

Reliance Standard Life Insurance Company

PRELIMINARY APPLICATION FOR GROUP INSURANCE

1. Prospective Policyholder: City of Durham
(Exact Legal Name)
2. Federal Employer Identification Number: _____
3. Complete address: 101 City Hall Plaza Durham, NC Durham 27701
(Street Address) (City and State) (County) (Zip Code)
- Executive Correspondent _____ Title _____ Phone _____
 Routine Correspondent _____ Title _____ Phone _____
 Mailing Address (If different) _____
4. Nature of business: (If Association: purpose, when formed) Municipality
5. The prospective policyholder is a corporation, partnership, proprietorship, union, association, other (specify) Municipality
6. INDICATE AFFILIATES OR SUBSIDIARIES TO BE COVERED, IF ANY:
(Include divisions only if all are not to be included)

Name and Location	Nature of Relationship	Nature of Business	No. of Employees by Coverage						
			Life	AD&D	WI	LTD	VAR	STOP LOSS	Other

7. POLICY TO BE ISSUED IN THE STATE OF : NC 8. Requested Effective Date: 9/1/2015
(If other than state of Applicant's main office, explain in REMARKS) (Month) (Day) (Year)
9. COVERAGES APPLIED FOR: Life, AD&D, WI, LTD, VAR, STOP LOSS, Other _____
10. Is any group insurance now in force or currently being applied for on the Proposed Insureds? yes no
 If yes, (A) Indicate in Remarks: name of carrier; type of coverage; effective date; brief benefit description; eligibility; etc.
 (B) Provide prior experience, including premiums and incurred claims(or paid claims and claim reserves at start and end of period.)
11. Is it proposed to terminate or change any existing group insurance coverage? yes no
 If yes, indicate in REMARKS: name of carrier; type of coverage, and date of termination, or date and type of change.
12. Are all Proposed Insureds actively at work? yes no If not, please list the following for employees not actively at work:
- | NAME | DATE OF BIRTH | LAST DAY WORKED | FACE AMOUNT | REASON FOR ABSENCE |
|------|---------------|-----------------|-------------|--------------------|
| | | | | |

REMARKS:

This Preliminary Application is subject to the acceptance and approval in writing by Reliance Standard Life Insurance Company at the Administrative Offices in Philadelphia, Pennsylvania; and nothing contained herein shall be binding upon said Company until this Preliminary Application is so approved. \$_____ has been paid herewith. It will be applied toward the first premium due on the policy or policies if any be issued. Such issuance is subject to the: terms; conditions; limitations; and exceptions of the policy or policies if any be issued.

Name of Agent or Broker of Record (print or type)	Share
John Gasiorowski-Independent Benefit Advisors	100 %
_____	_____ %
_____	_____ %

Print or type name of Broker's firm, if applicable
Independent Benefit Advisors

by _____ (authorized signature) _____ (Title)

by _____
 (authorized signature)

 (title or position with Applicant)

Dated at _____

Date _____

Agency _____ Group Office _____

RELIANCE STANDARD

Confirmation of Plan Information

(10 + Lives)

Employer Information (to supplement Preliminary Application)	Full Legal Name of Group: City of Durham		Website Address: http://durhamnc.gov		
	(exactly as to be shown in contract with exact abbreviations, punctuation, or capitalization)				
	Executive Contact Name:		Routine Contact Name:		
	Phone #:	Fax #:	Phone # :	Fax #:	
E-mail address: _____		E-mail address: _____			
Location: <input checked="" type="checkbox"/> Main <input type="checkbox"/> Other:		Location: <input type="checkbox"/> Main <input type="checkbox"/> Other:			
When did Company Operations begin? Month _____/Year 1869 _____					
100+ lives: Should we use Policy Anniversary as reporting date for 5500? <input type="checkbox"/> Yes (<i>standard</i>) <input type="checkbox"/> No, use _____					
Form completed by (print name): _____ <input type="checkbox"/> Employer <input type="checkbox"/> Broker <input type="checkbox"/> G.A./T.P.A. <input type="checkbox"/> Other: _____					
Is other group coverage(s) in force with Reliance Standard ? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Reliance Standard Group #: _____					

Billing	Bill Delivery & Employee Eligibility Method:	<input type="checkbox"/> On-Line List Billed (preferred method) (Employer maintains eligibility data on-line, real time) <input checked="" type="checkbox"/> On-Line Self-Administered (Employer maintains eligibility data & reports volume, lives & premium totals on-line) <input type="checkbox"/> Paper List Billed <100 lives (Reliance maintains eligibility data, mails bills, changes sent to Reliance Standard) <input checked="" type="checkbox"/> Paper Self-Administered (Employer maintains eligibility data & reports volume, lives & premium totals via mail) <input type="checkbox"/> TPA billing: Name: _____ Address: _____
	Please note that we need an up-to-date census listing so that we can accurately prepare your first bill.	
	Premium Payment Options:	<input type="checkbox"/> Check <input type="checkbox"/> Wire Transfer /ACH Credit - You transfer funds to Reliance Standard's bank account <input type="checkbox"/> ACH Debit (only available for on-line billing) - You authorize Reliance to deduct funds electronically from account
	Bills will go to each Correspondent as noted below. If more than three bill groups, please supply details on a separate page.	
1st Bill Group: Billing Group Name (optional): <u>Finance Office</u>		
<input type="checkbox"/> Routine Correspondent listed on Preliminary Application OR Correspondent: _____ Title: _____		
Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____		
Phone: _____ Fax: _____ Email: _____		
2nd Bill Group: Billing Group Name (optional): _____		
Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____		
Correspondent: _____ Title: _____		
Phone: _____ Fax: _____ Email: _____		
3rd Bill Group: Billing Group Name (optional): _____		
Location: <input type="checkbox"/> Main <input type="checkbox"/> Other/Address : _____		
Correspondent: _____ Title: _____		
Phone: _____ Fax: _____ Email: _____		

Life Coverage(s):	Basic		Dependent	Supplemental		Voluntary	
	Life <input checked="" type="checkbox"/>	AD&D <input checked="" type="checkbox"/>	Life <input checked="" type="checkbox"/>	Life <input checked="" type="checkbox"/>	AD&D <input checked="" type="checkbox"/>	Life (VG) <input type="checkbox"/>	AD&D (VAR) <input type="checkbox"/>
Sold Rate(s):	.102	.028	1.98	<input checked="" type="checkbox"/> Step rates attached		<input type="checkbox"/> Step rates attached	Employee Rate:
	per \$1,000		/ dep. unit				Family Rate:
Employer Contributions (%):	100	100	100	0	0		
For Contributory Coverages:	Payroll Deductions:	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly					
	Total Eligible Employees:						
	Total Participating Employees:						
	Flex / Section 125?	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y

Disability Coverage(s):	Short Term				Long Term		
	STD <input type="checkbox"/>	Voluntary STD(VPS) <input checked="" type="checkbox"/>	New York DBL <input type="checkbox"/>	New Jersey TDB <input type="checkbox"/> Hawaii TDI <input type="checkbox"/>	LTD <input type="checkbox"/>	Voluntary LTD (VPL) <input checked="" type="checkbox"/>	
Sold Rate(s):		<input type="checkbox"/> Step rates attached	\$_____ Male			<input type="checkbox"/> Step rates attached	
	per \$10		\$_____ Female	per \$10	per \$100		
Employer Contributions (%):		0				0	
For Contributory Coverages:	Payroll Deductions:	Pre-Tax <input type="checkbox"/> <input type="checkbox"/> Post-Tax Amount: \$_____	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax Amount: \$_____	\$_.60 / week <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax Amount: \$_____	Pre-Tax <input type="checkbox"/> <input type="checkbox"/> Post-Tax Amount: \$_____	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax Amount: \$_____
	Please ask us for guidance with additional disability taxation options.						
	Total Eligible Employees:						
	# Participating Employees:			All must be covered			
Flex / Section 125?	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Y	

Voluntary Coverages

Completion of this form confirms agreement to implement the aforementioned Reliance Standard Voluntary Coverage(s).

Eligible employees to be solicited starting on Client _____ through Choice _____. After enrollment, coverage will be effective 9/1/2015;

Beginning Payroll Cycle: Start date of first pay period: _____ End date of first pay period: _____

Starting Age Band for Step Rates: < Age 20 < Age 30

We will prepare brochures and employee enrollment applications with the Employer's name and policy number. Brochure rates **match** payroll deduction mode (in rate section above) unless otherwise noted; bills will reflect **monthly** rates.

Please start payroll deductions immediately for total requested amounts - including amounts above the Guaranteed Issue limit.

For VG (Voluntary Life only) Rate Type: Tobacco Use/Non-Tobacco Undifferentiated

Future **eligible** employees will be effective: 1st of month 1st of the 2nd month following date application is signed

Travel Accident (Special Risk) (SR) <input type="checkbox"/>	NA _____ Employees Covered
	Premium: <input type="checkbox"/> 1 Year <input type="checkbox"/> 3 Year <input type="checkbox"/> 5 Year <input type="checkbox"/> Prepaid <input type="checkbox"/> Annual Installments \$ _____

Employee Eligibility, Service Waiting Period & Earning Definition(s) (if different by coverage, please note)

Please select an eligibility description either for all employees (Class 1 box) **or** for each class as appropriate:

Note: All Classes standardly exclude temporary or seasonal employees.

Class 1	# of Hours worked per week: <input type="checkbox"/> Full-time hours: _____ <input type="checkbox"/> Part-time hours: _____ (if eligible)	Includes: <input type="checkbox"/> All Employees OR <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> Other Description: (I.e., Officer, etc...)
Class 2	# of Hours worked per week: <input type="checkbox"/> Full-time hours: _____ <input type="checkbox"/> Part-time hours: _____ (if eligible)	Includes: <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> Other Description: (I.e., Officer)
Class 3	# of Hours worked per week: <input type="checkbox"/> Full-time hours: _____ <input type="checkbox"/> Part-time hours: _____ (if eligible)	Includes: <input type="checkbox"/> Exempt <input type="checkbox"/> Union <input type="checkbox"/> Hourly <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Salaried	<input type="checkbox"/> Other Description: (I.e., Officer)

Other: (Attach page listing other eligibility categories or classes, if applicable)

Employee Service Waiting Period: (time employee must work before becoming eligible for insurance coverage)* n/a SR (Travel Acc.)

No service wait 30 Days 60 Days 90 Days 1 Month 3 Months Other:

*For present employees covered by prior plan (on policy effective date), time employed is credited towards service wait

Individual Effective Date: (coverage effective date once service waiting period is complete) (see page 2 for voluntary coverage options)

On the Date S.W.P. is completed 1st of the Month coinciding with or next following S.W.P. Other:

Class Specific Waiting Periods(if applicable): Class 1: _____ Class 2: _____ Class 3: _____

Individual Termination Date: (see page 2 for voluntary coverage options)

Employee Term. Date 1st of Mo. or Last Day of Mo. coinciding w/ or following Term. Date Other

Reinstatement Date: (not applicable for voluntary life)

Must employee returning from an **approved** leave of absence/lay-off **re-satisfy** Service Waiting Period?

No, if returning within 6 months (*standard*) Yes Other:

Benefit Change Date

1st of Month: Age, Class & Earnings changes effective the 1st of month coinciding with or next following change date

The Date: Age, Class & Earnings changes effective on the date of change

Other:

Earnings Definition	Applicable to Class(es) or Coverage(s): <input type="checkbox"/> All <input type="checkbox"/> Other:
<input type="checkbox"/> Basic Earnings Only - (standard) "Earnings": basic salary, prior to any deductions to a <input type="checkbox"/> 401(k)/403(b) <input type="checkbox"/> Section 125 plan(s). Excluding: commissions, overtime, bonuses or any other special compensation not received as basic salary.	
<input type="checkbox"/> Basic Earnings including - "Earnings": basic salary, prior to any deductions to a <input type="checkbox"/> 401(k)/403(b) <input type="checkbox"/> Section 125 plan(s). Including: <input type="checkbox"/> Bonuses <input type="checkbox"/> Commissions <input type="checkbox"/> Overtime <input type="checkbox"/> Incentive Pay Averaged over <input type="checkbox"/> 3 years (standard) <input type="checkbox"/> 2 years <input type="checkbox"/> One Year (n/a for GL (Life), VAR (Vol. AD&D) or SR (Travel Accident)). Averaging applies to: <input type="checkbox"/> All Employees <input type="checkbox"/> Salespeople <input type="checkbox"/> Commissioned Employees <input type="checkbox"/> Officers <input type="checkbox"/> Other:	
<input type="checkbox"/> W2 Earnings prior to any deductions to a <input type="checkbox"/> 401(k)/403(b) <input type="checkbox"/> Section 125 plan(s). Including: <input type="checkbox"/> Bonuses <input type="checkbox"/> Commissions <input type="checkbox"/> Overtime <input type="checkbox"/> Incentive Pay <input type="checkbox"/> Prior Year or <input type="checkbox"/> Averaged over <input type="checkbox"/> 3 years (standard) <input type="checkbox"/> 2 years Averaging applies to: <input type="checkbox"/> All Employees <input type="checkbox"/> Salespeople <input type="checkbox"/> Commissioned Employees <input type="checkbox"/> Officers <input type="checkbox"/> Other:	
Please submit Bonus Formula Questionnaire for any definition(s) that includes bonuses.	
<input type="checkbox"/> Use K1 Earnings for Partners: <input type="checkbox"/> Prior Year or <input type="checkbox"/> Averaged over: <input type="checkbox"/> 3 years (standard) <input type="checkbox"/> 2 years	
<input type="checkbox"/> Include S Corp wording: <input type="checkbox"/> Prior Year or <input type="checkbox"/> Averaged over: <input type="checkbox"/> 3 years (standard) <input type="checkbox"/> 2 years	

Booklet/Contract Printing	<input checked="" type="checkbox"/> Electronic, provided in Adobe PDF (standard)* <input type="checkbox"/> 5 ½ X 8 ½ Booklets* <input type="checkbox"/> 8 ½ X 11 Flat Certificates (no cover)* Include: <input type="checkbox"/> Company Logo (.tif format – 300 d.p.i) <input type="checkbox"/> Agent Name <input type="checkbox"/> Other: _____
	* Flat Certificates are the only option for Voluntary Lines (Life/STD/LTD & SR (Travel Accident)). <input checked="" type="checkbox"/> Same for Entire Group, combine multiple coverages (if applicable) (standard) *Note: there is a maximum of 2 coverages combined per booklet; coverages cannot be combined in certificates. <input type="checkbox"/> by Class <input type="checkbox"/> by Coverage <input type="checkbox"/> by Affiliate
Mail to:	<input checked="" type="checkbox"/> Policyholder's Routine Correspondent (standard) <input type="checkbox"/> Broker <input type="checkbox"/> Other: _____ Booklet mailing instructions for multiple locations, if applicable: Administration Kit will be mailed per above instructions unless otherwise noted.
ERISA/SPD	Include Summary Plan Description (SPD) in addition to standard ERISA wording ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide: ERISA plan number(s): Life _____ STD _____ LTD _____
	Plan Administrator: <input checked="" type="checkbox"/> Employer (standard) <input type="checkbox"/> Union Maintaining Plan <input type="checkbox"/> Other - Administrator Name & Address: _____
	How are Plan Records kept?: <input type="checkbox"/> Calendar Year <input checked="" type="checkbox"/> Fiscal Year _____ <input type="checkbox"/> Policy Year (Anniv.)
Family Medical Leave Act	Include FMLA coverage continuance provision?: <input type="checkbox"/> Yes <input type="checkbox"/> No (n/a for SR, STD, DBL, TDB & TDI)

Disability Claim Information: (Cumulative Monthly Case Summaries are automatically distributed for all STD & LTD claims)	Check Issuance: <input checked="" type="checkbox"/> Claimant, copy Policyholder (standard) <input type="checkbox"/> Claimant <input type="checkbox"/> Policyholder
	W-2's (including Employer FICA match) are automatically produced at no additional cost for LTD . For STD (including DBL, TDB & TDI), W-2 preparation is an option (at an additional cost – see proposal details)
	Who will prepare STD W-2's and make Employer FICA match: <input type="checkbox"/> Reliance Standard <input type="checkbox"/> Employer
	Claims Reports are mailed to the Routine Correspondent. Please advise of other instructions. STD Telephonic Claim Intake?:(50 + lives) <input type="checkbox"/> No <input type="checkbox"/> Yes - will you supply eligibility feed? <input type="checkbox"/> No <input type="checkbox"/> Yes
ASO STD Only:	Full ASO <input type="checkbox"/> Claim Payor Assist <input type="checkbox"/> Rate: \$ _____/employee Advice to Pay (ATP) <input type="checkbox"/> Fee per claim: \$ _____

Primary Broker Name (as shown on license) <u>John Gasiorowski</u> Share % : <u>100</u>	
Full Address: _____	
Contact for ?s: _____ Phone: <u>(919) 303-9690</u> Fax: _____ E-mail: <u>john@thebenefitadviso</u>	
<input type="checkbox"/> Individual	Individual SS #: _____ DOB: _____
<input type="checkbox"/> Corporation	Corporate Tax ID #: _____
Information must match individual signing preliminary application for corporation:	Broker Name (as shown on license) _____ SS#: _____
	Currently appointed with Reliance Standard in situs state? <input type="checkbox"/> No <input type="checkbox"/> Yes, Agent # _____ (if available) If no, please attach license copy. Our Licensing Dept. will provide appointment package for completion.
Additional Broker Name (as shown on license) _____ Share % : _____	
Please provide information as listed above for all additional brokers.	
(if applicable) <input type="checkbox"/> G.A. <input type="checkbox"/> T.P.A. _____ Tax ID #: _____	
Agreement on file with Reliance Standard? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact for questions: _____ Phone: _____	