

Supplement Replacement Questionnaire

Employee Information _____

Employee Social Security No: _____ Employee I.D.: _____

Employee Name: _____
First
M.I.
Last

Your employer has notified us that they previously offered similar coverage through another carrier. Is this coverage intended to replace any other accident, disability or health insurance presently in force? YES NO

If yes, please select the appropriate application and provide the necessary details surrounding your in force coverage with the other carrier.

New Policy Information			Previous Coverage Information		
Select	Proposed Insured	Coverage Type	Insurance Company	Coverage Type	Benefit Amount
<input type="checkbox"/>	E	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	_____	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	\$ _____
<input type="checkbox"/>	S	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	_____	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	\$ _____
<input type="checkbox"/>	C	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	_____	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	\$ _____
<input type="checkbox"/>	G	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	_____	<input type="checkbox"/> CBO <input type="checkbox"/> CI <input type="checkbox"/> CA	\$ _____

Agent Information
Please list any other accident and sickness insurance sold to applicant which are still inforce or sold in the past five (5) years which are no longer inforce. _____

(Date)
(Signature of Agent or Representative)

(Applicant's Signature)
(Typed or Printed Name of Agent or Representative)

(Type or Printed Name of Applicant)