APPLICATION
FOR GROUP INSURANCE

www.advanceinsurance.com

Application is being made to Advance Insurance Company of Kansas for Group Insurance based upon the following statements:

1. Name of policyholder ____________________

____

(If a division, subsidiary or affiliate is to be insured as a participating employer, list each by name and location. An extra page may be attached if necessary.)

Business address ____________________
Number and street name City State ZIP

Billing address ____________________
PO Box City State ZIP

Telephone ( ) ____________________ Fax ( ) ____________________

Nature of business ____________________

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

Insurance administrator ____________________ E-mail address ____________________

Executive contact ____________________ E-mail address ____________________

2. Requested effective date ____________________ Requested anniversary month ____________________

Insurance applying for: (►available as a stand-alone policy)	Percentage of premium paid by employer?
► ☐ Basic Term Life	________
☐ with Dependent Life	________
☐ with Optional Employee Life	________
► ☐ Basic Long Term Disability	________
► ☐ Basic Short Term Disability	________
► ☐ Voluntary AD&D	________
► ☐ Voluntary Long Term Disability	________
► ☐ Voluntary Short Term Disability	________

Select **only** one plan for Voluntary STD: ☐ 1-8-13 ☐ 15-15-13 ☐ 1-8-26 ☐ 15-15-26 ☐ 30-30-26 ☐ 1-8-52 ☐ 15-15-52

3. Enrollment requirements **(no open enrollment)**

Eligibility is to be based solely on conditions pertaining to employment; such as, the employee's length of employment, regularly working the hours required each week and classification. **Eligibility, participation and the percentage of the premium paid by the employer should not be based on enrollment in a health coverage plan**.

Contributory – both the employer and the employee contribute to the cost of the premium. A minimum of 75% of all full-time persons must participate. Late enrollees will be required to submit evidence of insurability.

Non-contributory – the employer pays 100% of the premium for every employee who qualifies for coverage (see Eligibility above). 100% of all full-time persons must enroll. Late enrollees will be backbilled.

Voluntary – the employee pays the premium. The proposal of coverage states the required participation level.

4. Eligibility requirements — minimum hours worked to be considered full-time:

Individuals must work a minimum of ________ hours[1] per week and satisfy the company imposed waiting period beginning on the first day of employment to be considered eligible.

[1]Must be at least 30 hours or more per week for Long Term Disability and 20 hours or more per week for all other coverages.

5. Individuals not eligible for coverage include part-time, seasonal, temporary persons and leased, contracted or 1099 employees. Do you exclude any others ? Please describe: ____________________

6. No. of full-time eligible* employees ________ No. still serving waiting period ________ No. enrolling ________

*as determined by conditions pertaining to employment such as the employee's length of employment, regularly working the required number of hours each week and the employee's classification.

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7. **Persons not actively at work will not be eligible for insurance until they have returned to an 'actively at work' status.** List any individual who is not now (or expected to be) at work on the Effective Date of Coverage. Attach a separate sheet to this application if more space is needed.

Name	Date last worked	Reason	Insured by Prior Carrier?
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8. Waiting period: list months or days
   - for Class 1 ________ ☐ months ☐ days
   - for Class 2 ________ ☐ months ☐ days
   - for Class 3 ________ ☐ months ☐ days

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

   Will part-time employment be used to satisfy the waiting period? ☐ Yes ☐ No

9. Effective date **(choose one)**
   - ☐ First of the month coinciding with or next following
   - ☐ Date of hire (no company imposed waiting period)
   - ☐ Other (explain) ____________________

10. Prior carrier information: Is the insurance being requested replacing other group insurance? ☐ Yes ☐ No in addition to other group insurance? ☐ Yes ☐ No

    Which benefits are being replaced? ____________________

    Which benefits are in addition to? ____________________

    If it replaces coverage, a copy of the prior plan is required for administration. **Claims or benefits may be affected if a copy of the prior carriers plan is not received.**

    Prior carrier ____________________ Termination date ____________________

11. Amount of advance premium $ __________ Premium is due monthly if $30 or more and quarterly if less than $30.

    The group insurance applied for will become effective, subject to the terms and conditions of the policies for which application is made, as of the effective date requested, provided this application is approved at the home office of Advance Insurance Company of Kansas and provided 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 coverage until notified by Advance Insurance Company of Kansas 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 Advance Insurance Company of Kansas.

    Signed at ____________________ (City) State of ____________ (State) on this ________ (Day), ____________ (Month), ________ (Year)

    ____________________ Agent representative | ____________________ Printed name of agent representative

    ____________________ Broker representative | ____________________ Printed name of broker representative

    ____________________ Full legal name of policyholder

    ____________________ Authorized signature of policyholder | ____________________ Title of authorized signatory

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