | Social Security No. |
| | | | | | |

| SECTION 5: ELIGIBILITY INFORMATION – Required for Guaranteed Issue and all levels of underwriting | | |
|---|---|---|
| | **Proposed Insured** | **Your Spouse** |
| 1. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system? | Yes ☐ No ☐ | |
| 2. Are you actively working?<br>If "No", are you disabled or unable to work? | Yes ☐ No ☐<br>Yes ☐ No ☐ | |
| 3. Is your spouse (if applying for coverage) disabled or unable to work? | | Yes ☐ No ☐ |

**AGREEMENT SECTION**

THE PROPOSED INSURED AGREES AS FOLLOWS:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I confirm I have read and understand the Fraud Statement attached. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the policy or certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy or certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the application.

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City_____ State _____ Date _____
mm/dd/yyyy

(x)_____
Signature of Proposed Insured

**AGENT SECTION**

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial Life's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

Date _____ (x)_____
mm/dd/yyyy Signature of Licensed Agent (if applicable)

Agent Name_____ License No._____ Code No._____

**Fraud Warning Notice**

| | |
|---|---|
| **For all states except those listed below:** | Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. |
| **Arizona** | For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties. |
| **Arkansas, Louisiana and West Virginia** | Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **Colorado** | It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. |
| **District of Columbia** | **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant. |
| **Florida** | **All statements and information found in the application are deemed representations and not warranties. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree**. |
| **Kentucky, Kansas and North Carolina** | Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties. |
| **Maine and Washington** | It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. |
| **New Jersey** | Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. |
| **New Mexico** | ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRUADULENT CLAIM FOR PAYMENT OR LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. |
| **Oklahoma** | WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. |
| **Oregon and Texas** | Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law. |
| **Pennsylvania** | Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. If coverage is contested, the company's only obligation will be to refund all premiums paid. |
| **Tennessee** | It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage. |
| **Virginia** | Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law. |