



The First Rehabilitation Life Insurance Company of America

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www.firstrehab.com

GROUP LONG TERM DISABILITY INSURANCE POLICY APPLICATION

APPLICATION is made to THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA for a policy of group Long Term Disability Insurance (which a copy of this application is attached to and made part of), based on the following: (Please print. Please answer all questions.)

1. Policyholder Name _____
Contact Person _____
Address _____

Telephone Number (____) _____-____-____ Ext. _____
2. Names and addresses of all subsidiaries or affiliated companies whose employees will be covered.

3. Nature of business (SIC Code) _____
4. Effective date: 12:01 am on _____
5. Full-time employees: _____ (A full-time employee is one who works a minimum of 30 hours per week on a permanent, full-time basis at the employer's usual place of business or at a location to which the employer's business requires the employee to travel.)
6. Eligible employees: _____ Enrolled employees: _____
7. Class(es) of eligible employees (describe): _____

8. Service Waiting Period
Current Employees: _____ New Employees: _____
9. Is the GLTD Insurance being applied for a replacement of similar coverage? Yes No
If Yes, a copy of the prior insurer's plan must be provided for claims administration.
Name of prior insurer: _____
Termination date of prior insurance: _____
Reason for termination? _____
10. Has the group ever had coverage with First Rehab Life? Yes No.
What type? _____ For how long? _____
Reason for termination? _____
11. Benefit Qualifying Period:
 30 days 90 days 150 days 365 days
 60 days 120 days 180 days
12. Benefit Percentage:
 50% 60% 66%

13. Total Disability for Own Occupation

24 Months

60 Months

36 Months

Continuous

14. Partial Disability

Requires total disability for duration of Benefit Qualifying Period

Does NOT require total disability for duration of Benefit Qualifying Period

15. Optional Coverages:

Mental Illness and Substance Abuse

Cost of Living Adjustment

12 months 24 months Unlimited

Workplace Modification Benefit

16. Social Security Integration

Employee

Employee and Family

17. Maximum Benefit Period:

Reducing SSNRA Schedule

5 year Reducing Benefit Duration

65/5/70

To 65 with Reducing Benefit Duration

18. Minimum Monthly Benefit:

greater of \$100 or 10% of gross disability payment

\$50

greater of \$50 or 10% of gross disability payment

\$100

19. Maximum Monthly Benefit: _____

20. Rates per employee per month: _____

Contributory

Non-Contributory

_____ % of premium employer contributes.

(Minimum required employer contribution is 50% of premium.)

(If this is a contributory program, at least 75% participation must be maintained.)

21. Premium is paid monthly on the first day of each calendar month.

One month's deposit premium of \$_____ must accompany this application.

No one except the President, a Vice President or the Secretary of The First Rehabilitation Life Insurance Company of America may make or modify any contract on behalf of The First Rehabilitation Life Insurance Company of America, and no waiver is valid unless in writing and signed by one of these officers.

All statements made by the applicant are true and correct to the best of the applicant's knowledge and belief.

NOTICE: 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Dated _____ Signature of Employer _____

Name _____

Title _____

Dated _____ Signature of Producer _____

Name _____

Producer's Address _____