USAble Life℠

P.O. Box 1650
Little Rock, Arkansas 72203

SMALL GROUP INSURANCE APPLICATION (GIIP)

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SECTION I. GROUP INFORMATION:

1. Legal Name of Policyholder:	2. Taxpayer ID#:	3. Effective Date of Coverage:

4. Type of Company: ☐ Corporation ☐ LLC ☐ PC ☐ S-Corp ☐ Sole Proprietor ☐ Partnership ☐ Government ☐ Other _____

5. Nature of Business	6. SIC Code	7. Name of Subsidiary or Affiliate Companies to be Covered	8. SIC Code/Affiliate

9. Mailing Address of Policyholder City State Zip +4 -

10. Contact Information at Company:

☐ Benefits or ☐ Billing Contact Person _____

Phone/Fax Number (___)_____ E-mail Address _____ Web Address _____

11. Class Definition. *All active full-time employees working a minimum of 25 hours or more per week.*

12. Do you have any employees located in states other than the Policyholder's main address? (if yes, please indicate states below) ☐ Yes ☐ No _____	13. Billing Method: ☒ On-Line Billing

14. Total number of eligible employees:	15. Total number of employees enrolled:	16. Employer contribution:

17. Do you allow Domestic Partner Coverage under the existing Medical Plan? ☐ Yes ☐ No

18. Eligibility waiting Period: ☐ First of the following Policy month after completion of _____ days, or ☐ Day following Hire Date

19. Eligible Waiting Period Applies to: ☐ Future Employees Only ☐ Present & Future Employees

Does the waiting period apply to employees rehired within 12 months of their termination date? ☐ Yes ☐ No

20. Replacement: Are any of the following a replacement of similar coverage? *If prior coverage, please include a copy of the prior carrier's plan.*

Yes	No	Coverage	If Yes, Previous Carrier	Termination Date
☐	☐	Life & AD&D Insurance		
☐	☐	Long Term Disability		

SECTION II. BENEFIT OPTIONS:

THIS APPLICATION IS FOR THE FOLLOWING OPTION. CHECK ONLY ONE BOX

Benefits	Groups of 2 to 50 Employees					
	Group Term Life Plans			Group Term Life + LTD Plans		
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Life Insurance	$20,000	$30,000	$50,000	$20,000	$30,000	$50,000
Waiver of Premium*	Yes	Yes	Yes	Yes	Yes	Yes
Accelerated Benefit*	80%	80%	80%	80%	80%	80%
Dependent Life	Yes	Yes	Yes	Yes	Yes	Yes
Spouse	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000
Children	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000
14 days - 6 months	$500	$500	$500	$500	$500	$500
Accidental Death & Dismemberment	$20,000	$30,000	$50,000	$20,000	$30,000	$50,000
Long Term Disability	No	No	No	Yes	Yes	Yes
Monthly Benefit	N/A	N/A	N/A	$2,000	$2,000	$2,000
Benefit Duration	N/A	N/A	N/A	5YR/RBD**	5YR/RBD**	5YR/RBD**
Elimination Period	N/A	N/A	N/A	90 Day	90 Day	90 Day
Monthly Premium	$7.54	$10.54	$16.54	$19.87	$22.87	$28.87
Select one Option	☐	☐	☐	☐	☐	☐

**Waiver of premium and Accelerated benefits are only applicable to Life insurance. **Reducing Benefit Duration*

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TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT FEATURES:				
AD&D Riders	Benefits for Life and AD&D reduce by the following amounts on the insured's birthday*			
☒ Seat Belt/Air Bag/Helmet	Reduction at Age of Employee			
☒ Coma	Age 65		Age 70	
☒ Repatriation	☒	35%	☒	50%
☒ Exposure and Disappearance	* Benefits for the covered person(s) terminate when no longer eligible or at retirement, whichever comes first.			

LONG TERM DISABILITY FEATURES:	
Disability Definition: Earnings / Occupation Test (80/20); 24 month own occupation	**Drug & Mental Illness Limitation:** 24 Month Lifetime Benefits
Benefits Duration: 60 months RBD	**Benefit Percentage:** Flat benefit not to exceed 60% of pre-disability earnings
Pre-existing Condition: 3/12	

W-2 Service Options for Long Term Disability

☐ 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 the 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 III. 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 USAble Life.

This application is governed by the laws of the state of Oregon.

Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at (City & State)	Date	Signature of Policyholder and Title

Name of Licensed Agent	Signature of Licensed Agent

For Home Office Use Only
Group #