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
❑	E	❑ CBO ❑ CI ❑ CA	_____	❑ CBO ❑ CI ❑ CA	$_____
❑	S	❑ CBO ❑ CI ❑ CA	_____	❑ CBO ❑ CI ❑ CA	$_____
❑	C	❑ CBO ❑ CI ❑ CA	_____	❑ CBO ❑ CI ❑ CA	$_____
❑	G	❑ CBO ❑ CI ❑ CA	_____	❑ CBO ❑ CI ❑ CA	$_____

_____ _____
(Date) (Signature of Agent or Representative)

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

_____
(Type or Printed Name of Applicant)