

UNIFIED LIFE INSURANCE COMPANY

Employer's Group Application

Medical, Dental and Disability Insurance Underwritten by: Unified Life Insurance Company, Overland Park, Kansas
Life and A&D Insurance Underwritten by: Jefferson Pilot Financial Insurance Company, Omaha, Nebraska
Administered by: Corporate Benefit Services of America, Inc., Minnetonka, Minnesota

PLEASE COMPLETE ENTIRE APPLICATION USING INK.

New Group Change to Existing Group Group Number
(Please complete Section One and any other sections applicable to your requested change.)

Requested Effective Date Important - coverage will not become effective until we notify you in writing.

1 General Information

Employer's Legal Name
Billing Address City State Zip
Mailing Address City State Zip
Telephone Number ( ) FAX Number ( )
Name/Title of Contact Person Email Address
Business Type Sole Proprietorship Partnership Corporation Other
Federal Tax ID Number Nature of Business

2 Eligibility

Total number of employees on payroll Minimum number of hours worked per week for full-time eligibility
Total number of permanent full-time eligible employees
(Please include a copy of your most recent quarterly wage and tax statement)
Employer will: Pay entire cost Share cost with insureds: % of employee cost (25% minimum); % of dependent cost
Probationary period for new employees - the first of the month following: 30 days 60 days 90 days Other
Are there new full-time employees that are currently in their probationary period? Yes No
If yes, list employee(s) name below and submit an employee application

3 Continuation/ Disability

A. Are any former employees and/or dependents eligible for medical coverage through COBRA? Yes No
If yes, please identify and provide a copy of a signed acceptance and completed application or rejection form.
(Include those in 60-day election period)
B. To the best of your knowledge, are any employees or dependents proposed for coverage, disabled, unable to work, or not at work because of a current or approaching hospital confinement, leave of absence, or are otherwise incapacitated? Yes No
If yes please provide the person's name/status

4 About Your Current Plan

A. Are you replacing existing group insurance? Yes No Name of Current Insurance Carrier
Effective Date of Existing Coverage Reason for Changing Carriers
If coverage was terminated, who terminated it? Employer Carrier Termination Date
B. Are all employees, including owners, partners and officers, covered by Workers' Compensation? Yes No
If no, list names of employees not covered



I hereby certify • I asked all questions and accurately and fully recorded all information given by the applicant • I advised the applicant not to terminate existing coverage unless, and until, the administrator notifies him/her, in writing, that this application has been approved • I used only advertising approved by the Insurer to solicit this application, I told the applicant nothing inconsistent with the approved advertising about the benefits/coverage(s) • I didn't guarantee the Insurer's approval of the application or issuance of coverage(s) • I didn't tell the applicant that the Insurer will cover any pre-existing condition(s) • I made no false, misleading, or deceptive statements and complied with all applicable insurance laws, underwriting requirements, and the market/sales standards maintained by the Insurer.

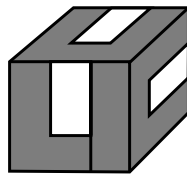
I understand that I'm liable for my acts and omissions to the extent provided by law, I understand I have no authority to alter this application, bind the Insurer by making promises and/or representations, or to waive or change the terms, conditions, and/or provisions of the policy(ies) or any requirement imposed by the Insurer. I understand I represent the employer, not the Insurer.

Signature of Writing Agent \_\_\_\_\_ Date \_\_\_\_\_  
*Month Day Year*

Agent's Social Security Number \_\_\_\_\_

**New Group Enrollment materials should include the following information:**

- ✓ Employer's Group Application
- ✓ An Employee Application for each eligible employee
- ✓ A check for the first month's premium, made payable to CBSA
- ✓ Quote
- ✓ A copy of the group's most recent Quarterly Wage and Tax Report (Account for any employee that appears on the statement but did not enroll for coverage)
- ✓ A copy of the most recent prior carrier's bill (Account for any employee that appears on the bill but did not enroll for coverage)
- ✓ Each employee's effective date of coverage with the prior carrier for pre-existing credit
- ✓ Copies of HIPAA Certificates of Creditable Coverage for those employees/dependents who had health insurance with a carrier other than through the employer's plan



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