



GE Employee Benefit Solutions

The Smart Choice for Small Business

Request for Participation & Enrollment Form

Underwritten by GE Group Life Assurance Company (GEGALAC)

2 - 24 Lives

Submission Requirements...

- Completed E-Z Choice Request for Participation & Enrollment form
- Initial deposit check equal to monthly premium amount
- Copy of current carrier's most recent billing statement
- Copy of current carrier's booklet for all LTD cases and all Dental cases requesting waivers
- Copy of sold proposal (including rate calculation sheet(s) if applicable) as presented to the employer

(If any of the above items are incomplete, processing of case may be delayed.)

If applicable...

- Notification of Waiver Form
- Evidence of Insurability Applications for benefits exceeding Non-Medical Issue Limits
- Quarterly State Wage Reports may be requested at the discretion of the Home Office.

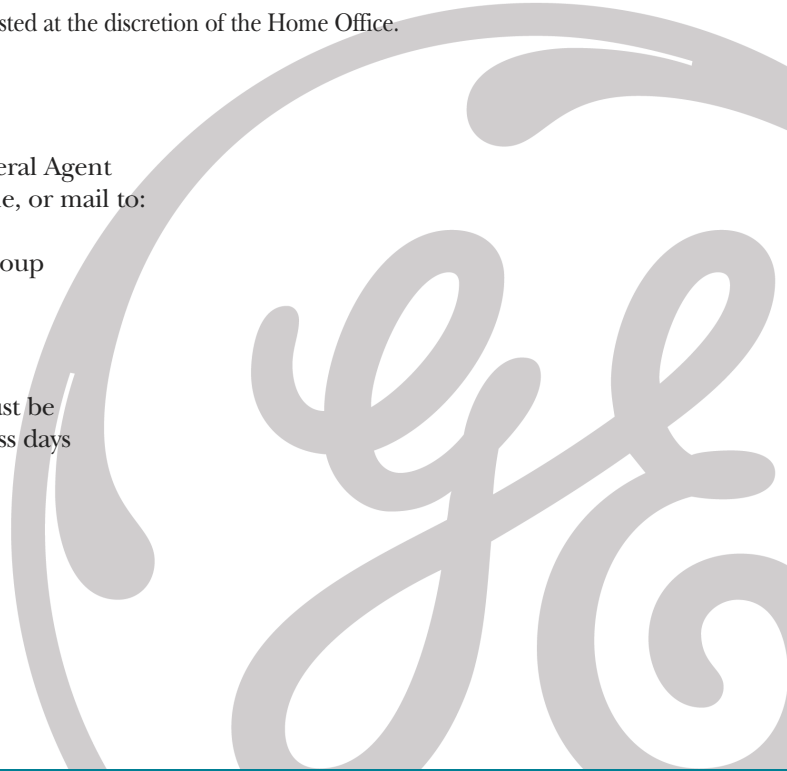
Submission instructions...

- Submit all required materials to General Agent or Master General Agent, if applicable, or mail to:

GE Financial Employer Services Group
Attn: E-Z Choice Unit 1E-204
100 Bright Meadow Blvd.
Enfield, CT 06083-1995

- New business submission material must be postmarked no later than five business days after the requested effective date. If later, the case effective date will be deferred to the following month.

E-Z Choice



GE Financial

Employer Services Group

We bring good things to life.

Employer Information

Please complete in full where appropriate. Incomplete applications delay processing.

Employer's Legal Name _____ **Employer's Tax ID#** _____

Employer's Business Address _____

City _____ **State** _____ **ZIP Code** _____

Firm Contact _____ **Title** _____ **Telephone ()** _____
(person to contact concerning coverages)

Fax () _____ **email address** _____ **Effective Date Requested** ____ / ____ / ____

Full Time Employees _____ **Years in Business** _____ **SIC Code & Nature of Business** _____

Please check appropriate box: Corporation Proprietorship Partnership Other _____

Subsidiaries/Alternate Locations Indicate subsidiaries or other locations, affiliates, to be covered:

Name _____ Address _____
(No., Street, City, State ZIP Code)

Tax I.D. _____ SIC Code _____ Nature of Business _____

Is this employer presently insured with GEGLAC or has this employer previously applied for or had coverage with GEGLAC? Yes No

If yes, please indicate coverage(s) _____ Account # _____

Are you in the process of filing bankruptcy (Chapter 7), reorganization (Chapter 11) or similar insolvency proceedings? Yes No

If yes, please explain _____

Are there any applicants who are totally disabled? Yes No If yes, please provide names here _____

Certificate – Please indicate certificate preference (check one): Electronic (Certificate will be emailed as an attachment) Paper Copies

Definition of Eligibility – Eligible employees must be working at the employer's usual place of business. Employees not regularly working at least 30 hours per week are considered part-time. (Foreign National employees are eligible for coverage while residing in the United States).

Eligibility includes: All full-time employees* Other (specify) _____
*Partnerships only – Eligibility includes Partners/Owners who are working full time for this employer. Yes No

The above definition of eligibility applies to: All Coverages or applies only to: Life/AD&D Dental Long Term Disability Short Term Disability

Important: "Basic earnings" means an employee's gross rate of earnings from the employer. It includes employee pre-tax contributions to a qualified deferred compensation plan, 401 (K) plan, or Section 125 plan.

This definition defines the base against which the premium and benefits will be paid. If any employee's compensation is not reported on a W-2 or if any employee is paid on a basis other than salaried or hourly, please provide specifics. The term "Basic Earnings" refers to: an annualized amount for Life/AD&D, a weekly amount for Short Term Disability, and a monthly amount for Long Term Disability.

Definition of Earnings (complete only for Life/AD&D, Short and/or Long Term Disability)

- Option 1: (Standard)**
Basic earnings **exclude overtime, bonuses, or other compensation.**
Earnings are based on: Current level of earnings or Prior calendar year earnings
- Option 2:**
Basic earnings **exclude other compensation or overtime but include:** Commissions Bonuses
Earnings are based on the average of the most recent:
 24 Months 36 Months Prior calendar year Prior 2 calendar years Prior 3 calendar years
- Option 3: (Partners only)**
Average earnings calculated from the Partnership Federal Income Tax return for the immediately prior:
 Tax Year Calendar Year

This definition of earnings option selected above applies to:

- All Coverages or Applies only to: Life STD LTD
 All Classes Applies only to class _____

Life / Accidental Death & Dismemberment (AD&D) (2 to 24 Lives)

Benefit Schedules:

Option 1 Coverage based on _____ times each employee's annual earnings

Option 2 Coverage based on job or payroll classification (A minimum of two employees per class is required.)

Classification	Basic Life/AD&D Amount	Maximum Benefit
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Dependent Life Option: Yes No
Requires 10 or more employees enrolled and at least 75% of employees with dependents enrolled

Option 3 \$_____ Coverage for each employee

Minimum Waiting Period 30 days (Standard) If longer, specify length _____
(Eligibility for coverage begins the first day of the month following the minimum waiting period.)

Participation	Total # of Eligible Employees _____	Total # of Employees Applying _____	Total # of Employees with Dependents _____	Number of Employees	Non-Medical Maximum Limit*	Maximum With Evidence	Minimum Participation Required
Employer Will Pay: _____ % of Employee costs _____ % of Dependent costs				Insure 2 to 5	\$25,000	\$200,000	All Eligible
				Insure 6 to 9	\$40,000	\$200,000	All or All but One
				Insure 10 to 24	\$65,000 or 3 times the average benefit, whichever is less	\$300,000	75% of those eligible

* Amounts elected in excess of the non-medical maximum limit will require medical underwriting which may include, but is not limited to, physical exams and blood testing.

(Employees may contribute up to 100% of the premium for dependents.)

Will this policy replace any existing policy of life insurance? **Employer:** Yes No **Producer:** Yes No

Dental (3 to 24 Lives)

Plan Selected (annual plan maximum) Brass (\$1000) Silver (\$1200) Gold (\$1200) Platinum (\$1500)

With PPO Yes No

With Vision Yes No

Is this plan replacing another group plan? Yes No If yes, attach a copy of the prior carrier's last bill and copy of certificate(s) of insurance and complete the following:

Name of Carrier(s) being replaced _____

Coverage(s) provided _____ Termination Date(s) _____

Reason(s) for change _____

Is your firm subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)? Yes No

Note: Your maximum coverage period will be measured from loss of coverage.

Is any person eligible to receive future benefits under your terminated plan, i.e., COBRA continuent? Yes No

If yes, list below the name(s) of the employees and/or dependents under COBRA for Dental coverage only, date of qualifying event and type of qualifying event (termination of employment, death, divorce, child reaching the limiting age):

Name	Date	Event
_____	_____	_____
_____	_____	_____
_____	_____	_____

Minimum Waiting Period 30 days (Standard) If longer, specify length _____
(Eligibility for coverage begins the first day of the month following the minimum waiting period.)

Waiting Period

- There is a 24 month waiting period for orthodontic coverage. (Only available with Platinum Plan.)
- There is a 12 month major services waiting period for all insured employees, unless they meet the requirements for a waiting period waiver. This benefit waiting period may be waived if the employer has existing group dental insurance, including comparable coverage for major services. The waiver will be granted to any employees who, on the day before their effective date for this coverage, would have been reimbursed for major services under the prior dental coverage. All employees that have satisfied the above requirements will be granted a waiver; there will not be any waivers for any future employees. (Only available with Silver, Gold and Platinum Plans.)

Is the employer eligible for a waiver? Yes No
(If yes, a copy of the existing dental plan, the last bill and proof of individual effective dates must be submitted.)

Participation Total # of Eligible Employees _____ (Excluding employees who waive dental coverage because they have such coverage through their spouses.)
Total # of Employees Applying _____
Total # of Eligible Employees with Dependents Applying _____

Employer Will Pay: _____ % of Employee costs (The employee may contribute up to 100% of the premium.)
_____ % of Dependent costs

Notification of Waiver Form *(This form may be photocopied)*

Please read, complete and sign this form if you are contributing toward the cost of coverage and are waiving coverage for any of the following insurance products: Life, Dental, Short Term Disability and/or Long Term Disability.

Note: Under contributory plans (where employees contribute towards the cost of coverage), eligible employees may elect to waive coverage. However, election to waive may not exclude that employee from the employer’s participation requirements. Under non-contributory plans, all eligible employees must enroll. Eligible employees are defined in the plan brochure.

Employee’s Name: _____

Name of Employer: _____ Account #: _____

Date of Birth: _____ Social Security #: _____

Please check the box for type(s) of insurance coverage you are waiving:

- Life Dental Short Term Disability Long Term Disability

If you are waiving dental coverage for yourself or your dependents, check all boxes that apply and provide information as applicable.

- I have similar dental coverage under my spouse’s plan; and/or
 My dependents have similar dental coverage under my spouse’s plan.

If either or both above boxes are checked, please provide the following information:

Name of spouse’s insurance company: _____

Spouse’s plan effective date: _____

- I do not have similar dental coverage under my spouse’s plan, but I am waiving the employee dental coverage.
 My dependents do not have similar dental coverage under my spouse’s plan, but I am waiving the dependent dental coverage.

Please read and sign:

I, the undersigned, hereby affirm that I have reviewed the insurance plan(s) from GE Group Life Assurance Company being offered by my employer. With my signature, I certify that I have decided to waive coverage as indicated above.

I understand that if I should later decide to enroll, I will be considered a late entrant and may be subject to Evidence of Insurability and/or reduced benefits.

Signature _____

Date _____

Census Information & Application Signatures

Important Note: Make a copy of this page if enrolling more than 12 employees. Complete and attach it to this form. Please print or type census information.

Employee's Social Security Number	Name (Last Name First)	Date of Birth		Sex	Date of Hire		Occupation	Class	Current Monthly Salary	Hours Worked Per Week	Coverage Selected						
		M / D / Y	M / D / Y		M / D / Y	M / D / Y					Other	LTD	STD	Dental / Life / Status ² AD&D	Dep. Life ³		
1.																	
2.																	
3.																	
4.																	
5.																	
6.																	
7.																	
8.																	
9.																	
10.																	
11.																	
12.																	

1. Any employee marked as "Preferred Risk" meets the definition of a "Preferred Risk Employee" i.e., they are classified as in-office executive, administrative, sales, supervisory and clerical employees who have no manual duties and spend at least 80% of their time inside the office.

2. Indicate: "S" for single, "+1" for employee plus one dependent or "F" for family coverage.

3. Must have 10 to 24 insureds to be eligible for Dependent Life coverage.

Continued on next page.

I (We) verify that all employees applying for coverage listed above are actively at work and working at least 30 hours per week, all employees listed above do not work where they reside, all employees, including myself, who are applying for disability coverage do not have other disability insurance currently in force or applied for, that when added to this insurance would exceed 75% of his/her individual current monthly earnings, and all employees meet the eligibility requirements listed in the brochure.

I (We) verify that GE Group Life Assurance Company's benefit plan(s) have been offered to all eligible employees. Completed waivers are attached for those employees and their dependents electing not to participate in the plan(s).

Please Note: Changes from the Census data, as previously submitted, may affect rates.

The undersigned employer requests that it be approved as a Participant in the Fund(s), and accepts and agrees to be bound by the terms of the trust agreements as amended. The undersigned employer further requests that insurance be provided in accordance with employer's specifications for group insurance to which this request is attached and shall be subject to the terms of the Group Insurance Policies issued to the trustee(s) by GEGLAC. The undersigned employer agrees that it will remit to the insurer or trustee(s) regularly in advance, the required premiums as they become due.

We have read this form and understand that:

1. This request for coverage is not effective until approved by GEGLAC in writing. Coverage may be declined or the effective date may be deferred for incomplete submission of information as outlined in GEGLAC's underwriting rules/standards. **Existing coverage should not be terminated until written approval has been received.**
2. All information given in connection with this request for participation is true and complete.
3. GEGLAC reserves the right to re-rate any coverage retroactively to the effective date or take other appropriate actions if any information provided to us is not true or is incomplete.
4. No producer can make or modify a contract for GEGLAC and all coverage will be as stated in GEGLAC policies.
5. Attached is an initial deposit check payable to GEGLAC equal to the **estimated first month's premium**. The amount will be returned if insurance does not become effective. Cashing of the check by GEGLAC does not constitute an approval of request.
6. Final premium rates are subject to final enrollment and any prior claim history that we may require.

Please add the figure(s) calculated using the Rate Calculation Sheet(s). GE Group Life Assurance Company reserves the right to decline a case.

Dental	\$	_____
w/Vision	\$	_____
Short Term Disability	\$	_____
Life/AD&D	\$	_____
Dependent Life	\$	_____
Long Term Disability	\$	_____
Billing Fee ⁴	\$	16.00
TOTAL MONTHLY PREMIUM:	\$	_____

4. If this is the employer's first application for E-Z Choice coverage, please add the \$16.00 Billing Fee. This fee has already been included in your billing if you currently have other E-Z Choice coverages. This fee will be charged for each billing cycle.

WARNING

STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto (in Oregon "may be guilty of insurance fraud") commits a fraudulent insurance act, which (in Oregon "may be subject to prosecution") is a crime and subjects such person to criminal and civil penalties.

THIS NOTICE DOES NOT APPLY IN VIRGINIA

IN CALIFORNIA:

"Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

IN FLORIDA:

"Any person who knowingly and with intent to defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree."

IN NEW JERSEY:

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

IN NEW YORK

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

Employer's Signature (Owner, Partner, CFO) Date

I have complied with the underwriting rules and have explained the coverage in detail to the participating employer. I represent that all information on this application is correct to the best of my knowledge.

Producer's Signature Date

Producer's Statement

Name of Participating Employer to be Insured _____

Attention Producers: This Enrollment Form must be completed in full. Missing information will delay the new business process and your COMMISSIONS! Make sure ALL items on the list on the front of this form are included.

Producer's Instructions: If you are currently appointed with the company, you only need to complete the **Producer Name, Firm Name, State License # and GEGLAC Producer Code** sections of this form.

If not currently appointed, complete all applicable sections of this form and contact our Licensing area at 1-800-451-2513 (at the prompts press zero, then extension 2534) for contracting material. We will also require a copy of your license and your firm's license if applicable.

Any product related questions should be directed to the E-Z Choice Unit at 1-800-451-2513 (at prompts press zero, then extension 6625).

Writing Producer 1 _____ % of payable commissions

Name _____
Last Name First Name Middle Initial

Home Address _____

City _____ State _____ ZIP _____

Social Security # _____

Firm Name _____

Firm Address _____

City _____ State _____ ZIP _____

Firm Tax ID # _____

State License # _____ State _____

GEGLAC Producer Code _____

Phone () _____ Fax () _____

E-mail Address _____

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? No Yes

Signature _____ Date _____

Writing Producer 2 (if applicable) _____ % of payable commissions

Name _____
Last Name First Name Middle Initial

Home Address _____

City _____ State _____ ZIP _____

Social Security # _____

Firm Name _____

Firm Address _____

City _____ State _____ ZIP _____

Firm Tax ID # _____

State License # _____ State _____

GEGLAC Producer Code _____

Phone () _____ Fax () _____

E-mail Address _____

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? No Yes

Signature _____ Date _____

General Agent (if applicable)

Name _____
Last Name First Name Middle Initial

Home Address _____

City _____ State _____ ZIP _____

Social Security # _____

Firm Name _____

Firm Address _____

City _____ State _____ ZIP _____

Firm Tax ID # _____

State License # _____ State _____

GEGLAC Producer Code _____

Phone () _____ Fax () _____

E-mail Address _____

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? No Yes

Questions about this case, contact:

Producer General Agent

Signature _____ Date _____

Master General Agent

Name _____
Last Name First Name Middle Initial

Home Address _____

City _____ State _____ ZIP _____

Social Security # _____

Firm Name _____

Firm Address _____

City _____ State _____ ZIP _____

Firm Tax ID # _____

State License # _____ State _____

GEGLAC Producer Code _____

Phone () _____ Fax () _____

E-mail Address _____

Commissions Payable in Your Name Firm's Name

If in Firm's name are you an officer of your firm? No Yes

Questions about this case, contact:

Producer General Agent Master General Agent

Signature _____ Date _____