

Kanawha Insurance Company (Hereafter the "Company")

Person applying for insurance (each applicant should complete a separate form): Employee Child
 Spouse Member

Applying for: Supplemental Amount \$ _____ Late Entry

Name of Applicant (Last Name, First Name, Middle Initial)

Address _____ City _____ State _____ ZIP _____

Daytime Telephone Number _____ Date of Birth _____ Place of Birth _____ Height _____ Weight _____

Name of Employee/Member

Name of Group Policyholder _____ Policyholder Group No. _____

Answer each of the following "Yes" or "No." For each **"Yes"** answer, **circle** the applicable item(s) and give full details in the space provided on Page 2.

1. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related conditions or tested positive for the HIV (AIDS) virus? Yes No

2. Within the past 5 years have you been diagnosed or treated by a member of the medical profession for a heart attack, heart surgery, heart disease, uncontrolled high blood pressure (unstable readings or frequent medication changes), stroke, transient ischemic attack (TIA), cancer, leukemia, Hodgkin's Disease, lymphoma, diabetes, nervous or mental disorder, kidney disease, renal failure, blood disorder, lupus, liver disease, lung disorder, emphysema, alcohol or drug abuse, multiple sclerosis, cerebral palsy, amyotrophic lateral sclerosis (ALS/Lou Gehrig's Disease), spina bifida, sickle cell anemia, or chronic hepatitis? Yes No

3. Have you:
 a. within the past 5 years seen any physician, clinic, or hospital for treatment of any condition not specifically asked about in Question 2? Yes No
 b. within the past 3 years been medically advised to have any diagnostic test, hospitalization, or surgery, which was not completed? Yes No
 c. within the past 12 months used cigarettes or any other tobacco products? Yes No

4. Are you presently taking medication(s)? Yes No

List medications _____

5. During the past 2 years have you been unable to work by reason of disability for 3 or more consecutive weeks? If "Yes," give dates and reasons on Page 2. Yes No

Indicate details of the "Yes" answers from Page 1.

Question No.	Nature of Illness or Injury	Date of Last Treatment	Describe Remaining Effects	Name/Address of Physician or Hospital

6. Do you intend to travel or reside outside of the United States? Yes No
 If "Yes," provide length of stay, locations, and number of travels per year.

7. Are you engaged in any occupational or recreational activities, such as: flying as a pilot, co-pilot or crew member, sky diving, skin or scuba diving, motorized racing, ballooning or hang gliding? Yes No
 If "Yes," provide details:

I acknowledge that, to the best of my knowledge and belief, each of the statements above are true and complete. The statements and answers given in this application and any statements made to the medical examiner will be the basis of any insurance issued. I agree that no insurance shall take effect unless this Evidence of Insurability is approved by Kanawha Insurance Company. In the event of such approval, the insurance will become effective as provided in the policy.

Authorization and Acknowledgement Statement

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically-related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution that has any records or knowledge of me, my spouse or my child for whom insurance application is made, or my health, my spouse's or my child's health, to give to Kanawha Insurance Company, or its reinsurers, any such information in order to determine eligibility for coverage and to testify as to such information, all to the extent permitted by law.

I acknowledge that I have been furnished the MIB Disclosure Notice and the Notice to Applicant.

Any person who, with 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 be guilty of insurance fraud.

 Signature of Applicant

 Date

MIB Disclosure Notice

Information regarding your insurability will be kept confidential. Kanawha Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau upon request will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, toll free telephone numbers 866-692-6901 or (TTY) 886-346-3642 for the hearing impaired.

Notice to Applicant

Thank you for giving Kanawha Insurance Company the opportunity to consider your insurance needs. As part of our normal procedure for processing Applications, we may order an investigative consumer report. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. You may request to be interviewed in connection with the preparation of this investigative consumer report and upon request you are entitled to receive a copy of the investigative consumer report. If you question the accuracy of information in the investigative consumer report, you may contact the Consumer Reporting Agency and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

We may telephone you to confirm information in your application or to obtain additional information needed to process your application.

All information requested in your application, or obtained from other sources, such as your physician or hospitals where you have been treated, is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be kept confidential. Upon your written request, we will furnish you or your physician with the nature or source of the information.

Leave this page with the Applicant

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