

APPLICATION FOR GROUP LIFE INSURANCE



P.O. BOX 7777, MERIDIAN, IDAHO 83680-7777

1. Legal Name of Policyholder					
2. Address of Policyholder	Telephone				
3. Name of Subsidiaries, Divisions or Affiliates to be Covered	4. Person Responsible for Administration of the Plan: _____ email address _____				
5. Nature of Business	6. Tax ID #				
7. Effective date - 12:01 A.M. Month _____ Day _____ Year _____	8. Deposit of \$ _____ to apply on the First Premium.				
EMPLOYEE ELIGIBILITY:					
9. Eligible Classes	10. Eligible Employees Must Work at Least _____ hrs. Per Week and be reported for Social Security Purposes.				
11. Employees will be Eligible after Working for the Policyholder: Present Employees _____ Months/Days New Employees _____ Months/Days					
12. Number of Employees: _____ Eligible _____ Enrolled If dependent benefits are included, number of eligible employees with eligible dependents: _____ Eligible _____ Enrolled					
13. Employees are required to contribute towards cost: Employee Insurance: () Yes () No If yes, the Employee will contribute _____. Dependent Insurance: () Yes () No If yes, the Employee will contribute _____.					
POLICY FEATURES: (enter information from proposal)					
14. Employee Classification	<table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;">_____ Amount of Insurance _____</td> </tr> <tr> <td style="text-align: center;">Life</td> <td style="text-align: center;">AD & D</td> </tr> </table>	_____ Amount of Insurance _____		Life	AD & D
	_____ Amount of Insurance _____				
	Life	AD & D			
15. Dependent Group Life Insurance: () Yes () No If yes, complete this section.					
<u>Classification</u>	<u>Amount of Insurance</u>				
Spouse	_____				
<u>Classification</u>	<u>Amount of Insurance</u>				
Children: _____	_____				
16. Accelerated Death Benefit: () Yes () No If yes, () Employee only () Employee & Dependents					

17. Accidental Death & Dismemberment Benefits (AD&D): () Yes () No

18. Employee Supplemental Life Insurance () Yes () No If yes, complete this section.

<u>Employee Classification</u>	<u>Amount of Supplemental Insurance</u>	
	<u>Life</u>	<u>AD & D</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Dependent Supplemental Life Insurance: () Yes () No If yes, complete this section.

<u>Classification</u>	<u>Amount of Insurance</u>	<u>Classification</u>	<u>Amount of Insurance</u>
Spouse	_____	Children: _____	_____
		_____	_____
		_____	_____

20. Does coverage continue for retired employees? () Yes () No If yes, complete the Retiree Specification sheet.

21. Is this a Replacement of Similar coverage? () Yes () No If yes, termination date of prior plan _____
Previous Company _____

22. Agent of Record (provided he is duly licensed as required by law):

Agents Name _____ Agency Name _____

Pay commission to: Agent Agency

23. The Applicant agrees that if the entire premium is paid for by the applicant, all eligible employees and dependents will be enrolled and reported to the Company as they become eligible.

24. The Applicant agrees that if eligible employees are required to contribute towards the cost, all eligible employees will be given an opportunity to enroll for insurance and to make the required premium contribution; and at least _____% of the eligible persons will be enrolled, for contributory coverage; and/or at least _____% of the eligible persons will be enrolled for voluntary coverage.

25. The Applicant agrees that no insurance shall take effect unless this application is approved by United Heritage Life Insurance Company, Meridian, Idaho.

26. This Application supercedes any previous application for this insurance coverage.

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and/or civil penalties.

Dated at _____ on _____
(City & State) (Date)

Witness _____ Applicant _____

By _____

Title _____



P.O. Box 7777, Meridian, ID 83680-7777

Case Issue Transmittal

This form must be included with all new cases. *Please complete this form in its entirety. An incomplete form may result in delayed processing.*

I. GROUP & CONTACT INFORMATION

Group Effective Date: _____

New Group

Change – Existing Group

Group/Policy Number: _____

Group Name: _____ SIC Code: _____

(Please print clearly)

Group Contact Name: _____

Group Contact Email Address: _____

Billing Contact Name: (if different than above) _____

Billing Contact Email Address: _____

II. GROUP ADMINISTRATION

A. Document Delivery – All documents will be issued electronically* unless otherwise indicated below.

*A welcome notice and instructions on accessing documents and Administrative Guides are e-mailed to the Group Administrator.

Group does not want documents sent electronically. Please indicate name and address materials should be sent to below.

Name: _____

Street Address (No P.O. Box) _____

City _____ State _____ Zip _____

Additional copy of policy/certificates to be sent to: *(If additional space is needed, please provide in Comments section below.)*

Name: _____

Street Address (No P.O. Box) _____

City _____ State _____ Zip _____

If multiple classes, does the group want separate certificates by class Yes No

B. Billing Method (please select one below)

Web Billing – We provide initial enrollment details through our Web-based application which an employer can use to manage additions, changes, and terminations.

Self-Administered – All enrollment and individual coverage information is kept by the employer and only aggregate coverage information is provided to us monthly along with the premium due.

List Billing – Enrollment additions and deletions are managed by us and the bill is presented to the employer with individual enrollment information in paper form.

Third Party Administration (TPA) - If TPA, please provide TPA name: _____.

Note: If any units are to be billed separately: (1) indicate the name and address of each unit in the Comments section below or on an attachment; (2) state the amount of the premium deposit to be applied to each unit; and (3) separate enrollment forms by unit.



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III. COMMISSIONS

Commissions are payable to (Please check all that apply):

Broker Agency **Producing Agent**

Commission Rate Payable: _____%

*If more than one, list all others in Comments section and indicate split (please indicate Tax ID or SS# for each.)

The following information must be provided (please print):

Broker Agency (If applicable) Yes No

Name: _____

Address: _____

City/State/Zip: _____

Tax ID or SS#: _____

Email: _____

Phone #: _____

Percentage of commission payable: _____%

AND/OR

Producing Agent Yes No

Name: _____

Address: _____

City/State/Zip: _____

Tax ID or SS#: _____

Email: _____

Phone #: _____

Percentage of commission payable: _____%

IV. SUBMISSION CHECKLIST

- Application or Participation Agreement Yes
- Completed Enrollment Forms Yes (or census)
- Occupations and Earnings Yes (required for all groups with STD/LTD coverage or salary based life coverage)
- Evidence of Insurability Form (if evidence is required) Yes
- Deposit Premium (equal to one billing mode) Yes
- Copy of Sold Proposal Yes
- Producer Appointment Documents (if applicable) Yes
- Copy of Prior Carrier's Plan Yes (if available)
- Provide Schedule A information for form 5500 on groups over 100 lives Yes No



**UNITED
HERITAGE**

P.O. Box 7777, Meridian, ID 83680-7777

Case Issue Transmittal

V. PRODUCTION: Please complete below.

	Employees # Elig/# Sold	Commissions*	Rate	Volume	Monthly Premium
Life	_____	_____	_____	_____	_____
AD&D	_____	_____	_____	_____	_____
Dependent Life	_____	_____	_____	_____	_____
STD	_____	_____	_____	_____	_____
LTD	_____	_____	_____	_____	_____
Supplemental Life/AD&D	_____	_____	Age	_____	_____
Supplemental Life-Spouse	_____	_____	Age	_____	_____
Supplemental Life-Children	_____	_____	_____	_____	_____
Voluntary Life - EE	_____	_____	Age	_____	_____
Voluntary Life - SP	_____	_____	Age	_____	_____
Voluntary Life - CH	_____	_____	_____	_____	_____
Voluntary STD	_____	_____	_____	_____	_____
Voluntary LTD	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Commission
S = Standard*

COMMENTS: