Application

for Group Insurance

ADVANCE Insurance Company of Kansas SM

Section 1 – Employer Information

CLEAR DATA

Employer/Policyholder Name

Business Physical Address

City

State ZIP Code +4

Business Billing Address (if different from physical address above)

City

State ZIP Code +4

Which of these addresses should your certificates be mailed to? ☐ Physical address ☐ Billing address

Nature of Business

Is your group an ERISA plan? ☐ Yes ☐ No

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that addresses and establishes certain rights and protections to participants of most employer welfare (e.g., health, dental, life) and pension (e.g., 401(k), retirement) benefit plans. For more information on ERISA, refer to **www.dol.gov/ebsa**, call the Department of Labor or contact your accountant.

____ / ____ / _____
Requested Effective Date

[select one]
Requested Anniversary Month ☐ Same month as Effective Date

(____) ____-____
Business Phone Number

(____) ____-____
Business Fax Number

Plan Administrator Representative Name

Plan Administrator Representative Email Address

Group Leader Name

Group Leader Email Address

Do you have union affiliation? ☐ Yes ☐ No

If yes, indicate name of union

Are you enrolling through an association? ☐ Yes ☐ No

If yes, give association name

Section 2 – Company-Imposed Waiting Period

Coverage for eligible employees begins (select one):

☐ The first day of the month following (or coinciding with) completion of your company's waiting period.

☐ The date of hire.

☐ Other (describe):

The waiting period requires an employee to actively work the specified period for the policyholder/participating employer before qualifying for benefits.

Class 1: ____ days or _____

Class 2: ____ days or _____

Class 3: ____ days or _____

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

Does the waiting period apply to employees that are rehired? ☐ Yes ☐ No

Will the time a person has been employed but not working enough hours to qualify for benefits (i.e., less than the minimum hours required each week) be used to satisfy the waiting period? ☐ Yes ☐ No

Please continue on the next page.

Section 3 – Working the Required Hours

Employees and owners must be actively at work, performing regular duties of their job and at the usual place of employment for a minimum of _____ hours* each week to be insured by this coverage.

* May not be less than 20 hours each week for [Basic or Voluntary] Life, Accidental Death & Dismemberment or [Basic or Voluntary] Short Term Disability; and not less than 30 hours each week for [Basic or Voluntary] Long Term Disability.

This coverage does not include persons that are seasonal, temporary, leased, contracted or 1099 employees. All others working the minimum hours each week should enroll (or waive coverage) unless you exclude them from coverage.

Do you exclude any others? ☐ Yes ☐ No

_____
If yes, please describe who

Section 4 – Actively at Work

Employees must be actively working to be insured. Employees that are not working (i.e., performing their regular duties, at the usual place of employment and working at least the minimum required hours each week) when this coverage becomes effective cannot be covered by this policy or by the benefit(s) being added. If an injury or illness causes an employee to be absent or incapable of working the required hours on the effective date of this policy, coverage should be continued with the prior carrier.

Employees that are not actively working (i.e., performing their regular duties, at the usual place of employment and working at least the minimum required hours each week) after the coverage becomes effective cannot continue to be insured except as provided specifically by the group policy.

Section 5 – Employees Not Actively Working on the Effective Date of Coverage

List any individual who is not actively working now or not expected to be actively working on the effective date of coverage. Attach a separate sheet to this application if more space is needed.

_____ _____ / _____ / _____
Employee Name Date Last Worked

_____ Insured by prior carrier? ☐ Yes ☐ No
Reason

_____ _____ / _____ / _____
Employee Name Date Last Worked

_____ Insured by prior carrier? ☐ Yes ☐ No
Reason

_____ _____ / _____ / _____
Employee Name Date Last Worked

_____ Insured by prior carrier? ☐ Yes ☐ No
Reason

_____ _____ / _____ / _____
Employee Name Date Last Worked

_____ Insured by prior carrier? ☐ Yes ☐ No
Reason

_____ _____ / _____ / _____
Employee Name Date Last Worked

_____ Insured by prior carrier? ☐ Yes ☐ No
Reason

Please continue on the next page.

Section 6 – Participants

Employees (and dependents, if applicable) must be a resident citizen of the United States or an alien legally residing in the United States to be eligible for coverage. Participation in this coverage is to be based solely on conditions pertaining to a person's employment which includes, but is not limited to, factors such as the length of employment, regularly working the required hours each week and belonging to a class of employees that is included in this plan. Please note: "Persons enrolling in health coverage" is not a valid class description.

Eligibility for the group life coverage, participating in the group life coverage or the amount of premium the employer contributes toward the cost of group life coverage cannot be based on the employee's participation in (i.e., enrolling in) the employer's group health plan.

_____ is the number of employees working at least the minimum hours shown in Section 3.
NOTE: Do not include in this count persons that are seasonal, temporary, leased, contracted or 1099 employees, as described in Section 3, as excluded from coverage or listed in Section 5 as not actively working.

Section 7 – Basic Group Benefits

1. Select the benefit(s) for which the group is applying.	2. Does the employer pay the entire cost of premium (this benefit costs the employee $0)? If no, answer question 3.	3. Is this benefit part of an allowance plan whereby each employee receives a fixed dollar amount and the employee selects from a variety of coverages to best fit their needs? If no, answer question 4.	4. Describe below how much of the premium the employer/participating employer will be funding for each enrolled employee (by benefit)*.
☐ **Term Life and AD&D**	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ with dependent life	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ with optional life	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ **Short Term Disability**	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____
☐ **Long Term Disability**	☐ Yes ☐ No	☐ Yes ☐ No	_____% or $_____

* If any part of your response changes with regard to the amount of (or percentage of) the premium this employer pays as part of the benefit plan for your employees, please notify Advance Insurance Company of Kansas of the change.

Section 8 – Voluntary Group Benefits

☐ Voluntary Term Life (with or without AD&D)
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability
☐ Voluntary Accident (employee only; or employee and family)

Please continue on the next page.

Section 9 – Prior Carrier

Is the insurance being requested replacing other group life or disability coverage? ☐ Yes ☐ No

If it is replacing a disability coverage, a copy of the prior plan is required for administration. Claims or benefits may be affected if a copy of the prior carrier's plan is not received.

Coverage Being Replaced

Prior Carrier Name

_____ / _____ / _____
Date of Termination

Is any of the insurance being requested also provided to your group by another carrier (i.e., the same benefit with more than one benefit plan co-existing)? ☐ Yes ☐ No

If yes, which benefits are those?

Section 10 – Application and Authorization

I understand: This Group Application and the Proposal of Coverage(s) constitute an application for group insurance with Advance Insurance Company of Kansas (AICK). The employer sponsoring this group plan is an active business operating on a full-time basis in the Blue Cross and Blue Shield of Kansas (BCBSKS) service area. I acknowledge that AICK has the right to request and receive any information necessary to validate representations about my business.

I understand that if my group replaces AICK with another life or disability insurer, any coverage provided pursuant to this application will be cancelled for both the group and its individuals except as provided by law.

All information provided on this Group Application is true and complete to the best of my knowledge. I acknowledge that AICK will rely on this information in evaluating this group for coverage and I will promptly notify AICK of any changes. I also acknowledge that any intentional misrepresentation of material fact in this application may result in termination or recision of coverage.

The group life and/or disability insurance applied for will become effective as of the effective date requested, subject to the terms and conditions of the policies for which application is made, provided 1) this application is approved at the home office of AICK and 2) 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 life and/or disability coverage until notified by AICK 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 AICK.

Please read each of the following sections and initial each after you have read them:

_____ I have read Section 4 and understand an employee must be actively at work to be insured. It is the responsibility of the policyholder/participating employer to submit to AICK for enrollment only those employees and dependents who meet the eligibility criteria of the policyholder/participating employer and AICK, and to ensure and verify the continued eligibility status of covered employees and dependents.

_____ AICK does not have Open Enrollment.

_____ Employees in a covered class and working at least the minimum hours each week should enroll at first opportunity to avoid being a Late Enrollee. Coverage will be based on the participant's earliest possible date of eligibility and backbilled accordingly unless the applicant is a Late Enrollee. Late Enrollees must provide AICK with satisfactory evidence of insurability to be covered; this may include answering medical questions and paying any fees charged for medical records or exams needed to underwrite the Late Enrollee's request for coverage.

Employer Name

Your signature required

Plan Administrator Representative

_____ / _____ / _____
Date Signed

Title

AICK Representative Signature

Broker Name/Agency

Broker Signature