



PRODUCTS APPLYING FOR (check all that apply): **GROUP #:** _____

Group Term Life/AD&D, Supplemental Life/AD&D, Dependent Life (**Please complete Sections I, II, III & VI**)

Group Short Term Disability (**Please complete Sections I, II, IV&VI**)

Group Long Term Disability (**Please complete Sections I, II, V & VI**)

I. APPLICANT INFORMATION Please Type Or Print All Information

Policyholder (correct legal name) _____

Mailing Address _____

Address (not P.O. Box) _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____

Group Contact _____

Email Address _____

Subsidiaries or Affiliates?: Yes No (If more than one, indicate on separate sheet.)

If Yes: Company Name _____

Address _____

Will they be billed separately?: Yes No (If separate bills are desired, list address of subsidiaries or affiliates on a separate sheet.)

Nature of Business	SIC Code	Effective Date 12:01 a.m.	First Anniversary
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Annual Enrollment Period for Contributory Coverages, if applicable: From _____ to _____

W-2 Information: A W-2 Agreement must be completed and attached to this Application for all groups with Disability coverage.

II. GENERAL INFORMATION

<p>Contributions: Employer will contribute:</p> <p>Group Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %</p> <p>Dependent Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %</p> <p>Supp. Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %</p> <p>STD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %*</p> <p>LTD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %*</p>	<p>*Is employee disability contribution made with pre-tax dollars (Section 125)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Check if applicable:</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Subchapter S Corp.</p> <p><input type="checkbox"/> Sole Proprietorship</p> <p><input type="checkbox"/> Corporation</p>			
<p>Eligibility Waiting Period:</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> First of month following completion of _____ Days</p> <p><input type="checkbox"/> Other _____</p>	<p>Eligibility Waiting Period applies to:</p> <p><input type="checkbox"/> All employees</p> <p><input type="checkbox"/> New employees only</p>				
<p>Participation Requirements for Group Products: 75% – Contributory (excludes Supp. Life & Dep. Life) 100% – Noncontributory</p>					
	Group Life/AD&D	Supplemental Life/AD&D	Dependent Life	STD	LTD
Total eligible employees	_____	_____	_____	_____	_____
Total enrolled	_____	_____	_____	_____	_____
<p>Initial Rates Guaranteed</p> <p>Life/AD&D: for _____ months</p> <p>STD: for _____ months</p> <p>LTD: for _____ months</p>	<p>Premium Payable: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly</p> <p><input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually</p> <p>Premium is due on the _____ day of each billing period.</p>				
<p>FOR GROUPS OF 100 + ONLY</p> <p>Form 5500, Schedule A <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, benefit plan year is: _____</p> <p>Account information should be sent to: _____</p>					



III: SCHEDULE OF BENEFITS: LIFE and AD&D

1. ELIGIBLE CLASSES - DESCRIBE BELOW

Class 1 _____ Class 2 _____ Class 3 _____ All active employees who work at least _____ hours per week are eligible for coverage. If blank, 30 hours per week will apply.	2. Prior Employment to Count for Employees Rehired Within 6 Months? <input type="checkbox"/> Yes <input type="checkbox"/> No
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3. Will this policy replace an existing policy?: Yes No
 If Yes: Carrier _____ (a copy of prior carrier's plan is required for claims administration)
 Termination Date: _____

SELECTION OF COVERAGE(S) (fill in all applicable blanks)

Class	Group Life Insurance Amount of Insurance	AD&D Principal Sum	Supplemental Life Amount of Insurance	Supplemental AD&D Principal Sum
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____

Guarantee Issue (GI): \$ _____ Amounts in excess of the GI are subject to satisfactory evidence of insurability. *Supplemental \$ _____
 *Combined Group and Supplemental \$ _____
 *Based upon a min. participation of _____ %

Dependent Life Insurance (Benefit amounts are limited in some states)

Spouse: _____ \$ _____
 Does Spouse include Domestic Partner? Yes No

Child(ren): (select one) from live birth to 6 months from 15 days to 6 months \$ _____
 (select one) 6 months to 19 years* 6 months to age _____ \$ _____
 (select one) Other: _____ to age _____ \$ _____
 * To age _____ if full-time student(s) and dependent upon the insured for support.

GENERAL PROVISIONS (fill in all applicable blanks)

1. Life and AD&D benefits include 24-hour coverage.
2. If the Life and AD&D benefit is a multiple of salary, amount should be rounded to:
 the next higher the next lower the nearest multiple of \$ _____.
3. Earnings for calculating salary based life insurance do not include bonuses, overtime, or any form of extra pay. If earnings are based in whole or in part on commissions, the benefit amount for life insurance will include the amount paid in commissions during the preceding 12-month period.
4. Group Life and AD&D benefits reduce by: 35% of the original amount at age 65, and further reduce to 50% at age 70.
 35% of the original amount at age 65, and to 50% at age 70, and to 25% at age 75, and to 15% at age 80.
 _____% of the original amount at age _____, and to _____% at age _____, and to _____% at age _____, and to _____% at age _____.
5. Supplemental Life and AD&D benefits reduce by _____% of the original amount at age _____, and to _____% at age _____, and to _____% at age _____, and to _____% at age _____.
6. Life and AD&D benefits terminate at retirement unless otherwise noted in the Eligible Classes section.
7. Accelerated Death Benefit: 50% 75% 100%; Maximum Accelerated Death Benefit \$ _____; Minimum Death Benefit \$ _____



The laws of some states require us to furnish you with the following notice:

Arizona & New Jersey - Claims

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Arkansas & Massachusetts

Any person who knowingly presents a false or fraudulent claim for payment of 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, 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.

Delaware, Idaho & Oklahoma

Any person who knowingly, with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

District of Columbia, Virginia & Washington

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 benefits if false information materially related to a claim was provided by the applicant.

Florida

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.

Louisiana & New Mexico

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New Hampshire

Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

New Jersey - Applications

Any person who knowingly files false or misleading information on an application for insurance coverage is subject to criminal and civil penalties.

Texas

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 include imprisonment, fines and denial of insurance benefits.

All Other States

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. (not enforceable in OR)