USAble Life
P.O. Box 1650
Little Rock, Arkansas 72203

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: ☐ Corporation ☐ LLC ☐ PC ☐ S-Corp ☐ Sole Proprietor ☐ Partnership ☐ 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. ☐ Yes ☐ No

11. Number of eligible Employees

12. Billing Method:
☐ Self Administration ☐ Billed by Blue Plan
☐ Benefit Focus ☐ List Bill

13. Changes in Benefits will Become Effective on:
☐ First day of the following month ☐ The next anniversary date ☐ The date of change

14. Do you allow Domestic Partner Coverage under the existing Blue Cross Blue Shield Medical Plan? ☐ Yes ☐ No

15. Eligibility Waiting Period *(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.)*

☐ First of Policy Month following: (a) ☐ completion of _____days of continuous active work, or (b) ☐ hire date
☐ Day following: (a) ☐ completion of _____days of continuous active work, or (b) ☐ hire date

Does Waiting Period apply to employees rehired within 12 months of their termination date? ☐ Yes ☐ No

16. Eligibility Waiting Period Applies to:
☐ Future Employees only ☐ 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)
(The insurer reserves the right to review and terminate all classes insured under this policy if any class ceases to be covered.)

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
☐ Basic Life				
☐ Basic AD&D*				
☐ Supplemental Life*				
☐ Supplemental AD&D*				
☐ Dependent Life* (Option 1)				
☐ Dependent Life* (Option 2)				
☐ Voluntary Life				
☐ 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

Legal Name of Policyholder	Taxpayer ID#

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*	☒					
Special Education	☐	☐	66 2/3%	33 1/3%	N/A	N/A
Paralysis	☐	☐	65%	50%	N/A	N/A
Common Carrier	☐	☐	65%	50%	25%	N/A
Felonious Assault	☐	☐				
Child Care Center	☐	**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	☐					
HIV	☐					
	☐					

**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
☐	☐	Basic Life		
☐	☐	Supplemental Life		
☐	☐	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
☐ Basic/Core STD				
☐ Buy Up STD*				
☐ Voluntary STD (VIP)				

**Cannot be purchased as stand alone coverage.*

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SECTION III. SHORT TERM DISABILITY CONTINUED

Basic Short Term Disability

Class	Core/Buy Up	■ Flat Amount	■ Percent of Salary	Max. benefit	Benefit Plan*
1	☐ Core				
	☐ Buy Up				
2	☐ Core				
	☐ Buy Up				
3	☐ Core				
	☐ Buy Up				
4	☐ Core				
	☐ 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
☐ Basic LTD				
☐ Buy Up LTD*				
☐ 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			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ Yes
2			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ Yes
3			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ Yes
4			☐	☐	☐ Yes	☐ Yes	☐ Yes	☐ 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	☐	☐	☐	☐
SS Normal Retirement Age (SSNRA)	☐	☐	☐	☐
2 Year benefit (ADEA)	☐	☐	☐	☐
3 Year benefit (ADEA)	☐	☐	☐	☐
5 Year benefit (ADEA)	☐	☐	☐	☐

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 _____%

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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
☐	☐	LTD		
☐	☐	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