

EMPLOYER PARTICIPATION APPLICATION

FOR VOLUNTARY LIFE INSURANCE • ADVANCE BUSINESS TRUST



1. Participating employer information:

Name of firm _____

Business address _____
Number and street City State ZIP

Billing address _____
P.O. Box City State ZIP

Firm contact _____ Title _____

Telephone () _____ Fax () _____

E-mail address: _____

No. of years in business _____ Nature of business: _____

2. Requested effective date _____ Requested anniversary month _____
 (The firm's effective date of coverage will be the first of the month following acceptance by Advance Insurance Company of Kansas.)

3. **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

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

Individuals must work a minimum of _____ hours¹ per week and satisfy the company imposed waiting period beginning on the first day of employment to be considered eligible.
¹Must be at least 20 hours or more per week.

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. Waiting period: list months or days (indicate days **only** if days are counted)

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

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

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

7. Prior carrier information. Is the insurance being requested replacing other group insurance? Yes No
 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 _____

8. Adoption and Participation Agreement (administered and underwritten by Advance Insurance Company of Kansas) Applicant applies for group insurance benefits as set forth in the above 'Employer Participation Application for the Advance Business Trust', and adopts the Advance Business Trust, which is made a part hereof. Applicant agrees to be bound by all the terms of the trust, including all amendments. Applicant agrees that if it ceases to provide payment for the coverage for its eligible employees under the contracts issued to the trustees, it will be deemed to have withdrawn from the trust. Applicant understands that the trust is a dry trust, with its only asset being the group insurance contracts held by it, and that any premiums due under contracts issued to the trustees will be payable solely to Advance Insurance Company of Kansas. Applicant agrees that the trustee is not an insurer, nor does the trustee have any obligation under any policy of insurance and that all claims for and benefits provided by the insurance being applied for will be made to and payable by Advance Insurance Company of Kansas under group policy(ies) issued to the trustees. Applicant understands that the trust is not a substitute for any obligation under the Employee Retirement Income Security Act of 1974 to hold funds in a trust. Applicant agrees that coverage shall not commence until Advance Insurance Company of Kansas has accepted this application and notice of approval has been transmitted to Applicant. Applicant understands that it should not cancel any existing coverage until notified that Advance Insurance Company of Kansas has accepted this application.

Signed at _____ State of _____ on this _____, _____, _____
City State Day Month Year

 Agent representative

 Printed name of agent representative

 Broker representative

 Printed name of broker representative

 Full legal name of participating employer

 Authorized signature of policyholder

 Title of authorized signatory