

**GROUP INSURANCE APPLICATION**

Type or Print In Black Ink

**For Home Office use only**

Group #:

**SECTION I. GROUP INFORMATION**

1. Legal Name of Policyholder		2. Taxpayer ID#	
3. Type of Company: <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> PC <input type="checkbox"/> S-Corp <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Government			
4. Mailing Address of Policyholder		City	State      Zip+4
5. Street Address of Policyholder (if different from above)		City	State      Zip+4
6. Contact Information at Company:			
Benefits Contact Person: _____			
Phone Number: _____		Fax Number: _____	
Email Address: _____		Web Address: _____	
Billing Contact Person: _____			
Phone Number: _____		Fax Number: _____	
Email Address: _____		Web Address: _____	
7. Name of Subsidiary or Affiliate Companies to be Covered		8. Nature of Business	9. SIC Code
10. Do you have any employees located in states other than the Policyholder's main address? If yes, please list states below. <input type="checkbox"/> Yes <input type="checkbox"/> No		11. Number of eligible Employees	12. Billing Method: <input type="checkbox"/> Self Administration <input type="checkbox"/> Billed by Blue Plan <input type="checkbox"/> Benefit Focus <input type="checkbox"/> List Bill
13. Changes in Benefits will Become Effective on: <input type="checkbox"/> First day of the following month <input type="checkbox"/> The next anniversary date <input type="checkbox"/> The date of change			
14. Do you allow Domestic Partner Coverage under the existing Blue Cross Blue Shield Medical Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
15. Eligibility Waiting Period ( <i>Should an employee enter another class, he will not be eligible for any additional benefits until he has completed a 30-day waiting period and has been actively at work one full day in the new class.</i> ) <input type="checkbox"/> First of Policy Month following: (a) <input type="checkbox"/> completion of _____ days of continuous active work, or (b) <input type="checkbox"/> hire date <input type="checkbox"/> Day following: (a) <input type="checkbox"/> completion of _____ days of continuous active work, or (b) <input type="checkbox"/> hire date Does Waiting Period apply to employees rehired within 12 months of their termination date? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16. Eligibility Waiting Period Applies to: <input type="checkbox"/> Future Employees only <input type="checkbox"/> Present & Future Employees		17. Minimum hours worked per week to be eligible: Basic benefits: _____ Voluntary benefits: _____	
18. Annual Enrollment date for Voluntary Coverage: _____			
19. Class Definitions (if more than one class, definitions must be specific) ( <i>The insurer reserves the right to review and terminate all classes insured under this policy if any class ceases to be covered.</i> )			
Class	Description of Class	Waiting Period, if Different	
1			
2			
3			
4			

*Employees working less than the minimum hours per week are not eligible for coverage unless otherwise noted in class description above and approved by us. If more than four classes, use a separate sheet.*

**SECTION II. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT**

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
<input type="checkbox"/> Basic Life				
<input type="checkbox"/> Basic AD&D*				
<input type="checkbox"/> Supplemental Life*				
<input type="checkbox"/> Supplemental AD&D*				
<input type="checkbox"/> Dependent Life* (Option 1)				
<input type="checkbox"/> Dependent Life* (Option 2)				
<input type="checkbox"/> Voluntary Life				
<input type="checkbox"/> Voluntary AD&D				

\*Cannot be purchased as stand alone coverage.

Multiple of salary benefits will be rounded to the  nearest  lower  higher \$ \_\_\_\_\_, if not already a multiple

**SECTION II. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT CONTINUED**

**Basic Life and/or AD&D**

Class	Flat Amount ■	Multiple of Salary ■	(Complete if Multiple of Salary)	
			Min Amount of Coverage	Max Amount of Coverage
1				
2				
3				
4				

**Supplemental Life and/or AD&D**

Class	Flat Amount ■	Multiple of Salary ■	Elected in Increments of ■	(Complete if Multiple of Salary or Increments)	
				Min Amount of Coverage	Max Amount of Coverage
1					
2					
3					
4					

**Voluntary Life and/or AD&D**

Employee and Spouse coverage elected in \$10,000 increments: \$10,000 min \$\_\_\_\_\_ Max  
 Employee coverage elected as multiple of salary schedule: \_\_\_\_\_ times annual salary \$\_\_\_\_\_ Maximum.  
 Spouse coverage 50% of employee amount.  
 Are Voluntary Life rates smoker distinct rates:  Yes  No      Children - \$5,000 and \$10,000 only

**Dependent Life**

Class	Option 1			Option 2 (if available)		
	Spouse Amount	Child Amount	Reduced Infant Amount	Spouse Amount	Child Amount	Reduced Infant Amount
1						
2						
3						
4						

Infant Ages:  from live birth to 6 months     from 15 days to 6 months  
 Child Ages:  6 months to 25 years     6 months to age \_\_\_\_\_

AD&D Riders	Reductions & Termination				
	Benefit reduction due to age will be effective on the employee's birthday*				
	Reduction at Age of Employee				
		65	70	75	80
Standard Riders*	<input checked="" type="checkbox"/>				
Special Education	<input type="checkbox"/>	<input type="checkbox"/>	66 2/3%	33 1/3%	N/A
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	65%	50%	N/A
Common Carrier	<input type="checkbox"/>	<input type="checkbox"/>	65%	50%	25%
Felonious Assault	<input type="checkbox"/>	<input type="checkbox"/>			N/A
Child Care Center	<input type="checkbox"/>	*Employee benefits terminate at retirement, unless termination age is noted. Termination age _____. Spouse benefits terminate at employee's retirement or spouse age 65, whichever is earlier. All reductions apply to the pre-age 65 amount.			
Spouse Training	<input type="checkbox"/>				
HIV	<input type="checkbox"/>				

\*AD&D Standard Riders: Seat Belt/Air Bag, Coma, Repatriation, Exposure and Disappearance

**Portability:**

Voluntary Life     Basic Life (Underwriting approval and rate adjustment required)

**Replacement:** Are any of the following a replacement of similar coverage?

Yes	No		If yes, Previous Carrier	Termination Date
<input type="checkbox"/>	<input type="checkbox"/>	Basic Life		
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Life		
<input type="checkbox"/>	<input type="checkbox"/>	Voluntary Life		

If prior coverage, include a copy of the prior carrier's plan.

**SECTION III. SHORT TERM DISABILITY**

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
<input type="checkbox"/> Basic/Core STD				
<input type="checkbox"/> Buy Up STD*				
<input type="checkbox"/> Voluntary STD (VIP)				

\*Cannot be purchased as stand alone coverage.

**SECTION III. SHORT TERM DISABILITY CONTINUED**

**Basic Short Term Disability**

Class	Core/Buy Up	Flat Amount	Percent of Salary	Max. benefit	Benefit Plan*
1	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				
2	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				
3	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				
4	<input type="checkbox"/> Core				
	<input type="checkbox"/> Buy Up				

*\*Example of a Benefit Plan: 1-8-13; This means disabilities due to accidents begin on the first day. Disabilities due to sickness begin on the eighth day. Benefits will be paid for a 13 week duration.*

**Voluntary STD Income Protection (VIP)**

Amount of insurance selected by the employee in increments of \$10 not to exceed \_\_\_\_\_% of weekly earnings.

Minimum: \$100 Maximum:  \$750  \_\_\_\_\_

Benefit Plan\*: \_\_\_\_\_ Industry Class: \_\_\_\_\_

Reduction & Termination: Benefit reduction due to age will be effective on the anniversary following the insured's birthday. Benefits reduce to 66 2/3% at age 65, and terminate at age 70 or upon retirement, whichever occurs first.

Are premiums sheltered under a Section 125 Cafeteria plan?  Yes  No

*\*Example of a Benefit Plan: 1-8-13; This means disabilities due to accidents begin on the first day. Disabilities due to sickness begin on the eighth day. Benefits will be paid for a 13 week duration*

**Replacement:** Is VIP a Replacement from Another Carrier?  Yes  No

Previous Carrier \_\_\_\_\_ Termination Date \_\_\_\_\_

*If prior coverage, include a copy of the prior carrier's plan.*

**SECTION IV. LONG TERM DISABILITY**

This application is made for the following coverages. Check only those boxes that apply.

	Employer Contribution	Enrolled Employees	Effective Date	Renewal Date
<input type="checkbox"/> Basic LTD				
<input type="checkbox"/> Buy Up LTD*				
<input type="checkbox"/> Voluntary LTD				

*\*Cannot be purchased as stand alone coverage.*

**Basic and Buy Up Features**

Class	Elimination Period	Own Occupation Monthly Period	Salary Includes		SS Integration		Benefit Calculation	
			Bonuses	Commissions	Primary Only	Primary/Family	Direct	70% all Sources
1			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
2			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
3			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
4			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

Class	Basic		Buy Up	
	% of Salary	Monthly Max	% of Salary	Monthly Max
1				
2				
3				
4				

Maximum Benefit Period	Class			
	1	2	3	4
Reducing Benefit Duration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SS Normal Retirement Age (SSNRA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Year benefit (ADEA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Year benefit (ADEA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Year benefit (ADEA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Minimum Monthly Benefit**

Flat amount \$ \_\_\_\_\_; or  Flat amount of \$ \_\_\_\_\_ or 10%, whichever is greater

**Optional LTD Riders**

Education Benefit     
  Medical and COBRA Premium \$ \_\_\_\_\_     
  Cost of Living Adjustment  
 Activities of Daily Living     
  Accidental Dismemberment     
 \_\_\_\_\_ # of Adjustments \_\_\_\_\_%

**SECTION IV. LONG TERM DISABILITY CONTINUED**

**Disability Definition:**  Earnings & Occupation Test     Occupation Test Only  
 Earnings, Occupation, and Contagious Disease (Only available for Medical Groups)

**Pre-Existing Condition Exclusion**  
 3/3/12     3/6/12     12/6/24     6/12     6/6/12     12/12     \_\_\_\_\_

**Voluntary Long Term Disability (VLTD)**  
Industry Class: \_\_\_\_\_ Elimination Period:  90 Days     180 Days  
Maximum Benefit Period:  
 2 years Sickness or Accident     5 years Sickness or Accident     SSNRA Sickness or Accident  
a. Amount of Insurance: Selected by the employee in increments of \$100 not to exceed 60% of monthly salary.  
b. Pre-existing Condition Exclusion: 12/6/24 (unless state law requires otherwise)  
c. The Minimum Monthly Benefit is \$ 50.00 or 10% of the Monthly Disability Benefit, whichever is less (unless state law requires otherwise)  
d. Policy Features include: • 24 Month Own Occupation • Three month Survivor Benefit • Waiver of Premium  
• 24 Month Special Conditions Limitation • Primary and Family Social Security Integration  
e. Are premiums sheltered under a Section 125 Cafeteria plan?  Yes  No

**Replacement:** Are any of the following a replacement of similar coverage?

Yes	No	If yes, Previous Carrier	Termination Date
<input type="checkbox"/>	<input type="checkbox"/>	LTD	
<input type="checkbox"/>	<input type="checkbox"/>	VLTD	

*If prior coverage, include a copy of the prior carrier's plan.*

**W-2 Service Options for LTD:**  
 Option 1: Withhold federal income taxes and the employee's portion of FICA. Prepare and file W-2 Forms.  
 Option 2: Withhold federal income taxes and the employee's portion of FICA. Policyholder waives W-2 Forms services.  
A detailed description of the W-2 services elected by policyholder pursuant to this application will be sent to the policyholder by mail. Such services will be performed in accordance with the above election and established standard procedures.

**SECTION V. AUTHORIZATION**

REMARKS OR SPECIAL PROVISIONS:

  
  
  
  
  
  
  
  
  
  

The undersigned employer and/or authorized representative hereby request that it be approved for insurance coverage through USAble Life and agrees to comply with all terms and provisions of the Group Policy(ies) issued in response to this application.  
It is understood and agreed that this application shall be made a part of the policy or policies applied for and that no insurance shall be effective until approved by the Company at its Home Office.  
**Warning:** It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines or a denial of insurance benefits in accordance with applicable state law.

_____	_____	_____
Dated at (City, State)	Date	Signature of Policyholder and Title
_____	_____	_____
Signature of Marketing Representative	Signature of Marketing Manager	Signature of Broker, if applicable