



Group Insurance Employer Application

Home Office Use Only
Group Number:
SIC/NAICS Code:

Applicant Information (Please complete using dark ink)

Legal Name of Policyholder		Requested Effective Date	
Street Address	City	State	Zip
Years in Business	Nature of Business	Telephone Number	

Check one:  C Corporation     LLC     LLP     Subchapter S Corp.     Partnership  
 Sole Proprietorship     Government Entity     Other \_\_\_\_\_

Application is being made for the following coverage(s):

	Basic	Voluntary		Basic
Life with AD&D	<input type="checkbox"/>	<input type="checkbox"/>	Short Term Disability	<input type="checkbox"/>
Dependent Life	<input type="checkbox"/>		Long Term Disability	<input type="checkbox"/>
Dependent Life with AD&D		<input type="checkbox"/>		
Dental	<input type="checkbox"/>	<input type="checkbox"/>		
Vision	<input type="checkbox"/>	<input type="checkbox"/>		

Rates Below are Initial Rates

Basic Life / Basic AD&D:

Basic Life Rate per \$1,000 of Benefit Volume: \$ \_\_\_\_\_  
Basic AD&D Rate per \$1,000 of Benefit Volume: \$ \_\_\_\_\_  
Basic Dependent Life Rate of \$ \_\_\_\_\_ Per Employee (with or without Dependents)

Basic Short Term Disability:

Basic Short Term Disability Rate per \$10 of Covered Benefit: \$ \_\_\_\_\_

Basic Long Term Disability:

Basic Long Term Disability Rate per \$100 of Monthly Covered Payroll: \$ \_\_\_\_\_

**LIFE AND DISABILITY INSURANCE**  
**Employer Application (cont.)**

**Dental**

Per Covered Employee	\$ _____	Employee & Child(ren)	\$ _____
Employee & Spouse / Domestic Partner	\$ _____	Family	\$ _____
Add Orthodontic Benefit Rider <input type="checkbox"/>		Add TMJ Rider (for Washington Residents Only) <input type="checkbox"/>	
Dental Rates Guaranteed Until (month/day/year) _____			

**Vision**

Per Covered Employee	\$ _____	Employee & Child(ren)	\$ _____
Employee & Spouse / Domestic Partner	\$ _____	Family	\$ _____
Vision Rates Guaranteed Until (month/day/year) _____			

**Rates for Voluntary coverage, if elected, are shown in the Benefit Proposal.**

**LIFE AND DISABILITY INSURANCE  
Employer Application (cont.)**

**Name of Policyholder**

**The Plan Benefits Will be Those Shown in the Benefit Proposal**

**Agreement**

The Applicant hereby applies for the group insurance coverage(s) shown on page one. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Any statement by the Applicant to obtain coverage for any Policy issued will be a representation and not a warranty. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will **(a)** be issued only if the requested insurance is acceptable to LifeMap Assurance Company (the Company) and is legally permissible; **(b)** be issued under a group Policy or Policies in the language customarily used by the Company; **(c)** be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable); **(d)** be subject to all exclusions and limitations of the Policy; and **(e)** take effect on the date determined by the Company.

The Applicant understands that no insurance producer has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an Employee is required to submit satisfactory Evidence of Insurability will be determined in accordance with the Policy's terms, and will be subject to the Actively at Work requirement. The Applicant agrees not to **(a)** collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or **(b)** distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This Application and the payment of premium constitutes the consideration for any Policy issued. After receipt of the Policy, payment of premium is deemed acceptance of the Policy's terms. This Application shall be attached to any Policy issued.

**Disclosure**

If you have an insurance producer, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from LifeMap Assurance Company. Incentives may be based on any of several factors including the size of group business, the products you buy, your insurance producer's volume of business with LifeMap Assurance Company and the other services your insurance producer provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your insurance producer.

**Insurance Fraud Warning**

**Unless specific state language is provided below, the following general fraud notice applies:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

**For residents of Washington:** 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.

I have read and understand this entire Application. The information provided is accurate to the best of my knowledge. I understand that the information on this Application and any other information I provide shall serve as the basis for the insurance to be issued, and that I have a duty to notify the Company of any changes. It is understood and agreed that no insurance shall be effective until approved by the Company at its home office.

**Note: The Accidental Death and Dismemberment (AD&D), Critical Illness and Accident Only Insurance Policies provide limited benefits. Review your policy carefully.**

Name and Title of Authorized Group Executive or Administrator (please print)	Initial Premium Amount \$ _____ (to be applied to initial premium payment)
Signature of Group Executive or Administrator	Date
Insurance Producer	Dated at (City, State)
LifeMap Insurance Producer Appointment Number	Insurance Producer E-Mail: <b>Required</b>