



EMPLOYER GROUP HEALTH APPLICATION

Employer Information

Employer Name _____ Requested Effective Date _____

Corporation Partnership Proprietorship Other _____ Years in Business _____

Employer Tax ID # _____ E-mail _____ Primary PPO Network _____

Street Address _____
Street County City State Zip Code

Mailing Address (if different) _____
Street County City State Zip Code

Contact _____ Title _____ Phone (include area code) _____ Fax _____

Nature of Business _____ SIC Code _____ Are affiliates/subsidiaries to be included? Yes No

If yes, name of affil./sub. _____ City _____ State _____ # of Employees _____

Waiting period for initial Employees _____ Employer Contribution Percentage For:
Waiting period for subsequent Employees _____ Medical Employee _____% Dependent _____%

Current group medical insurance? Yes No Life Employee _____% Dependent _____%
Carrier _____ Account # _____

Do you offer another medical plan? (i.e. HMO) Yes No
Carrier _____ Account # _____

Please indicate the carrier(s) you have been insured with in the last 5 years:

Carrier _____ Effective _____ Terminated _____
Carrier _____ Effective _____ Terminated _____
Carrier _____ Effective _____ Terminated _____
Carrier _____ Effective _____ Terminated _____

Workers Compensation Coverage:

Carrier _____
Account # _____

Schedule of Benefits

Please circle requested benefit level

Deductible \$250 \$500 \$1,000 \$1,500 \$2,000 \$5,000

Co-Insurance 90% 80% 70% 50%

Stop Loss \$5,000 \$10,000 \$15,000 \$20,000 \$30,000

PCP Co-Pay YES NO

Specialist Co-Pay YES NO

Maternity YES NO
(Not Available For Groups with less than 5 covered employees)

Supplemental Accident YES NO

RX Card YES NO

If Yes, Please Check One Below

___ Plan B Generic Only (Name Brand drugs covered under medical, subject to annual deductible) YES NO
___ Plan H (10/25/50) or 20% Greater of
___ Plan D (10/50/100) or 20% Greater of
___ Plan E (10/25/50, \$150 Annual Deductible) or 20% Greater of

If no RX Card: Drugs covered under medical coverage, subject to annual medical deductible?
 YES NO

Life Volume Selected

Flat Amount For All Employees \$ _____
(\$15,000 minimum) Maximum Life Amount (\$50,000)
+ Life amounts will reduce to 65% at age 65, 42% at age 70, 27% at age 75, 18% at age 80, 12% at age 85, terminate at retirement.

Employer Information:

- Total number of employees (including active Partners, Proprietors, and Corporate Officers) _____
- Number of eligible full time employees working 30 or more hours per week _____
- Number of employees ineligible because they are: Part-time _____ Seasonal _____ Covered under another group plan _____
Other _____ Explain _____
- Number of former employees / dependents on COBRA _____
- Has the company employed 20 or more full-time and part-time employees for 20 or more weeks during the prior calendar year? Yes No

The Administrator is Universal Fidelity Life Insurance Co, Inc.. The Insurer of medical and life coverage applied for is _____ . I, the undersigned employer, wish to become a participating employer. I am acquainted with the rules of eligibility and understand that the effective date of the insurance for which I am applying shall be subject to the written approval of the Administrator, acting on behalf of the Insurer. I understand that the benefits provided shall be subject to the terms of the group insurance policy(ies) as amended from time to time, and that these group insurance policies may be terminated by the Insurer following due notice. I agree to remit to the Administrator regularly, in advance, the required monthly premium contributions for insurance, and I understand that failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the 31-day grace period. I agree to offer the insurance to all present and future new employees who work for remuneration on a full-time basis. I also agree to maintain the participation requirements of the plan with respect to eligible employees and their eligible dependents in order to procure and continue the requested insurance and agree that any insurance issued as a result of this request may be cancelled as of any monthly premium due date if participation requirements are not maintained.

Dated at _____ on _____
 City State Month Day Year

Employer's Legal Business Name _____

Employer's Signature _____ Title _____

Writing Agent

Name _____
 Please Print

Street City State Zip

Telephone (Please include area code) _____ Fax (please include area code) _____

Agent's Statement

To the best of my knowledge all statements in the Employer Group Health Application, Group Insurance Enrollment Cards, and Health Statements are complete and true. My client has been advised by me not to terminate any existing coverage until receiving notice that the coverage being applied for is accepted. I agree that I have no right to bind this coverage, alter terms of the insurance contract or Employer Group Health Application, or adjust any claim for benefits under the insurance contract.

Agent's Signature _____ Date _____

Check one: Social Security # _____ Tax ID # _____

Where would you like for us to send the PD's and ID Cards? Agent Address _____

Service Fees Payable to: Group Address _____

Universal Fidelity Life Insurance Co, Inc.
 1525 Merrill Drive, Suite 2000 Little Rock, AR 72211
 Telephone: (501) 224-8269 Fax: (501) 312-4666

To be Completed by Administrator

Underwriter	Effective Date	Policy #	Approval Date	Decline Date

Check Amount Received _____ Check # _____

Agent Check List

- Have you included:
- ECHP Notice of Approval?
 - Employer Group Health Application?
 - Employee Enrollment forms? (No Faxed Copies)
 - Current Insurance Bill plus original effective dates?
 - Deductible Report if applicable?
 - Quarterly Tax & Wage Report?
 - Pan Am Application?
 - TPA Agreement?
 - Business check payable to Universal Fidelity Life Insurance Co, Inc.?