

# EMPLOYER'S GROUP APPLICATION

Please complete Sections 1, 2, and 6 regardless of the benefits you select.

New Group     Change to Existing Group Number \_\_\_\_\_

(Please complete the Employer Information and any other sections applicable to your requested change.)

Requested Effective Date \_\_\_\_\_ **Important**—coverage won't become effective until we notify you in writing.

Requested Anniversary Date \_\_\_\_\_

Employer Name \_\_\_\_\_ Federal Tax ID Number \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ FAX Number (\_\_\_\_) \_\_\_\_\_ Business Start Date \_\_\_\_\_

Name/Title of Contact Person \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

Type of Ownership <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship	Nature of Business (please be specific)	SIC
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Will this coverage replace existing group insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide name of current carrier	Anticipated Termination Date
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Please list the name of all subsidiaries and/or affiliated companies.    Are you requesting coverage for this group?

\_\_\_\_\_ →  Yes     No    Number of Eligible Employees \_\_\_\_\_

\_\_\_\_\_ →  Yes     No    Number of Eligible Employees \_\_\_\_\_

\_\_\_\_\_ →  Yes     No    Number of Eligible Employees \_\_\_\_\_

Is the firm applying for coverage eligible to file a tax return with the above named subsidiaries and/or affiliated companies?     Yes     No

**A. Total Number of Employees** \_\_\_\_\_

Employees in Classes Not Eligible \_\_\_\_\_

Part-time Employees \_\_\_\_\_

Seasonal Employees \_\_\_\_\_

Employees in Probationary Period \_\_\_\_\_

Other (please explain) \_\_\_\_\_

**Total Number of *Ineligible* Employees** \_\_\_\_\_

**Total Number of *Eligible* Employees** \_\_\_\_\_ *(Subtract Ineligible Employees from Total Employees)*

**Employees are eligible if they work: 30 hours per week for groups with 2-50 eligible employees; or 80 hours or more per month for groups with 51 or more eligible employees.**

- B.** To the best of your knowledge, and belief, is any employee or dependent proposed for coverage now disabled, not at work, unable to work, confined to a hospital or contemplating a confinement, on a leave of absence, handicapped, or otherwise incapacitated as of the requested effective date?  
 Yes     No    If yes, please provide each person's name and status \_\_\_\_\_
- C.** Are any employees or dependents (including spouses) proposed for coverage currently on group continuation coverage, including COBRA coverage?  
 Yes     No    If yes, date on which continuation coverage began \_\_\_\_\_ for how many months?     18     29     36  
Employee's Name \_\_\_\_\_
- D.** Is each coverage applied for subject to or part of a union-negotiated collective bargaining agreement?     Yes     No  
(If yes, when does that agreement expire?) \_\_\_\_\_
- E.** Is this application being made on behalf of an Association, Chamber, or Trust?     Yes     No  
(If yes, name of the Association, Chamber, or Trust) \_\_\_\_\_
- F.** Are any classes of eligible employees to be excluded from any coverage?     Yes     No    (If yes, please explain and identify each coverage.) \_\_\_\_\_

**Please provide any class descriptions for your group and check the appropriate probationary period for each class. Please note that groups with 2-50 enrolled employees can only have one probationary period.**

- A. Group Life/AD&D/STD/LTD Coverage(s)—Employee Class Description**
- Class 1 \_\_\_\_\_ 1st day of the calendar month following     1     2     3     4     5    \* \_\_\_\_\_ months of full-time employment
- Class 2 \_\_\_\_\_ 1st day of the calendar month following     1     2     3     4     5    \* \_\_\_\_\_ months of full-time employment
- Class 3 \_\_\_\_\_ 1st day of the calendar month following     1     2     3     4     5    \* \_\_\_\_\_ months of full-time employment
- B. Group Dental/Vision Coverage(s)—Employee Class Description**
- Class 1 \_\_\_\_\_ 1st day of the calendar month following     1     2     3     4     5    \* \_\_\_\_\_ months of full-time employment
- Class 2 \_\_\_\_\_ 1st day of the calendar month following     1     2     3     4     5    \* \_\_\_\_\_ months of full-time employment
- Class 3 \_\_\_\_\_ 1st day of the calendar month following     1     2     3     4     5    \* \_\_\_\_\_ months of full-time employment

\*Other options are available only to groups with more than 50 insureds.

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- A.** Eligibility (please check one)  Employee & Dependents (including spouse)  
 Employee Only
- B.** What percentage of the premium is to be paid by the employer for each of the following coverages.
- |                                |       |                        |       |              |
|--------------------------------|-------|------------------------|-------|--------------|
| 1. Group Term Life/AD&D        | _____ | % per Employee         |       |              |
| 2. Group Dependent Term Life   | _____ | % per Spouse/Dependent |       |              |
| 3. Group Short Term Disability | _____ | % per Employee         |       |              |
| 4. Group Long Term Disability  | _____ | % per Employee         |       |              |
| 5. Group Vision                | _____ | % per Employee         | _____ | % per Family |
| 6. Group Dental                | _____ | % per Employee         | _____ | % per Family |
- C.** The applicable benefit options are the coverage and corresponding benefit options stated in the final, written quote and/or Group Benefit Request Form E10387 that was issued by EPIC and signed by the Employer's Representative in Section 6 below. If EPIC approves this application, the actual benefit options for this employer's group coverage(s) will be contained in the EPIC Certificate of Insurance(s) which is part of the group insurance policy(ies) issued by EPIC to the employer as the EPIC group policyholder.

**A. Premium**

A check for \$ \_\_\_\_\_ made payable to EPIC is being submitted with this application as payment by this employer to be applied toward the initial month's premium if this application is approved by EPIC and the group policy(ies)/coverages is issued. The monthly premium billed by EPIC will be due and payable to EPIC on the first day of the coverage month.

**B. Group Billing Options**

- Automatic Withdrawal.** We electronically transfer your premium directly from your bank account monthly. If you select automatic withdrawal from your checking account, please attach a check with "VOID" written across it and complete the Authorization Agreement for Electronic Fund Transfer in Section 9 of this application.
- Direct Bill.** We send a premium notice directly to your billing address monthly. You return the payment to EPIC by the premium due date. An additional \$5.00 fee will be added to your bill if you select this option.
- Bill Type:**  List Bill  Self Bill (only available to groups with 100 or more enrolled employees)
- Bill Mode:**  Monthly  Quarterly  Other \_\_\_\_\_

EPIC may investigate the information on this application. Any findings may be used to deny coverage for one or more employees of the group or the entire group. Please indicate the name, title, and telephone number of an employee in your firm who can provide necessary clarification of the employee and group information provided on this application.

Name \_\_\_\_\_ Position/Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been advised: • Not to terminate all existing coverage(s), whether on an insured or self-funded basis, unless and until EPIC notifies me in writing that coverage(s) has been approved • EPIC doesn't guarantee approval of this application or issuance of coverage(s) • This application or any coverage may be declined by EPIC • The agent represents the employer, not EPIC • Pre-existing conditions may be subject to waiting periods and other policy limitations and restrictions.

I understand that EPIC will rely, in part, on the information provided in this application to issue or deny coverage(s). If EPIC approves this application, I understand coverage(s) will become effective on the date assigned by them; no coverage(s) will be in force until that date.

I understand no coverage(s) will become effective for an eligible employee (and his/her dependents, if any) if he/she isn't actively at work with the employer on the assigned effective date. Such coverage(s) will become effective on the first day after he/she returns to work on a full-time basis performing all the usual tasks of his/her job.

I understand no agent or other person has the authority to alter, bind EPIC, waive or change any terms, conditions, and/or provisions of the policy(ies) or any other requirement imposed by EPIC. I understand the employer represents its employees and their dependents, not EPIC. As the employer's authorized representative and acting on that employer's behalf. I understand, agree with, and approve each and every certification made by the writing agent in Section 7 Agent Certification of this application.

If this application is approved, I understand that EPIC will not be, and are not, a plan sponsor, plan administrator, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any other state or federal law. I understand the employer is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies.

Signature of Employer Representative \_\_\_\_\_ Date \_\_\_\_\_

Signed at \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_

I hereby certify and represent all of the following as being true: • I asked all questions accurately and fully recorded all information given by the Employer Representative in this application • I advised the Employer Representative not to terminate existing coverage unless, and until, EPIC notifies him/her, in writing, that this application has been approved • I used only advertising approved by EPIC to solicit this application • I told the Employer Representative nothing inconsistent with, or contrary to, the approved advertising about the benefits, group policy(ies)/and or coverage(s) • I didn't guarantee EPIC's approval of this application or EPIC's issuance of coverage(s) • I didn't tell the Employer Representative that EPIC will cover any pre-existing condition(s) of any person proposed for coverage, and • I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and the marketing/sales standards maintained by EPIC.

I hereby certify and represent all of the following as being true: • I told the Employer Representative that EPIC has no liability for anything I said or failed to say before, during, or after the application process, that's not subsequently confirmed in writing by and EPIC authorized officer, including, but not limited to answers given by me in response to questions asked by that Representative or anyone else; and • I told the Employer Representative that EPIC is not liable for any statement, representation, or other information provided to that Representative or anyone else that isn't expressly contained in a written document provided to them and signed by an EPIC authorized officer; • I understand that I'm liable for my acts and omissions to the extent provided by law; • I understand I have no authority to alter this application, bind EPIC by making promises and/or representations or to waive or change the terms, conditions, and/or provisions of the group insurance policy(ies) or any requirement imposed by EPIC.

Signature of Writing Agent \_\_\_\_\_ Date \_\_\_\_\_

Please Print Writing Agent's Name \_\_\_\_\_ Writing Agent's Social Security Number \_\_\_\_\_

Agency \_\_\_\_\_ Tax ID Number \_\_\_\_\_

Business Address \_\_\_\_\_  
Number and Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Agency Telephone Number \_\_\_\_\_ Agency Number \_\_\_\_\_

Agency FAX Number \_\_\_\_\_ EPIC Representative Name \_\_\_\_\_

Initial issue of contract documents are to be sent to: ( ) District Office ( ) Agency ( ) Employer  
( ) Other \_\_\_\_\_

**IMPORTANT—DID YOU REMEMBER TO INCLUDE:**

- A signed copy of the EPIC Quote/Proposal and/or completed EPIC Group Benefit Request Form E10387
- Completed and signed Employee(s) Group Enrollment Application for each eligible employee,
- A check made payable to EPIC for the first month's premium,
- A copy of the most recent bill from the prior carrier or administrator,
- A copy of the group's most recent Quarterly Wage and Tax Report (groups with 51 or more eligible employees should include a census of all full and part-time employees).

Group's Legal Name \_\_\_\_\_ Group Number \_\_\_\_\_

I hereby authorize The EPIC Life Insurance Company, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my:

- Checking Account\*       Savings Account      (select one)

indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name \_\_\_\_\_ Branch \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Transit Number \_\_\_\_\_ Account Number \_\_\_\_\_

This authority is to remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Signature of Employer Representative \_\_\_\_\_ Date \_\_\_\_\_

Name and Title of Employer Representative (please print) \_\_\_\_\_

Telephone Number \_\_\_\_\_

\*IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.