

APPLICATION FOR GROUP INSURANCE

JEFFERSON PILOT LIFEAMERICA INSURANCE COMPANY
Group Insurance Service Office: 8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

GENERAL INFORMATION

Office Use Only: ID# _____

Application for group insurance is hereby made to Jefferson Pilot LifeAmerica Insurance Company (the Company).

A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy): _____

2. **Main Office Address** (physical location and contract issue state):
Street _____ City _____ State _____
Zip _____ Phone # () _____ FAX # () _____ E-Mail Address _____
(if available)

3. **Administrator Name** _____
Mailing Address (if different): P.O. Box (if any) _____
Street _____ City _____ State _____
Zip _____ Phone # () _____ FAX # () _____ E-Mail Address _____
(if available)

B. REQUESTED PLAN

1. **Requested Effective Date** of insurance (month/day/year): _____

2. **Coverages elected** and Benefits Supplement Form to be completed for each coverage:
 Life and AD&D - Complete Life Benefit Supplement Indemnity Dental - Complete Dental Benefit Supplement
 Short Term Disability - Complete STD Benefit Supplement Dental PPO - Complete PPO Benefit Supplement
 Long Term Disability - Complete LTD PP Supplement

C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify): _____
Years in Business _____ Federal Tax ID# _____

2. **Business is Organized As** (select one):
 Corporation Non-Profit Organization
 Partnership Proprietorship Other _____

3. **Financial Risk** (If Yes to any part, please explain below.)
 Yes No Has Applicant ever filed for bankruptcy?
 Yes No Does Applicant anticipate ceasing or materially reducing active business operations?
 Yes No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?
Explanation: _____

4. **Funding** - Employer premium contributions will be funded from: General Assets Section 125/Cafeteria Plan

D. IMPORTANT NOTICES

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 material fact 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.

ACCELERATED DEATH BENEFIT INFORMATION. This benefit is included with Employee Life insurance, at no additional premium charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, Employees should consult their personal tax advisors before claiming this benefit.

E. AGREEMENT

The Applicant hereby applies for group insurance as provided in the attached Supplements, which are made a part of this Application. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim.

The Applicant understands that the requested group insurance will:

- (a) be issued only if the requested insurance is acceptable to Jefferson Pilot LifeAmerica Insurance Company (the Company) and is legally permissible;
- (b) be issued under a group Policy or Policies in the language customarily used by the Company;
- (c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
- (d) be subject to all exclusions, limitations and other provisions of the Policy; and
- (e) take effect on the date determined by the Company, in accord with the provisions of the Policy.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to the Active Work requirement and all other terms of the Policy.

The Applicant agrees **not** to:

- (a) collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or
- (b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law.

Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the payment of premium constitutes the consideration for any Policy issued. After receipt of the Policy, payment of premium is deemed acceptance of the Policy's terms (including any corrections, additions or changes shown in the spaces marked "For Group Insurance Service Office Use Only"). This Application, including the attached Supplements, shall be made a part of any Policy issued.

Writing Agent
Or Broker's Signature _____

Signed by Applicant's Authorized Representative:

Typed or Printed Name _____

Signature _____

License Number: _____ State _____

Typed or Printed Name _____

Title _____

State Signed: _____ Date _____
(Must be signed prior to Effective Date)

F. ADMINISTRATIVE INFORMATION

Administrative Guide and forms can be found on-line at www.jpfinancial.com.

1. **Group Administrative Guide:** Indicate format desired: CD ROM Paper Binder

2. **Shipping Address** for Group Administrative Guide and supplies (Do not show P.O. Box):
 Name/Firm _____
 Street _____ City _____ State _____ ZIP _____

3. Does Applicant have **any other group policy inforce with the Company?** Yes No
 If Yes, show Policy Number(s) if known _____

4. **Binder** payment submitted: Amount \$ _____

5. **Type of Policy Administration:** List Billing by the Company* Self-Administration Billing by Third Party Administrator**

*If List-Billed group requires separate billing locations, please complete Section I and/or J.
 **TPA Agreement and copy of any TPA license(s) must be on file with Company.

G. ELIGIBILITY, WAITING PERIOD

If requirements differ by coverage types, please explain below (or complete a sheet for each plan).

1. **Eligible Classes** will be as described in each Benefits Supplement Form.
Minimum Hours - All Eligible Employees must work a minimum of _____ regularly scheduled hours per week. Standard is 30 hours.

2. **Eligibility Waiting Period**
 A. Present Employees (hired on or before the Effective Date of this Policy) who have not yet satisfied the new employee Eligibility Waiting Period:
 must also complete the new employee Eligibility Waiting Period before becoming eligible for insurance
 will not be required to satisfy an Eligibility Waiting Period before becoming eligible for insurance
 must be employed in an eligible class for _____ before becoming eligible for insurance
 B. New Employees (hired after this Policy's Effective Date) must be employed in an eligible class with the Applicant for _____ before becoming eligible for insurance.

3. **Employee Effective Date** - Subject to the Active Work rule, employees become insured on:
 1st day of employment (If no Eligibility Waiting Period)
 1st day of the insurance month coinciding with or next following completion of the Eligibility Waiting Period
 The day following completion of the Eligibility Waiting Period
 Other (must be approved by the Home Office) _____

4. **Excluded Classes** - The Policy standardly excludes retirees, temporary, seasonal or part-time employees working less than the Minimum Hours selected. Also exclude the following: _____

NOTE: Subject to Active Work Rule, benefit increases will take effect on the 1st day of the insurance month coinciding with or next following the increase, unless requested otherwise in **REMARKS** and agreed upon by the Company. Decreases will take effect on the date of the change.

H. ERISA PLAN INFORMATION

1. **Summary Plan Description (SPD)** - ERISA requires distribution of SPDs for most employee benefit plans. The Certificate can serve as the SPD, if certain plan information and a Statement of ERISA Rights are added.
 Yes No Should ERISA information be included to form a combined SPD/Certificate? If Yes, supply information below.

A. Plan Year ends on each _____ (month and day).
 B. Plan Number assigned to each line of coverage by Applicant (3 digits starting with "5" -- 501, 502, etc.):
 Life/AD&D _____ STD _____ LTD _____ Dental _____

2. Other information to be included in SPD, complete **if applicable**.
 A. Plan Administrator or Fiduciary: Same as Applicant Other as shown below
 Name/Title _____ Phone(_____) _____
 Address _____ City _____ State _____ ZIP _____
 B. Agent for Service of Legal Process, Plan Trustees, Relevant Union Contract, **if applicable**: _____

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 benefits laws, and for obtaining any necessary counsel from their own tax and legal advisors. The Company's obligations are governed solely by the Policy.

I. SUBSIDIARY OR AFFILIATE INFORMATION (Complete only if separate firm is to be added. Attach a separate sheet for additional Units.)

A "**Subsidiary**" or "**Affiliate**" is a separate firm which is owned or controlled by the Applicant. Its employees will be insured under the Policy **only if requested** below and approved by the Company. Please complete the following for each **subsidiary or affiliate** to be insured under the Policy.

Unit Name _____ Unit's Total Eligible Employees _____ No. selecting each coverage _____

Physical Address _____

City _____ State _____ Zip _____

Mailing Address (If different) _____

City _____ State _____ Zip _____

Nature of Unit's Business is Same Other _____

Is separate billing required? Yes No Contact Person _____

Binder payment amount for this Billing Unit: \$ _____

J. DIVISION INFORMATION (Complete for a division which is in a different location or industry, or which requires a separate billing location. Attach a separate sheet for additional divisions.)

A "**Division**" is a subdivision, branch or location of the Applicant's same firm. It will be **automatically included** under any Policy issued; unless its employees are listed as an excluded class in the Eligibility section of your General Information Form. Complete the following for each **division** to be insured under the Policy, if: (a) it is in a **different location**; (b) it is engaged in a **different business** or industry; or (c) a **separate billing location** is required.

Unit Name _____ Unit's Total Eligible Employees _____ No. selecting each coverage _____

Physical Address _____

City _____ State _____ Zip _____

Mailing Address (If different) _____

City _____ State _____ Zip _____

Nature of Unit's Business is Same Other _____

Is separate billing required? Yes No Contact Person _____

Binder payment amount for this Billing Unit: \$ _____

REMARKS (Identify by section name and item number)

FOR GROUP INSURANCE SERVICE OFFICE USE ONLY

A. CLASSES FOR LIFE & AD&D BENEFITS

LIFE & AD&D BENEFITS SUPPLEMENT

CLASS 1 DESCRIPTION	COVERAGES	BENEFITS												
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Employer Contribution for Basic Life/AD&D _____ %</p> <p>Employer Contribution for Dependent Life _____ %</p>	<p><input type="checkbox"/> Basic Life</p> <p><input type="checkbox"/> Basic AD&D</p> <p><input type="checkbox"/> Optional Life</p> <p><input type="checkbox"/> Optional AD&D</p> <p><input type="checkbox"/> Basic Dependent Life</p> <p><input type="checkbox"/> Optional Dependent Life</p>	<p>Basic Benefit Amount (select one):</p> <p><input type="checkbox"/> Flat benefit amount \$ _____</p> <p><input type="checkbox"/> Multiple of salary: <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> Other _____</p> <p style="margin-left: 20px;">Subject to \$ _____ Minimum and \$ _____ Maximum</p> <p style="margin-left: 20px;">Rounded to next higher \$1,000 unless requested otherwise below.</p> <p><input type="checkbox"/> Other _____</p> <p>Dependent Life (May not exceed 100% of employee's amount for spouse, or \$4,000 for child):</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Basic</th> <th style="text-align: center;">Optional</th> </tr> </thead> <tbody> <tr> <td>Spouse (Coverage terminates at age 70)</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> </tr> <tr> <td>Child (14 Days - 6 Mo.)</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> </tr> <tr> <td>Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student)</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> </tr> </tbody> </table> <p>Optional Benefit Amount (describe): _____</p>		Basic	Optional	Spouse (Coverage terminates at age 70)	\$ _____	\$ _____	Child (14 Days - 6 Mo.)	\$ _____	\$ _____	Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student)	\$ _____	\$ _____
	Basic	Optional												
Spouse (Coverage terminates at age 70)	\$ _____	\$ _____												
Child (14 Days - 6 Mo.)	\$ _____	\$ _____												
Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student)	\$ _____	\$ _____												

CLASS 1 EARNINGS DEFINITIONS - Complete Only for Salary Based Plan. In no event will salary exceed the amount shown in the Employer's payroll records, or for which premium has been paid (if less).

Earnings standardly include **annual base salary**, or annualized hourly pay (excluding overtime) and any commissions averaged over prior 12 Months. Earnings are determined on the last day worked. If any other compensation is to be included or an alternate definition is wanted, describe below:

Also include:

- Bonuses averaged over 36 Months.
- Other (subject to Home Office Approval) _____

Instead base on:

- Each Employee's W-2 earnings for prior year.
- Other (subject to Home Office Approval) _____

CLASS 2 DESCRIPTION	COVERAGES	BENEFITS												
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Employer Contribution for Basic Life/AD&D _____ %</p> <p>Employer Contribution for Dependent Life _____ %</p>	<p><input type="checkbox"/> Basic Life</p> <p><input type="checkbox"/> Basic AD&D</p> <p><input type="checkbox"/> Optional Life</p> <p><input type="checkbox"/> Optional AD&D</p> <p><input type="checkbox"/> Basic Dependent Life</p> <p><input type="checkbox"/> Optional Dependent Life</p>	<p>Basic Benefit Amount (select one):</p> <p><input type="checkbox"/> Flat benefit amount \$ _____</p> <p><input type="checkbox"/> Multiple of salary: <input type="checkbox"/> 1X <input type="checkbox"/> 2X <input type="checkbox"/> 3X <input type="checkbox"/> Other _____</p> <p style="margin-left: 20px;">Subject to \$ _____ Minimum and \$ _____ Maximum</p> <p style="margin-left: 20px;">Rounded to next higher \$1,000 unless requested otherwise below.</p> <p><input type="checkbox"/> Other _____</p> <p>Dependent Life (May not exceed 100% of employee amount for spouse, or \$4000 for child)</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Basic</th> <th style="text-align: center;">Optional</th> </tr> </thead> <tbody> <tr> <td>Spouse (Coverage terminates at age 70)</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> </tr> <tr> <td>Child (14 Days - 6 Mo.)</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> </tr> <tr> <td>Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student)</td> <td style="text-align: center;">\$ _____</td> <td style="text-align: center;">\$ _____</td> </tr> </tbody> </table> <p>Optional Benefit Amount (describe): _____</p>		Basic	Optional	Spouse (Coverage terminates at age 70)	\$ _____	\$ _____	Child (14 Days - 6 Mo.)	\$ _____	\$ _____	Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student)	\$ _____	\$ _____
	Basic	Optional												
Spouse (Coverage terminates at age 70)	\$ _____	\$ _____												
Child (14 Days - 6 Mo.)	\$ _____	\$ _____												
Child (6 Mo. - 19 Yrs.; 23 Yrs. if full-time student)	\$ _____	\$ _____												

CLASS 2 EARNINGS DEFINITIONS - Complete Only for Salary Based Plan. In no event will salary exceed the amount shown in the Employer's payroll records, or for which premium has been paid (if less). Must be the same for all classes, if list billed.

Earnings standardly include **annual base salary**, or annualized hourly pay (excluding overtime) and any commissions averaged over prior 12 Months. Earnings are determined on the last day worked. If any other compensation is to be included or an alternate definition is wanted, describe below:

Also include:

- Bonuses averaged over 36 Months.
- Other (subject to Home Office Approval) _____

Instead base on:

- Each Employee's W-2 earnings for prior year.
- Other (subject to Home Office Approval) _____

(Attach separate sheet for additional classes)

B. PARTICIPATION

Total Number of Eligible Employees _____
Number to be insured for Life/AD&D _____

Number with Eligible Dependents _____
Number to elect Dependent Life _____

C. AGE REDUCTIONS AND TERMINATIONS FOR ALL CLASSES

1. **Age Reductions** - Life and AD&D Benefits reduce 35% at age 65, another 25% of the original amount at 70, and another 15% of the original amount at 75; unless requested otherwise. Other (Specify) _____
2. **Termination** - Life and AD&D Benefits standardly terminate at retirement (recommended for compliance with age discrimination law); unless requested otherwise. Other (Specify) _____

D. REPLACEMENT COVERAGE

Yes No Will all or part of this plan **supplement** or **replace** similar Life and/or AD&D coverage? **If Yes, provide details below and enclose a copy of each contract to be replaced or supplemented. If replacement, prior insurance credit will be provided.**

Prior Carrier

Effective Date of Prior Plan

Termination Date of Prior Plan

REMARKS (Identify by section name and item number)

FOR GROUP INSURANCE SERVICE OFFICE USE ONLY

A. CLASSES FOR SHORT TERM DISABILITY INSURANCE

STD Benefit Supplement Form

CLASS 1 DESCRIPTION	BENEFIT AMOUNT	DAY BENEFITS BEGIN			BENEFIT DURATION
_____	Percent of Basic Weekly Earnings: <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____%	Accident: <input type="checkbox"/> 1st day <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day <input type="checkbox"/> 31st day <input type="checkbox"/> Other _____	Sickness & Pregnancy: <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day <input type="checkbox"/> 31st day <input type="checkbox"/> Other _____	Benefit on 1st day of Hospital Confinement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum Benefit Period:* <input type="checkbox"/> 13 Wks <input type="checkbox"/> 26 Wks <input type="checkbox"/> 52 Wks <input type="checkbox"/> Other _____
Employer Contribution Percentage: _____%	Maximum Weekly Benefit: <input type="checkbox"/> \$ _____				

CLASS 1 EARNINGS DEFINITION. In no event will salary exceed the amount shown in Employer's payroll records, or the amount for which premium has been paid (if less).

Earnings standardly include **weekly base salary**, or hourly pay (excluding overtime) and any commissions averaged over prior 12 Months. Earnings are determined on the last day worked. If any other compensation is to be included or an alternate definition is wanted, describe below:

Also include (if applicable):

Bonuses averaged over 36 Months.

Other (subject to Home Office Approval) _____

Instead base on:

Each Employee's W-2 earnings for prior year.

Other (subject to Home Office Approval) _____

CLASS 2 DESCRIPTION	BENEFIT AMOUNT	DAY BENEFITS BEGIN			BENEFIT DURATION
_____	Percent of Basic Weekly Earnings: <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____%	Accident: <input type="checkbox"/> 1st day <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day <input type="checkbox"/> 31st day <input type="checkbox"/> Other _____	Sickness & Pregnancy: <input type="checkbox"/> 8th day <input type="checkbox"/> 15th day <input type="checkbox"/> 31st day <input type="checkbox"/> Other _____	Benefit on 1st day of Hospital Confinement? <input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum Benefit Period: <input type="checkbox"/> 13 Wks <input type="checkbox"/> 26 Wks <input type="checkbox"/> 52 Wks <input type="checkbox"/> Other _____
Employer Contribution Percentage: _____%	Maximum Weekly Benefit: <input type="checkbox"/> \$ _____				

CLASS 2 EARNINGS DEFINITION. In no event will salary exceed the amount shown in Employer's payroll records, or the amount for which premium has been paid (if less). Must be the same for all classes, if list billed.

Earnings standardly include **weekly base salary**, or hourly pay (excluding overtime) and any commissions averaged over prior 12 Months. Earnings are determined on the last day worked. If any other compensation is to be included or an alternate definition is wanted, describe below:

Also include (if applicable):

Bonuses averaged over 36 Months.

Other (subject to Home Office Approval) _____

Instead base on:

Each Employee's W-2 earnings for prior year.

Other (subject to Home Office Approval) _____

(Attach separate sheet for additional classes.)

Office Use Only - ID # _____

A. LONG TERM DISABILITY INSURANCE FOR CLASS 1

CLASS DESCRIPTION	BENEFIT AMOUNT	ELIMINATION PERIOD	MAXIMUM BENEFIT PERIOD	OWN OCCUPATION PERIOD
_____ _____ _____ _____ Employer Contribution _____%	Percent of Basic Monthly Earnings: <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____% Maximum Monthly Benefit: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$7,000 <input type="checkbox"/> Other _____	<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> Other _____	<input type="checkbox"/> To Social Security Normal Retirement Age (SSNRA) <input type="checkbox"/> To Age 65, Reducing Benefit Duration <input type="checkbox"/> 65/5/70 <input type="checkbox"/> To Age 70 <input type="checkbox"/> Other _____	<input type="checkbox"/> 24 Month <input type="checkbox"/> 36 Month <input type="checkbox"/> 60 Month <input type="checkbox"/> To end of Maximum Benefit Period <input type="checkbox"/> Other _____

B. LONG TERM DISABILITY INSURANCE FOR CLASS 2

(Attach separate sheet for additional classes.)

CLASS DESCRIPTION	BENEFIT AMOUNT	ELIMINATION PERIOD	MAXIMUM BENEFIT PERIOD	OWN OCCUPATION PERIOD
_____ _____ _____ _____ Employer Contribution _____%	Percent of Basic Monthly Earnings: <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% <input type="checkbox"/> 70% <input type="checkbox"/> Other _____% Maximum Monthly Benefit: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$7,000 <input type="checkbox"/> Other _____	<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> Other _____	<input type="checkbox"/> To Social Security Normal Retirement Age (SSNRA) <input type="checkbox"/> To Age 65, Reducing Benefit Duration <input type="checkbox"/> 65/5/70 <input type="checkbox"/> To Age 70 <input type="checkbox"/> Other _____	<input type="checkbox"/> 24 Month <input type="checkbox"/> 36 Month <input type="checkbox"/> 60 Month <input type="checkbox"/> To end of Maximum Benefit Period <input type="checkbox"/> Other _____

C. EARNINGS DEFINITIONS FOR ALL CLASSES

Earnings standardly include **monthly base salary**, or hourly pay for regularly scheduled work (excluding overtime), and any **commissions** averaged over prior 12 Months. Earnings will be determined on **the last day worked**; unless requested otherwise. If any other compensation is to be included or alternate definition is wanted, describe below:

Also include: Bonuses averaged over 36 Months. Other (subject to Home Office Approval) _____

Instead base on: Each Employee's W-2 earnings for prior year. Other (subject to Home Office Approval) _____

NOTE: In no event will salary exceed the amount shown in the Employer's payroll records, or for which premium has been paid (if less).

D. OTHER INFORMATION FOR ALL CLASSES

PARTICIPATION
 Total Number of Eligible Employees _____ Number to be insured for LTD _____

D. OTHER INFORMATION FOR ALL CLASSES (Continued)

MINIMUM MONTHLY BENEFIT (select one)

- \$50.00 Greater of \$50.00 or 10% of Monthly Benefit Other _____
 \$100.00 Greater of \$100.00 or 10% of Monthly Benefit

INTEGRATION (select one) Benefits will be reduced by Other Income Benefits stated in the Policy, including:

- Primary Social Security Primary & Family Social Security with 70% All Sources
 Primary & Family Social Security Primary & Family Social Security with 70% Backdoor Integration

PRE-EXISTING CONDITIONS EXCLUSION (select one)

- 3/12 3/6/12 6/12 6/6/12 Other _____

NOTE: First number is "look-back period" of months prior to insured's effective date, when any conditions treated will be considered Pre-Existing. Middle number (if any) is "treatment-free period" of months following his effective date, which satisfy the limitation period if no treatment. Last number is "limitation period" of months following his effective date, which must be satisfied if treatment-free period is not included or met.

Maximum Pre-Existing Conditions Exclusion allowed in New York is 6/12. A 12-month look-back or 24-month limitation period is not available.

E. OTHER PROVISIONS (select all that apply)

NOTE: Not all options are available in every state.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Substance Abuse Limitation (2 Years) | <input type="checkbox"/> Pension Contribution Benefit at _____ % (2% - 15%) |
| <input checked="" type="checkbox"/> Mental Illness Limitation (2 Years) | <input type="checkbox"/> 401(k) Contribution Benefit at _____ % (2% - 15%) |
| <input checked="" type="checkbox"/> Vocational Rehabilitation Benefit | <input type="checkbox"/> COLA Adjustments at 3% or 4% (specify) |
| <input type="checkbox"/> Conversion Privilege | <input type="checkbox"/> 5 adjustments at _____ % |
| <input checked="" type="checkbox"/> 3 Month Family Income Benefit (Survivor Income Benefit) | <input type="checkbox"/> 10 adjustments at _____ % |
| | <input type="checkbox"/> Maximum Benefit Period at _____ % |

F. ADDITIONAL INFORMATION

1. Yes No **State Plans Available** - Are there any Eligible Employees working in CA, HI, NJ, NY or RI? If Yes, please indicate in **REMARKS** the state, number of Eligible Employees there, and number covered by state disability plan. **Note: The Company cannot write state disability plans in any state.**
2. Yes No **International Employees** - Are there any Eligible Employees working or residing outside the United States? If Yes, please indicate in Remarks the country, number of Eligible Employees there, their citizenship and expected return dates.

G. REPLACEMENT COVERAGE

Yes No Will all or part of this plan **replace** similar LTD coverage? **If Yes, provide details below and enclose a copy of the inforce contract to be replaced.**

Prior Carrier Effective Date of Prior Plan Termination Date of Prior Plan

A. DENTAL INSURANCE - INDEMNITY PLAN

Dental Benefits Supplement Form

Class Description (attach a separate sheet for additional classes):

All full-time employees Other _____

B. BENEFITS

SERVICES COVERED	PERCENTAGE PAYABLE / MAXIMUMS	PLAN OPTIONS
Check (✓) all that apply	Check (✓) one for each type of service selected. Applies to 90 th Percentile UCR charges incurred for covered services in excess of the Deductible.	Check (✓) one for each option. Must be the same for all classes.
<input type="checkbox"/> Diagnostic/Preventive Services (Type I)	<input type="checkbox"/> 100% <input type="checkbox"/> 80% <input type="checkbox"/> 90% <input type="checkbox"/> 70% <input type="checkbox"/> _____%	Sealants: <input type="checkbox"/> Preventive <input type="checkbox"/> Basic <input type="checkbox"/> Not Covered
<input type="checkbox"/> Basic Services (Type II)	<input type="checkbox"/> 90% <input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 60% <input type="checkbox"/> _____%	Endodontics: <input type="checkbox"/> Basic <input type="checkbox"/> Major
<input type="checkbox"/> Major Services (if included) (Type III)	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> _____%	Periodontics: <input type="checkbox"/> Basic <input type="checkbox"/> Major
ANNUAL MAXIMUM for Types I, II and III	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> Other _____	
<input type="checkbox"/> Orthodontic Services (Type IV)	<input type="checkbox"/> 50% <input type="checkbox"/> _____%	Orthodontics: <input type="checkbox"/> Not Covered <input type="checkbox"/> Child(ren) Only <input type="checkbox"/> Family
ORTHODONTIC MAXIMUM While covered (if included)	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> Other _____	

C. ANNUAL DEDUCTIBLE

(Applies on a Calendar Year basis, unless otherwise requested in REMARKS and agreed upon by the Group Insurance Service Office.)

Does deductible apply to Diagnostic & Preventive (Type I) Services? Yes No

Deductible, per Individual: \$50 \$100 Other _____

Family Deductible Limit: 3 per family None Other _____

D. BENEFIT WAITING PERIOD

Benefit Waiting Period:

Basic Services None

Major Services None 6 Months _____ Months

Orthodontic Services None* 12 Months _____ Months

Benefit Waiting Period Waived For Current Employees and Dependents:**
 (If "No" is checked, prior insurance credit will apply).

Major Services Yes No

Orthodontic Services Yes* No

* The Benefit Waiting Period may not be waived for Orthodontic Services (Type IV) in plans which include Orthodontic coverage for the first time.
 ** Current Employees and Dependents means those who are covered on this Policy's effective date.

Late Entrant Limitations Will Apply

A. DENTAL PPO INSURANCE

PPO Dental Benefits Supplement

Class Description (attach a separate sheet for additional classes):

All full-time employees located in a PPO Service Area Other _____

For groups with employees located outside a PPO service area, select one of the following and complete section I or J of the General Information Section.

In-Network Benefits Out-of-Network Benefits Other (attach additional Dental Benefits Supplement Form)

Note: Employees located outside a PPO Service Area may automatically be transferred to the In-Service Area plan on each Policy Renewal Date, if the dental PPO becomes available in their area.

B. BENEFITS / PERCENTAGE PAYABLE / MAXIMUMS

SERVICES COVERED	IN-NETWORK SERVICES Based on Network's Discounted Fees.	OUT-OF-NETWORK SERVICES Based on <input type="checkbox"/> 90 th Percentile UCR or <input type="checkbox"/> Other _____, or <input type="checkbox"/> Schedule	PLAN OPTIONS
Check (✓) all that apply.	Check (✓) one for each type of service selected.	Check (✓) one for each type of service selected. May not be higher % than In-Network Benefits.	Check (✓) one for each option. Must be same for all classes.
<input checked="" type="checkbox"/> Diagnostic/Preventive Services (Type I)	<input type="checkbox"/> 100% <input type="checkbox"/> 70% <input type="checkbox"/> 90% <input type="checkbox"/> _____% <input type="checkbox"/> 80%	<input type="checkbox"/> 100% <input type="checkbox"/> 70% <input type="checkbox"/> 90% <input type="checkbox"/> _____% <input type="checkbox"/> 80%	Sealants: <input type="checkbox"/> Preventive <input type="checkbox"/> Basic <input type="checkbox"/> Not Covered
<input checked="" type="checkbox"/> Basic Services (Type II)	<input type="checkbox"/> 90% <input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> _____% <input type="checkbox"/> 70%	<input type="checkbox"/> 90% <input type="checkbox"/> 60% <input type="checkbox"/> 80% <input type="checkbox"/> _____% <input type="checkbox"/> 70%	Endodontics: <input type="checkbox"/> Basic <input type="checkbox"/> Major
<input type="checkbox"/> Major Services (if included) (Type III)	<input type="checkbox"/> 60% <input type="checkbox"/> 50% <input type="checkbox"/> _____%	<input type="checkbox"/> 50% <input type="checkbox"/> Other _____	Periodontics: <input type="checkbox"/> Basic <input type="checkbox"/> Major
ANNUAL MAXIMUM for Types I, II and III combined	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> Other _____	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> Other _____	
<input type="checkbox"/> Orthodontic Services (Type IV)	<input type="checkbox"/> 50% <input type="checkbox"/> _____%	<input checked="" type="checkbox"/> Same as In-Network	Orthodontics: <input type="checkbox"/> Not Covered <input type="checkbox"/> Child Only <input type="checkbox"/> Family
ORTHODONTIC MAXIMUM While covered (if included)	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> Same as In-Network	

C. ANNUAL DEDUCTIBLE

(Will apply on a Calendar Year basis, unless otherwise requested in REMARKS and agreed upon by the Group Insurance Service Office.)

	In-Network Services	Out-of-Network
Does deductible apply to Preventive & Diagnostic (Type I Services)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deductible per Individual (In and Out-of-Network combined)	<input type="checkbox"/> \$50 <input type="checkbox"/> \$ _____	<input type="checkbox"/> Same <input type="checkbox"/> \$ _____
Family Deductible Limit (Same for In and Out-of-Network Services)	<input type="checkbox"/> 3 per Family <input type="checkbox"/> \$ _____	

D. BENEFIT WAITING PERIOD

Benefit Waiting Period:

Basic Services None
Major Services None 6 Months _____ Months
Orthodontic Services None* 12 Months _____ Months

Benefit Waiting Period Waived For Current Employees and Dependents:**
(If "No" is checked, prior insurance credit will apply).

Major Services Yes No
Orthodontic Services Yes* No

* The Benefit Waiting Period may not be waived for Orthodontic Services (Type IV) in plans which include Orthodontic coverage for the first time.
** Current Employees and Dependents means those who are covered on this Policy's effective date.

Late Entrant Limitations Will Apply

E. CONTRIBUTIONS AND PARTICIPATION

1. Employer Contribution: Employee _____ % Dependent _____ %
2. Participation:
Total Number of Eligible Employees _____ Number to be insured for Dental _____
If Applicable, Number with Eligible Dependents _____ Number Dependent Units selected _____

F. REPLACEMENT COVERAGE

Yes No Will this plan **replace** similar Dental coverage? **If Yes, provide details below and enclose a copy of the inforce contract to be replaced.**

Prior Carrier Effective Date of Prior Plan Termination Date of Prior Plan

DHMO/Prepaid Plan? Yes No

REMARKS (Identify by section name and item number)

FOR GROUP INSURANCE SERVICE OFFICE USE ONLY