Voluntary Benefit Program Application

Based upon the following information, application is hereby made for group insurance with **Jefferson Pilot LifeAmerica Insurance Company**. Their Group Insurance Service Office is located at 8801 Indian Hills Drive, Omaha, Nebraska 68114.

General Information

Legal Name of Employer (as to be shown in contract): _____

Contact Name: _____ Title: _____ Phone: (____) _____ Fax: (____) _____

Main Office Address: Street: _____ City/State/Zip: _____

Mailing Address (if different than above): P.O. Box: _____ City/State/Zip: _____

Shipping Address for initial certificate supply (not a P.O. Box):

☐ Employer's Main Office ☐ Regional Group Office ☐ Broker at address below ☐ Other at address below

Name/Firm: _____ Street: _____ City/State/Zip: _____

Nature of Business (Describe product, service, any special hazards): _____

_____

Years in Business: _____ Federal Tax ID #: _____ State Tax ID #: _____

Business is organized as (check one):

☐ C-Corporation ☐ Partnership ☐ Union
☐ S-Corporation ☐ Sole Proprietorship ☐ Political Subdivision
☐ Limited Liability Co. ☐ Not-for-profit Organization ☐ Association

Please list any **Subsidiaries, Divisions, or Affiliates** to be included. In ***REMARKS***, show for each the location, number of eligible employees and nature of business (if different): _____

_____

Has firm ever applied for, or does firm anticipate applying for bankruptcy? ☐ Yes* ☐ No

Does firm anticipate ceasing or materially reducing active business operations? ☐ Yes* ☐ No

Has firm opted out, or does firm anticipate opting out of Workers Compensation? ☐ Yes* ☐ No

Are any employees working in CA, HI, NJ, NY or RI eligible for disability income insurance? ☐ Yes* ☐ No
(If yes, list state, number eligible and number covered by state disability plan. Please note that Jefferson Pilot LifeAmerica Insurance Company **cannot** write the state disability plan in any state.)

Are any employees working or residing outside the US to be eligible for disability income insurance? ☐ Yes* ☐ No
(If yes, list country, number eligible, citizenship and expected return date.)

*If yes to any of the above questions, please give details: _____

_____

If applying for disability income insurance, please show other plans in which eligible employees participate (check all that apply):

☐ Social Security or similar plan ☐ Public Employees Disability/Retirement System ☐ Sick Leave
☐ State Disability Income Benefits ☐ State Teachers Retirement System
☐ Workers Compensation ☐ Other pension, retirement, or disability benefits

Does the employer have any other group policy in-force with Jefferson Pilot LifeAmerica Insurance Company? ☐ Yes** ☐ No

If Yes, list Policy number(s): _____

Will any of the requested Voluntary options **supplement** similar coverage now in-force or being applied for? ☐ Yes** ☐ No

Will any of the requested Voluntary options **replace** similar coverage now in-force? ☐ Yes** ☐ No

** If yes, please provide details below. For Prior Insurance Credit under a Dental Plan, enclose a copy of the inforce contract to be replaced and the prior carrier's last monthly billing.

Coverage	Carrier	Effective Date	If replacement, Termination Date

Program Options

☐ **Voluntary Term Life/Optional AD&D** (Employee Choice) ☐ $10,000 increments ☐ $5,000 increments
Employee enrollment kits will be in $10,000 increments unless requested otherwise.

Accelerated Death Benefit: This benefit is included with Employee and Spouse Life coverage, at no additional premium charge. The Death Benefit payable upon the insured's death will be reduced by any Accelerated Death Benefits received plus an interest charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, insureds should consult their personal tax advisors before claiming this benefit.

☐ **Voluntary Short Term Disability** (Employee choice)

☐ Employee Choice: 1/8/13, 1/8/26, 8/8/13, 8/8/26, 15/15/13, or 15/15/26 as elected on the enrollment forms.*

☐ Employer Choice (choose one) ☐ 1/8/13 ☐ 1/8/26 ☐ 8/8/13 ☐ 8/8/26 ☐ 15/15/13 ☐ 15/15/26 *

☐ Other (specify any of above options) _____

* **NOTE**: First number is day benefits begin for disability due to injury; second number is day benefits begin for disability due to sickness, and third number is maximum benefit duration (in weeks) for disability due to injury or sickness.

☐ **Voluntary Long Term Disability -** Choose one: ☐ Employee Choice ☐ Employer Choice*

* If electing the employer choice option, please select the requested plan design options from the menu below:

Elimination period (choose one)	☐ 60 days	☐ 90 days	☐ 180 days
Benefit duration (choose one)	☐ 2 years	☐ 5 years	☐ to age 65
Benefit percentage (choose one)	☐ 50 %	☐ 60 %	

☐ **Voluntary Dental** - Choose one: ☐ Incentive plan ☐ Traditional plan

Will this replace current dental coverage? ☐ Yes ☐ No

For Prior Dental Insurance Credit, enclose a copy of the in-force contract to be replaced and the prior carrier's last monthly billing.

Current Dental Carrier: _____ Effective: _____ Terminates: _____

Please mark the correct plan design options:

Deductible waived on preventive care		☐ Yes	☐ No	
Number of oral exams/cleanings per calendar year:		☐ 1	☐ 2	
Individual calendar year deductible (choose one)		☐ $50	☐ $75	☐ $100
Calendar year maximum	☐ $500	☐ $1,000	☐ $1,500	☐ $2,000
Orthodontia lifetime maximum (if applicable)		☐ $500	☐ $750	☐ $1,000

* Traditional Plan: Please mark the plan design choices from the following menu:

Preventive Care (choose one)	☐ 100 %	☐ 80 %
Basic Care (choose one)	☐ 80 %	☐ 50 %
Major Care (choose one)	☐ 50 %	☐ 0 %
Major Care Elimination Period (choose one)	☐ 12 month	☐ 6 month
Orthodontia (choose one)	☐ 50 %	☐ 0 %

* Incentive Plan: Please mark the selected coverage amount for Orthodontia during the 3rd year in the program:

Orthodontia (choose one)	☐ 50 %	☐ 0 %

☐ **Voluntary Vision Discount Plan -** Employer must offer at least one other voluntary benefit to be eligible for this product.

Employee Enrollment Information

Successful voluntary programs are predicated on solid employee enrollment plans. Employee enrollment kits cannot be processed without the following information.

The initial enrollment period will be held between the dates of (dd/mm/yy)_____ and (dd/mm/yy)_____.

Employee enrollment meetings will begin on the following date (dd/mm/yy)_____.

Each employee will be provided with an informational enrollment kit and application. **How many kits are needed**? _____.

Mailing address for employee enrollment kits: (Please do not indicate a P.O. Box)

Company name: _____

Street Address: _____

City, State, Zip: _____

Attention: _____

Date kits must arrive: _____

Enrollment Requirements

Employer agrees to provide Jefferson Pilot LifeAmerica Insurance Company representatives access to all eligible employees on company premises during normal business hours for the purpose of explaining the Voluntary Program(s) and enrolling participants. Employer will allow Jefferson Pilot LifeAmerica Insurance Company representatives to carry on a promotional process that will include any or all of the following:

a) meetings with mangers and supervisors, and with employee groups to distribute product brochures and enrollment forms;
b) individual meetings between Jefferson Pilot LifeAmerica Insurance Company representatives and employees for enrollment purposes;
c) a program announcement letter on employer stationary and payroll stuffers sent to all eligible employees;
d) annual meetings to promote existing and/or new Voluntary Programs.

Eligibility and Effective Date

Total number of eligible employees _____ If applicable, number with eligible dependents _____

Minimum hours: All eligible employees must work at least _____ regularly scheduled hours per week. (Minimum of 20 hours for term life or AD&D; 30 hours for disability income or dental insurance.)

Waiting period: Current employees must be employed _____ days and new employees (hired on or after the effective date of coverage) must be employed _____ days in an eligible class before becoming eligible for coverage.

Excluded classes: The plan standardly excludes temporary, seasonal and part-time employees working less than the minimum hours elected above. The following groups are also excluded:

☐ Employees working at _____

☐ Employees working in positions subject to collective bargaining with Union Local _____

☐ Other _____

Requested effective date: _____. The program will take effect no earlier than the 1st of the month following Jefferson Pilot LifeAmerica Insurance Company's approval of this application and acceptance of enrollment forms meeting the minimum participation requirements.

Minimum participation requirements: During the initial enrollment period, this Voluntary Benefit Program requires enrollment and acceptance of at least 10 employees per coverage offered by an employer group. In addition, premium must total at least $100 per month per coverage. The required participation rate under each coverage offered by an employer group is 50% of those eligible for coverage, or 50 employees, whichever is less.

Employees declined due to unsatisfactory evidence of insurability will be discounted, in determining whether the required rate is met. An individual's coverage will not take effect until the 1st of the month following Jefferson Pilot LifeAmerica Insurance Company's approval of the enrollment form, based upon any evidence of insurability required, and receipt of the first premium. The effective date will be delayed for an employee who is not actively at work or a dependent whose activities are limited due to sickness or injury on the date coverage would otherwise take effect.

Billing Information

Is any premium paid through an existing Section 125 Plan? ☐ Yes ☐ No

Premiums shall be payable **monthly** to Jefferson Pilot LifeAmerica Insurance Company. Payroll deductions will be made on the following **payroll cycle**. Rate schedules in the employee enrollment kit(s) will be designed accordingly (except for vision products which will be shown as monthly.) Payroll cycle:

☐ Weekly - 52 per year ☐ Bi-Weekly - 26 per year ☐ Semi-Monthly - 24 per year ☐ Monthly - 12 per year

Next payroll cycle begins on (day) _____, (month/date/year) _____

Agreement

The following group insurance is requested. We understand that the requested group insurance plan:

a) will be issued only if it is legally permissible and meets Jefferson Pilot LifeAmerica Insurance Company's underwriting and participation requirements; and
b) will take effect only if this Application is approved by Jefferson Pilot LifeAmerica Insurance Company's underwriters.

If the insurance is approved, we understand that the group Policy will be in language customarily used by Jefferson Pilot LifeAmerica Insurance Company, and will contain limitations not stated in this Agreement. We understand that we will receive a supply of group Certificates and agree to distribute them to each Employee enrolled in the program. After receipt of the group Certificates, payment of premium is deemed acceptance of the Policy's terms. This Application will be made a part of any contract issued.

We agree to honor and administer on a timely basis the written payroll deduction request of each participant, in the amount required to pay the necessary premium to keep coverage in-force. Payroll deductions will be remitted to Jefferson Pilot LifeAmerica Insurance Company on a timely basis, in accord with the billing schedule agreed upon. We agree to promptly furnish Jefferson Pilot LifeAmerica Insurance Company any information reasonably required to administer the coverage and claims under it.

We understand that we may terminate the program at any time by giving prior written notice to Jefferson Pilot LifeAmerica Insurance Company. The effective date of termination will be the date the notice is received by Jefferson Pilot LifeAmerica Insurance Company's Group Insurance Service Office, or on any later date stated in the notice.

We understand that Jefferson Pilot LifeAmerica Insurance Company may terminate our participation or change any premium rate, as provided in any Policy issued.

Signature

I hereby represent that I have the authority to bind the Employer for the proposed insurance, and that all statements on this document are complete and true to the best of my knowledge. I understand that Jefferson Pilot LifeAmerica Insurance Company will rely on these statements as the basis for approving this application, and that omission or misrepresentation of known information could affect the validity of any insurance issued and could cause the denial of an otherwise valid claim.

I have read and understand the agreement as outlined and will comply with the agreement as stated. I have reviewed, understand and agree to the proposal, rate structure, and enrollment strategy presented to me by the Jefferson Pilot LifeAmerica Insurance Company representative. I understand that no agent, broker or field representative has any right to bind the requested coverage, alter the terms of the policies or enrollment materials, adjust any claim for benefits, or waive any of Jefferson Pilot LifeAmerica Insurance Company's rights or requirements.

I certify that we have been advised not to terminate any existing coverage until we receive notice that the requested coverage has been approved. I agree not to distribute materials describing the coverage to persons to be insured without Jefferson Pilot LifeAmerica Insurance Company's prior written consent, or to collect premium for the coverage before receiving Jefferson Pilot LifeAmerica Insurance Company's written acceptance.

Printed Name of Authorized Company Officer	Signature of Authorized Company Officer
Title	Date

Producer

I warrant that I have reviewed all materials and have advised my client not to terminate any existing coverage, if any, until receiving notice that the coverage applied for is approved. I understand that I have no right to bind this coverage, alter the terms of the policies or enrollment materials, or adjust any claim for benefits under the policies.

Producer			
Printed Name	License No. & State	Signature of Producer	Date

ACCIDENT & HEALTH INSURANCE FRAUD. Any person who knowingly and with intent to defraud any insurance company or other person:

(a) files an application for insurance or a statement of claim containing any materially false information; or

(b) conceals for the purpose of misleading, information concerning any fact material thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

ERISA Plan Supplement

Summary Plan Description (SPD) - ERISA generally requires private employers of all sizes to distribute Summary Plan Descriptions to their employee benefit plan participants. (There are exemptions for plans covering a sole proprietor and spouse, government employers and certain church plans.) Jefferson Pilot LifeAmerica Insurance Company's certificate of group insurance can serve as the Summary Plan Description if the following information and required Statement of ERISA rights are added.

Should ERISA information be included to form a combined SPD/Certificate? ☐ Yes ☐ No
If yes, please supply the following information:

a) **Plan Year**: The plan year ends on each _____ (month/day)

b) **Plan Number:** The employer must assign a plan number to each line of insurance coverage requested through Jefferson Pilot LifeAmerica Insurance Company for annual reporting purposes.

NOTE: Each number should be three digits starting with "5" to identify it as an insured health and welfare plan (501, 502, 503, etc.).

Voluntary Term Life/Optional AD&D: 5 _ _ Voluntary STD: 5 _ _

Voluntary Dental: 5 _ _ Voluntary LTD: 5 _ _

c) **Plan Administrator or Fiduciary**:
Name/Title _____ Phone (____) _____
Address _____
City _____ State _____ Zip _____

d) **Agent for Service of Legal Process**: ☐ Same as Plan Administrator ☐ Other as shown below

Name/Title _____ Phone (____) _____
Address _____
City _____ State _____ Zip _____

e) **Plan Trustees,** if applicable: _____

Union Contract: Is there any relevant Collective Bargaining Agreement? ☐ Yes ☐ No
If Yes, please attach a copy of the pertinent sections and indicate number of eligible employees whose positions are subject to the agreement: _____

Plan Fiduciary Responsibilities - Jefferson Pilot LifeAmerica Insurance Company cannot be named a plan fiduciary and shall not be responsible for any tax or legal aspects of the employer's plan. The employer is responsible for compliance with tax, employment and fringe benefit laws, and for obtaining any necessary counsel from their own tax and legal advisors. Jefferson Pilot LifeAmerica Insurance Company's obligations are governed solely by the Policy provisions.

Remarks

For Group Insurance Service Office Use Only

JEFFERSON PILOT FINANCIAL

Jefferson Pilot LifeAmerica Insurance Company
Service Office Address: 8801 Indian Hills Drive, Omaha, NE 68114-4066
Home Office: Florham Park, NJ
Phone (800) 423-2765

DESIGNATION OF ON-LINE SERVICES ACCOUNT ACCESS

Please submit this form with your insurance application, keeping a copy for your records.

After your contract is issued, you'll receive an e-mail which will provide a User ID and instructions on how to access your On-line Services account. The User ID and your chosen password (shown below) will give the designated individual full authority to immediately access your account via On-line Services. This includes the ability to view information (including salary information), administer the groups' benefits and delegate services.

Your Client Management representative will be calling you soon to demonstrate our On-line Services capabilities and answer any questions you may have.

If you need assistance in the interim, please call us at 800-423-2765.

Name:	
Group Name:	
Telephone Number:	
E-mail Address:	
Password:	*Passwords must be between 8 and 16 characters and contain both letters and numbers, all lower case.*