Application
for Group Insurance

CLEAR DATA

ADVANCE Insurance Company of Kansas SM

Employer/Policyholder _____

Requested effective date _____ Requested anniversary month (choose month)
☐ Same month as effective date

Business address _____
Physical address Street

_____ _____ _____
City State Zip

Billing address _____
☐ Same as business address above

_____ _____ _____
City State Zip

Which of these addresses (if different) should your certificates be mailed to? ☐ Business address ☐ Billing address

Phone _____ Fax _____

Plan administrator rep _____ E-mail _____

Group leader _____ E-mail _____

Nature of business _____

Union affiliation? ☐ Yes ☐ No If yes, indicate name of union _____

Enrolling through Association? ☐ Yes ☐ No Association name _____

ERISA

Is your group an ERISA plan? ☐ Yes ☐ No

(The Employee Retirement Income Security Act of 1974 [ERISA] is a federal law that addresses and establishes certain rights and protections to participants of most employer welfare [e.g., health, dental, life] and pension [e.g., 401K, retirement] benefit plans.) For more information on ERISA, refer to www.dol.gov/ebsa, call the Department of Labor, or contact your accountant.

A. The company-imposed waiting period

1) Coverage for eligible employees begins (select one):

☐ the first day of the month following (or coinciding with) completion of your company's waiting period;

☐ the date of hire; or

☐ other (describe) _____

2) The Waiting Period requires an employee to Actively Work the specified period for the policyholder/participating employer before qualifying for benefits:

Class 1 _____ days; or ☐ other (describe) _____

Class 2 _____ days; or ☐ other (describe) _____

Class 3 _____ days; or ☐ other (describe) _____

3) Does the waiting period apply to eligible employees employed on or prior to the policy's effective date? ☐ Yes ☐ No

4) Does the waiting period apply to employees that are rehired? ☐ Yes ☐ No

5) Will the time a person has been employed but not working enough hours to qualify for benefits (i.e., less than the minimum hours required each week) be used to satisfy the waiting period? ☐ Yes ☐ No

Please continue on the next page.

B. Working the required hours

1) Employees and owners must be Actively at Work performing the regular duties of their job and at the usual place of employment for a minimum of _____ hours* each week to be insured by this coverage.
(*May not be less than 20 hours each week for [Basic or Voluntary] Life, Accidental Death & Dismemberment or [Basic or Voluntary] Short Term Disability; and not less than 30 hours each week for [Basic or Voluntary] Long Term Disability.)

2) This coverage does not include persons that are seasonal, temporary, leased, contracted or 1099 employees. All others working the minimum hours each week should enroll (or waive coverage) unless you exclude them from coverage. Do you exclude any others? ☐ Yes ☐ No If yes, please describe who:

C. Actively at work

Employees must be Actively Working to be insured. Employees that are not actively working (i.e., performing their regular duties, at the usual place of employment, and working at least the minimum required hours each week) when this coverage becomes effective cannot be covered by this policy [or by the benefit(s) being added]. If an injury or illness causes an employee to be absent or incapable of working the required hours on the effective date of this policy, coverage should be continued with the prior carrier.

Employees that are not actively working (i.e., performing their regular duties, at the usual place of employment, and working at least the minimum required hours each week) after the coverage becomes effective cannot continue to be insured except as provided specifically by the group policy.

D. Employees not actively working on the effective date of coverage

List any individual who is not actively working now or not expected to be actively working on the Effective Date of Coverage. Attach a separate sheet to this application if more space is needed.

Name	Date last worked	Reason	☐ Yes ☐ No Insured by prior carrier?

E. Participants

Employees (and dependents, if applicable) must be a resident citizen of the United States or an alien legally residing in the United States to be eligible for coverage. Participation in this coverage is to be based solely on conditions pertaining to a person's employment which includes, but is not limited to, factors such as the length of employment, regularly working the required hours each week, and belonging to a class of employees that is included in this plan (please note: "persons enrolling in health coverage" is not a valid class description).

Eligibility for the group life coverage, participating in the group life coverage, or the amount of premium the employer contributes toward the cost of the group life coverage cannot be based on the employee's participation in (i.e. enrolling in) the employer's group's health plan.

1) _____ is the number of employees working at least the minimum hours shown in section B.1.
NOTE: do not include in this count persons that are seasonal, temporary, leased, contracted, 1099 employees, described in section B.2. as excluded from coverage, or listed in Section D. as not Actively Working.

Please continue on the next page.

F. Basic group benefits

1) Select the benefit(s) for which the group is applying.	2) Does the employer pay the entire cost of premium (this benefit costs the employee zero)? If NO, answer question 3.	3) Is this benefit part of an allowance plan whereby each employee receives a fixed dollar amount and the employee selects from a variety of coverages to best fit their needs? If NO, answer question 4.	4) Describe below how much of the premium the employer/participating employer will be funding for each enrolled employee (by benefit)*.
☐ **Term life and AD&D**	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ with dependent life	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ with optional life	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ **Short term disability**	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ **Long term disability**	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____

*If any part of your response changes with regard to the amount of (or percentage of) the premium this employer pays as part of the benefit plan for your employees please notify AICK of the change.

G. Voluntary group benefits

☐ Voluntary term life (with or without AD&D)

☐ Voluntary short term disability

☐ Voluntary long term disability

☐ Voluntary accident (employee only; or employee and family)

H. Prior carrier

1) Is the insurance being requested replacing other group life or disability coverage? ☐ Yes ☐ No

2) If it is replacing a disability coverage, a copy of the prior plan is required for administration. Claims or benefits may be affected if a copy of the prior carrier's plan is not received.

Coverage being replaced?	Prior carrier	Date of termination

3) Is any of the insurance being requested also provided to your group by another carrier (i.e., same benefit with more than one benefit plan co-existing)? ☐ Yes ☐ No

4) Which benefits are those?_____

Please continue on the next page.

I. Application

I understand:

1. This Group Application and the Proposal of Coverage(s), constitute an application for group insurance with Advance Insurance Company of Kansas (AICK). The employer sponsoring this group plan is an active business operating on a full-time basis in the BCBSKS service area. I acknowledge that AICK has the right to request and receive any information necessary to validate representations about my business.
2. I understand that if my group replaces AICK with another life or disability insurer, any coverage provided pursuant to this application will be cancelled for both the group and it's individuals except as provided by law.
3. All information provided on this Group Application is true and complete to the best of my knowledge. I acknowledge that AICK will rely on this information in evalutating this group for coverage and I will promptly notify AICK of any changes. I also acknowledge that any intentional misrepresentation of material fact in this application may result in termination or recision of coverage.
4. The group life and/or disability insurance applied for will become effective as of the effective date requested, subject to the terms and conditions of the policies for which application is made, provided: 1) this application is approved at the home office of AICK and 2) the number of individuals to be insured are not less than the number of lives required by the laws of Kansas. If this application is not approved, no insurance will become effective and any advance payment will be refunded. Approval of this application is not guaranteed. The Policyholder/ participating employer should not cancel any other life and/or disability coverage until notified by AICK that this application has been approved. No agent or broker is authorized to approve applications, modify policies, alter, or waive any rights or requirements of AICK.
5. Please initial sections a., b., and c. after you have read them:

_____ **a.** I have read Section C. and understand an employee must be Actively at Work to be insured.

It is the responsibility of the Policyholder/participating employer to submit to AICK for enrollment only those employees and dependents who meet the eligibility criteria of the Policyholder/participating employer and AICK; and to ensure and verify the continued eligibility status of covered employees and dependents.

_____ **b.** AICK does not have Open Enrollment.

_____ **c.** Employees in a covered class and working at least the required minimum hours each week should enroll at first opportunity to avoid being a Late Enrollee.

Coverage will be based on the participant's earliest possible date of eligibility and backbilled accordingly unless the applicant is a Late Enrollee.

Late Enrollees must provide AICK with satisfactory evidence of insurability to be covered; this may include answering medical questions and paying any fees charged for medical records or exams needed to underwrite the Late Enrollee's request for coverage.

Employer name_____

Signature_____ _____
Plan administrator representative Date

Title_____

AICK representative signature_____

Broker name/agency_____

Broker signature_____

Thank you for your application.