



P. O. Box 1650
Little Rock, AR 72203

EMPLOYER GROUP LTD TRUST PARTICIPATION APPLICATION & AGREEMENT

Type Or Print In Black Ink

H.O. Use Only

Group #

Effective Date

1. Legal Name of Employer		Taxpayer ID#	
2. Mailing Address of Policyholder		City	State Zip+4
3. Street Address of Policyholder (if different from above)		City	State Zip+4
4. Name of CEO, President or Owner of Company	Name of Insurance Contact at Company	Telephone	Fax Number
5. Nature of Business	Effective as of 12:01 a.m.	SIC Code	Billing Mode
6. Number of Employees Eligible _____ Enrolled _____	Number of new employees in the waiting period and not eligible for coverage at this time _____	Number of family members of partners or officers working for the firm _____	
7. Waiting Period <input type="checkbox"/> Premium Due Date following completion of _____ <input type="checkbox"/> Day following completion of _____ NOTE: The waiting period will never be less than 30 days for Present and Future Employees.			Employer Contribution _____ %
8. Eligible Employees <input type="checkbox"/> All Fulltime Employees <input type="checkbox"/> All Fulltime Employees except _____			
9. Amount of Insurance: 60% of Basic Monthly Earnings (excluding bonuses, overtime and extra compensation other than commissions) not to exceed a maximum monthly benefit of \$5,000 (less other income benefits explained in the policy and which include Primary and Family Social Security Benefits). Minimum Monthly Benefit is \$100.			
10. Elimination Period: <input type="checkbox"/> 90 days <input type="checkbox"/> 180 Days			
11. MAXIMUM BENEFIT PERIOD		POLICY FEATURES	
<u>Age at Disability</u>	<u>Benefit Duration</u>	<ul style="list-style-type: none"> Full Maternity Benefit Progressive Partial Disability Benefit Three Month Survivor Benefit 24-Month "Own Occupation" Definition of Disability Continuity of Coverage 24-Month Mental Illness and Substance Abuse Limitation Full Family Social Security Integration Minimum Monthly Benefit is \$100 3/6/12 Pre-existing Conditions Exclusion. 	
Less Than 60	To age 65		
60	60 Months		
61	48 Months		
62	42 Months		
63	36 Months		
64	30 Months		
65	24 Months		
66	21 Months		
67	18 Months		
68	15 Months		
69 and over	12 Months		
12. Is this a Replacement of Similar Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, a copy of prior carrier's plan is required for claims administration.)</i>			
13. Previous Carrier		Termination Date of Prior Plan	
14. Premium Monthly		Deposit of \$ _____ to apply to the first premium.	
15. General Conditions			
<ul style="list-style-type: none"> Eligibility: All full-time employees who work a minimum of 30 hours per week. Employees must be actively at work on their effective date for coverage to be effective. Participation: Contributory Plans - 75%; Noncontributory Plans - 100%. Satisfactory Evidence of Insurability is required for all members of groups with fewer than 6 eligible employees and for late applicants on contributory plans. All benefits terminate at retirement. 			

Group Trust Participation Agreement

This Participation Agreement relates to participation in the following group insurance trust policy:

1. **Name of Policyholder:** The Trustee of the USABLE Life Group Insurance Trust
Situs of Trust: Little Rock, Arkansas
2. **Group Policy Number:** 10011680-TLT
3. **Effective Date of Policy:** July 1, 2004
4. **Name of Insurance Company:** USABLE Life
5. **Eligible Participants:** A Tennessee employer with at least 2 but less than 10 eligible employees on the date of issue.

Request for Participation:

I hereby apply for participation in the group insurance trust policy identified above. To the best of my knowledge, all responses on this application are complete and true. I understand and agree that:

- This application for participation will also be offered as an inducement for the issuance of group insurance. It will form a part of the group policy identified above.
- The Participating Employer will furnish and maintain the records necessary for the administration of the plan and will report changes to and from the group.
- The Participating Employer will remit all premiums which become due and payable on the first day of each premium period. In the event coverage is terminated due to non-payment of premium the Participating Employer will be liable for all premiums for coverage provided during the 31 day grace period. Any offer to reinstate coverage is made at the insurer's sole discretion.
- Only active, full time employees working the minimum number of hours per week specified on the participation application are eligible for coverage.
- Insurance under the group policy at the insurer's rates and under the terms and conditions of the policy will take effect when the application is accepted at the home office of the insurer. The effective date of insurance will be the first day of a premium period.
- The initial employee participation requirement (if applicable) is satisfied and must be maintained or exceeded in order for coverage to remain in force.
- If the application is not accepted, no insurance will become effective and any premium advanced will be refunded. No individual will be covered unless he or she is eligible under the terms of the policy.
- Insurance coverage on any individual shall become effective on the next premium due date coinciding with, or next following, satisfaction of any waiting period and receipt and approval of proper enrollment material (including evidence of insurability if required).
- If a present or new employee is not actively at work on the day he or she would ordinarily become insured, insurance will not begin until the employee returns to active work.
- That a copy of the Plan is maintained in USABLE Life's principal business office in Little Rock, Arkansas and is subject to examination by participating employers.

FRAUD WARNING – 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.

Acceptance by Participating Employer

Firm Name

Signature

Title

Date

Representative's Name (please print)

Representative's Signature (Must be resident licensed agent)

Acceptance by USABLE Life

Signature

Title

Date