



Transamerica Life Insurance Company
 Home Office: Cedar Rapids, IA
 Administrative Office: P.O. Box 8063
 Little Rock, Arkansas 72203-8063

**Life and Health
 Group Application
 and Agreement
 Multi-State Version**

Name of Group ("you, your"):		Tax ID Number:	SIC Code:	Website Address:
Street Address:		City:	State:	ZIP Code:
Contact Name:	Email Address:		Phone #:	Fax #:
Nature of Group:		# of Employees/Members:	# Eligible for Coverage:	# of Years in Existence:
Billing Address: <i>(if different)</i>		City:	State:	ZIP Code:
Billing Contact Name: <i>(if different)</i>	Email Address:		Phone #:	Fax #:
Billing Address is For: <input type="checkbox"/> Group Policyholder <input type="checkbox"/> Third Party Administrator <input type="checkbox"/> Premium Collection Agency <i>(Requires a Premium Collection Agreement)</i>				

You hereby authorize Transamerica Life Insurance Company, our authorized agents or our enrollers (collectively referred to as we, us, or our) to offer each of your eligible employees/members the opportunity to purchase insurance coverage as described in this form. This authorization is based upon the following agreements:

- We customarily conduct an annual enrollment program for your eligible employees/members. You will provide us with census data if needed for us to determine proper enrollment eligibility.
- The initial enrollment shall take place from _____ to _____. You will provide us direct access to your employees/members to obtain applications through group meetings and individual interviews in a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
- Unless otherwise agreed upon by you and us, you will collect premium contributions from your participating employees/members and forward to us when due. We customarily bill you each month. You will forward the premiums due to us within 15 days of the receipt of the monthly bill. You will maintain records of all premium contributions from your employees/members while this agreement remains in force and for two years after it terminates. These records will remain open to inspection and audit by us during normal business hours during this time.
- in the event of any misappropriation by you, your employees or your agents, of funds owed to us, you will reimburse us for our entire loss including attorney fees and expenses incurred in collection, and any benefits we would not have had to pay but for such misappropriation.
- Do benefit selections vary by class? No Yes *(define classes below)*

Definition of Class 1:	
Definition of Class 2:	
Definition of Class 3:	
Definition of Class 4:	

- Eligibility for insurance:

	Class 1	Class 2	Class 3	Class 4
a. Employer Groups - eligible employees are defined as those who work at least _____ and have been so employed for at least _____				
b. Member Groups - eligible members are defined as members of an eligible class of members, who are in good standing in accordance with your by-laws, who are not currently disabled and are able to perform the normal activities of a person of like age and gender.				
- Is dependent coverage being offered? Yes No
 If yes, do you include same-sex partners? No Yes, state mandate *(Not applicable in TX)* Yes, corporate decision *(attach eligibility requirements)*

Billing Information

Pay periods per year:	Payments will be remitted: <input type="checkbox"/> After each deduction <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____
Payroll deductions per year:	Premium amount on bill should reflect: <input type="checkbox"/> Levelized amount over 12 months <input type="checkbox"/> Actual amount of deductions occurring each month
First payroll deduction date:	Preferred billing sequence: <input type="checkbox"/> Alphabetical <input type="checkbox"/> Social Security Number <input type="checkbox"/> Employee/Member ID <input type="checkbox"/> Other _____
First bill due date:	Preferred Billing Method: <input type="checkbox"/> Paper <input type="checkbox"/> Electronic <i>(via website)</i> <input type="checkbox"/> Self-Bill Multiple Billing Locations: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(attach listing)</i>

Name of Section 125 Plan Administrator <i>(if applicable)</i>	Plan Start Date	Plan Anniversary Date
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Fraud Warning

District of Columbia, Louisiana, and Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Maryland

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts, North Carolina and Oregon

I understand that 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, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

New Jersey

I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. I represent that all statements made to or attached to this application are true and complete to the best of my knowledge and belief.

Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico

Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee and Washington

It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia

I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Vermont

I understand that 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, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.

For Maine and All other states

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 subjects such person to criminal and civil penalties.

I understand and agree that this application will be made part of each group master policy issued as a result of this application. The Group listed above will be named as the Policyholder for each group master policy. I agree that no insurance will be effective until approved by us at our administrative office.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____, _____.

Signature of Officer

Email Address

Print Name and Title of Officer

Signature of Licensed Agent/Producer

Email Address

Print Name of Licensed Agent/Producer

Agent/Producer Number

License Number

Insurance Selections

(Product and Rider availability subject to state approval)

Participation Requirement: Each group master policy requires a minimum of 2 covered lives or the state minimum, whichever is greater, in order to be issued and remain in force. Any group master policy that falls below this requirement may be terminated, subject to the notice requirements in the master policy. Special underwriting offers may require higher participation in order to continue receiving the special underwriting offer for new insureds.

<input type="checkbox"/> Group Universal Life Insurance – TransElite <i>Product not available in CA, CT, HI, IL, MA, OH, PA, PR, VT, VI, VA, WA</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
Coverage: <input type="checkbox"/> High Face Amount <input type="checkbox"/> High Accumulation Value ***Attach a copy of the Rate Sheet***		
Accelerated Death Benefit for Terminal Illness/Condition in all states except LA. Waiver of Monthly Deductions for Layoff included in all states except TN.		
Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Critical Condition: <input type="checkbox"/> 25% <input type="checkbox"/> 50% <i>(Not available in FL, LA)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Living Benefit <i>(Not available in MD; Only available to large group (51+) in FL)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Extension of Benefits Rider <i>(Not available in FL, MD, TN)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Benefit Restoration Rider <i>(Not available in FL, MD, TN)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment <i>(Not available in MN)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Automatic Face Amount Increase Option: <input type="checkbox"/> \$1 for 10 years <u>OR</u> <input type="checkbox"/> \$2 for 5 years <input type="checkbox"/> All Employees <input type="checkbox"/> Employee Option
<input type="checkbox"/>	<input type="checkbox"/>	Child Level Term Insurance Rider
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Monthly Deductions for Total Disability
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		
IRS Type: <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____		

<input type="checkbox"/> Group Universal Life Insurance – TransLegacy <i>Available as an Individual policy in VT.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
Coverage: <input type="checkbox"/> High Face Amount <input type="checkbox"/> High Accumulation Value ***Attach a copy of the Rate Sheet***		
Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA. Waiver of Monthly Deductions for Layoff included in all states except MA, MD, PR, TN, VA, VT, and WA.		
Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Critical Care: <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100% <i>(Not available in CT, FL, MA, or NJ)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Long Term Care <i>(Not available in MA, PR or UT) (Only available to large group (51+) in FL)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Extension of Benefits Rider <i>(Not available in CT, FL, MA, NC, NJ, PA, PR, TX, UT, or VT)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment <i>(Accidental Death in VT)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Automatic Face Amount Increase Option: <input type="checkbox"/> \$1 <input type="checkbox"/> \$2 for <input type="checkbox"/> 3 <input type="checkbox"/> 5 years <input type="checkbox"/> All Employees <input type="checkbox"/> Employee Option
<input type="checkbox"/>	<input type="checkbox"/>	Child Level Term Insurance Rider <i>(Not available in VA)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Level Term Insurance Rider: <input type="checkbox"/> Employee Choice <input type="checkbox"/> 10 year term only <input type="checkbox"/> 20 year term only
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Monthly Deductions for Total Disability
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		
IRS Type: <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____		

<input type="checkbox"/> Group Interest Sensitive Whole Life – Trans\$ure <i>Product not available in PR. Available as an Individual policy in MT, VT.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
Coverage: <input type="checkbox"/> Money Purchase <input type="checkbox"/> Defined Benefit ***Attach a copy of the Rate Sheet***		
Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA. Waiver of Premium for Layoff included in all states except MA, MN, VA, and VT.		
Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Critical Care: <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100% <i>(Not available in CT, FL, MA, or NJ)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Long Term Care <i>(Not available in MA or UT) (Only available to large group (51+) in FL)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Extension of Benefits Rider <i>(Not available in CT, FL, MA, NJ, NC, PA, TX, UT or VT)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment <i>(Not available in MN) (Accidental Death in VT)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Child Level Term Insurance Rider <i>(Not available in VA)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Premium for Total Disability
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		
IRS Type: <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____		

<input type="checkbox"/> Group Term Life Insurance – Trans Select <i>Product not available in VT.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:			
Coverage: Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA. Waiver of Premium Due to Layoff or Strike included in all states except CT, MA, MD, NJ, PR, TN, and VA.					
Accept	Decline		<input type="checkbox"/> 5 Year Term	<input type="checkbox"/> 10 Year Term	<input type="checkbox"/> 20 Year Term
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Critical Care: <i>(Not available in CT, FL, MA or NJ)</i>	<input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%	<input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%	<input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Long Term Care with Extension of Benefits <i>(Not available in CO, MD, MA, NV, PR, TX, UT or WA) (Extension of Benefits not available in FL, NJ, NC or PA)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment <i>(Not available in MN or OH)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Premium	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Child Level Term Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes					
IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____					

<input type="checkbox"/> Group Term Life Insurance – VTL <i>Product not available in VT.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:			
Coverage: Continuation of Coverage and Waiver of Premium included in all states. Terminal Illness/Condition Accelerated Death Benefit included in all states except FL, OR.					
Accept	Decline				
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Critical Care:	<input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100%	<i>(Not available in CT, FL or OR)</i>	
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment			
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes					
IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____					

<input type="checkbox"/> Self-Administered Basic Term Life Insurance	Group Contribution? <input checked="" type="checkbox"/> Yes Policyholder pays 100% of Basic Life Insurance	Requested Effective Date:		
Coverage: <input type="checkbox"/> With Benefit Reduction <input type="checkbox"/> Without Benefit Reduction				
Basic Life Insurance: <input type="checkbox"/> Flat Amount <input type="checkbox"/> Multiple of Salary/not to exceed	Class 1	Class 2	Class 3	Class 4
<input type="checkbox"/> Supplemental Life Insurance: <input type="checkbox"/> Flat Amount <input type="checkbox"/> Multiple of Salary	Minimum			
	Maximum			
	In Increments of			
<input type="checkbox"/> Dependent Life Insurance: Child Coverage is always \$10,000	Minimum			
	Maximum			
	In Increments of			
<input type="checkbox"/> Optional Accidental Death & Dismemberment? <i>(Not available in FL or MN)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Optional Critical Illness? <i>(Not available in CA, CT, FL, MA, MD, NJ, SD, VA, VT, WA)</i>	\$	\$	\$	\$
Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA and OH. Waiver of Premium included in all states.				
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes				
IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____				

<input type="checkbox"/> Group Term Life and Accident Package - myPack <i>Product not available in GU, PR, VT.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
Coverage: <i>This is a package containing 2 separate products in a combined sale to offer simplified rates and special underwriting.</i>		
Group Term Life Base: Ages 18-39: \$50,000, Ages 40-49: \$30,000, Ages 50-64: \$15,000 Accelerated Death Benefit for Critical Care (25%) included for all states except CT, FL or OR. Continuation of Coverage included in all states. Terminal Illness/Condition Accelerated Death Benefit included in all states except OR. Waiver of Premium included in all states.		
Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	Optional Dependent Coverage
<input type="checkbox"/>	<input type="checkbox"/>	Group Term Life Buy-up: Ages 18-39: \$25,000, Ages 40-49: \$15,000, Ages 50-64: \$7,500
<input type="checkbox"/>	<input type="checkbox"/>	TransAccident Accident-Only Insurance <i>(not available in CT, FL, ID, MD, MN, MT, NM, PA or WA)</i> Off-the-Job Accident Disability Rider with 6-Month Benefit included. Sickness Disability Rider with 14-Day Elimination Period and 6-Month Benefit included.
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		
IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____		
Workers' Compensation: Are all employees/members covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain below)</i>		

<input type="checkbox"/> Group Accident Insurance – AccidentAdvance <i>Product not available in MN, PR, or WA. Available as an Individual policy in FL.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
Coverage: <input type="checkbox"/> 24-Hour Coverage <input type="checkbox"/> Off-the-Job Only Coverage <input type="checkbox"/> HealthPak AccidentAdvance <i>(No Sickness DI Rider)</i>		
	Plan 1	Plan 2
Module 1 – Accident Emergency Treatment Benefits	Units	Units
Module 2 – Follow-Up Visits and Physical Therapy Benefits	Units	Units
Module 3 – Initial Accident Hospitalization	Units	Units
Accept	Decline	Optional Riders
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death and Dismemberment Rider
<input type="checkbox"/>	<input type="checkbox"/>	Accident Hospital & ICU Income Rider
<input type="checkbox"/>	<input type="checkbox"/>	Expanded Benefits Rider <i>(Not available in NH)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Wellness Benefit Rider <i>(Not available in CO, CT, DC, KS, MA, NH, or VT)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Accident Only Disability Income Rider <i>(Not available in CA)</i> Elimination Period-0 Days Benefit Period: <input type="checkbox"/> 6 <input type="checkbox"/> 12 Months
<input type="checkbox"/>	<input type="checkbox"/>	Sickness Only Disability Income Rider <i>(Not available in CA, CO, NH, or VT)</i> Elimination Period: 14 Days Benefit Period: <input type="checkbox"/> 6 <input type="checkbox"/> 12 Months
<input type="checkbox"/>	<input type="checkbox"/>	Spouse Off-the-Job Accident Only Disability Income Rider <i>(Not available in CA)</i> Elimination Period-0 Days Benefit Period: 6 Months
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		
IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____		
Workers' Compensation: Are all employees/members covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain below)</i>		

<input type="checkbox"/> Individual Accident Insurance – AccidentSelect Accident AnswerSelect in MN <i>Product not available in CT, FL, GU, MA, NJ, OR, VT, or WV.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
Coverage: <input type="checkbox"/> Plan I <input type="checkbox"/> Plan II		
Accept	Decline	
<input type="checkbox"/>	<input type="checkbox"/>	Accident Only Disability Income Rider <i>(Not available in PA)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Sickness Only Disability Income Rider <i>(Not available in CO, MD, SC or VA)</i> <i>(Accident & Sickness Disability Rider in MN)</i>
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes		
IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____		
Workers' Compensation: Are all employees/members covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain below)</i>		

<input type="checkbox"/> Group Cancer Insurance – CancerSelect Plus <i>Product not available in MN. Available as an Individual policy in CT, FL, ID, MD, NJ, PR, UT, WA Available to large groups (51+) only in MA.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:																																																												
Coverage: <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th colspan="3"></th> <th style="text-align: center;">Plan 1</th> <th style="text-align: center;">Plan 2</th> <th style="text-align: center;">Plan 3</th> </tr> </thead> <tbody> <tr> <td colspan="3">Module 1 – Hospital Benefits</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> <tr> <td colspan="3">Module 2 – Surgery Benefits</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> <tr> <td colspan="3">Module 3 – Radiation and Chemotherapy Benefits</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> <tr> <td colspan="3">Module 4 – Wellness and Miscellaneous Benefits</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> <tr> <td colspan="3">Module 5 – Drug-Related Expense Benefits</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> <tr> <th style="text-align: center;">Accept</th> <th style="text-align: center;">Decline</th> <th style="text-align: left;">Optional Riders</th> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>First Occurrence Rider <i>(Lum Sum Diagnosis Rider in SD)</i></td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Intensive Care Rider <i>(Not available in CT, MA, NH, NJ, VT or WA) (Module 6 in TN)</i></td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Specified Disease Rider <i>(Not available in OR, SD or WA)</i></td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> <td style="text-align: center;">Units</td> </tr> </tbody> </table>						Plan 1	Plan 2	Plan 3	Module 1 – Hospital Benefits			Units	Units	Units	Module 2 – Surgery Benefits			Units	Units	Units	Module 3 – Radiation and Chemotherapy Benefits			Units	Units	Units	Module 4 – Wellness and Miscellaneous Benefits			Units	Units	Units	Module 5 – Drug-Related Expense Benefits			Units	Units	Units	Accept	Decline	Optional Riders				<input type="checkbox"/>	<input type="checkbox"/>	First Occurrence Rider <i>(Lum Sum Diagnosis Rider in SD)</i>	Units	Units	Units	<input type="checkbox"/>	<input type="checkbox"/>	Intensive Care Rider <i>(Not available in CT, MA, NH, NJ, VT or WA) (Module 6 in TN)</i>	Units	Units	Units	<input type="checkbox"/>	<input type="checkbox"/>	Specified Disease Rider <i>(Not available in OR, SD or WA)</i>	Units	Units	Units
			Plan 1	Plan 2	Plan 3																																																									
Module 1 – Hospital Benefits			Units	Units	Units																																																									
Module 2 – Surgery Benefits			Units	Units	Units																																																									
Module 3 – Radiation and Chemotherapy Benefits			Units	Units	Units																																																									
Module 4 – Wellness and Miscellaneous Benefits			Units	Units	Units																																																									
Module 5 – Drug-Related Expense Benefits			Units	Units	Units																																																									
Accept	Decline	Optional Riders																																																												
<input type="checkbox"/>	<input type="checkbox"/>	First Occurrence Rider <i>(Lum Sum Diagnosis Rider in SD)</i>	Units	Units	Units																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Intensive Care Rider <i>(Not available in CT, MA, NH, NJ, VT or WA) (Module 6 in TN)</i>	Units	Units	Units																																																									
<input type="checkbox"/>	<input type="checkbox"/>	Specified Disease Rider <i>(Not available in OR, SD or WA)</i>	Units	Units	Units																																																									
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____																																																														

<input type="checkbox"/> Group CI Insurance – CriticalAssistance Advance <i>Product not available in CO, FL, NJ and WA. Available as in Individual policy in CT and MD. Available to large groups (51+) only in MA.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:																																																		
Coverage: <i>For GA only: Are you offering the <input type="checkbox"/> group policy or <input type="checkbox"/> individual policy</i> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="text-align: center;">Accept</th> <th style="text-align: center;">Decline</th> <th colspan="3"></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Cancer Benefit Rider <i>(Part of Policy in GA)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Occupational HIV Benefit Rider <i>(Not available in CA, GA, OR, or PR)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Quality of Life Benefit Rider <i>(Not available in CA, CT, GA, HI, KS, LA, MA, MN, NC, NH, OR, PA, PR, SD, TN, or UT)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Recurrent Critical Illness Benefit Rider <i>(Not available in MA)</i> Benefit: <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75%</td> </tr> <tr> <td colspan="2"></td> <td style="text-align: right;">Benefit Amount Paid For By:</td> <td style="text-align: center;">Policyholder</td> <td style="text-align: center;">Employee</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Intensive Care Rider <i>(Not available in GA, MD, MN, NH, PR, or VT)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Initial Hospitalization for Accidental Bodily Injury Benefit Rider <i>(Not available in CA, CT, GA, KS, MA, MD, MN, NH, PA, PR, or VT)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Accident Emergency Treatment Benefit Rider <i>(Not available in CA, CT, GA, KS, MA, MD, MN, NH, PA, PR, or VT)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td colspan="3">Wellness Benefit Rider</td> </tr> </tbody> </table>			Accept	Decline				<input type="checkbox"/>	<input type="checkbox"/>	Cancer Benefit Rider <i>(Part of Policy in GA)</i>			<input type="checkbox"/>	<input type="checkbox"/>	Occupational HIV Benefit Rider <i>(Not available in CA, GA, OR, or PR)</i>			<input type="checkbox"/>	<input type="checkbox"/>	Quality of Life Benefit Rider <i>(Not available in CA, CT, GA, HI, KS, LA, MA, MN, NC, NH, OR, PA, PR, SD, TN, or UT)</i>			<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Critical Illness Benefit Rider <i>(Not available in MA)</i> Benefit: <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75%					Benefit Amount Paid For By:	Policyholder	Employee	<input type="checkbox"/>	<input type="checkbox"/>	Intensive Care Rider <i>(Not available in GA, MD, MN, NH, PR, or VT)</i>			<input type="checkbox"/>	<input type="checkbox"/>	Initial Hospitalization for Accidental Bodily Injury Benefit Rider <i>(Not available in CA, CT, GA, KS, MA, MD, MN, NH, PA, PR, or VT)</i>			<input type="checkbox"/>	<input type="checkbox"/>	Accident Emergency Treatment Benefit Rider <i>(Not available in CA, CT, GA, KS, MA, MD, MN, NH, PA, PR, or VT)</i>			<input type="checkbox"/>	<input type="checkbox"/>	Wellness Benefit Rider		
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<input type="checkbox"/> Self-Administered Basic Critical Illness Insurance <i>Product not available in CA, CO, CT, FL, GA, MD, MN, NH, NJ, PR, UT, or WA.</i>	Group Contribution? <input checked="" type="checkbox"/> Yes Policyholder pays 100% of Basic CI Insurance	Requested Effective Date:																																																																																										
Coverage: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;"></th> <th style="width:10%;"></th> <th style="width:10%;">Class 1</th> <th style="width:10%;">Class 2</th> <th style="width:10%;">Class 3</th> <th style="width:10%;">Class 4</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Basic CI Insurance: <input type="checkbox"/> Core Complete <input type="checkbox"/> Essential </td> <td style="text-align: center;">Insured</td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> </tr> <tr> <td style="text-align: center;">Dependents</td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> </tr> <tr> <td>First Occurrence Rider <i>(Not available in: DC, GU, IL, IN, OH, SD)</i></td> <td></td> <td style="text-align: center;"><input 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Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____																																																																																												

<input type="checkbox"/> Group CI Insurance – CriticalAssistance Select <i>Product not available in CT, GU, MA, MN, MT, NH, PR or WA. Available as an Individual policy in FL and MD.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:				
Coverage: <input type="checkbox"/> With Benefit Reduction <input type="checkbox"/> Without Benefit Reduction <input type="checkbox"/> HealthPak CI <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Option A – Cancer, Heart Attack, Stroke, End Stage Renal Failure, and Major Organ Transplant</td> </tr> <tr> <td><input type="checkbox"/> Option B – Heart Attack and Stroke Only <i>(Not available in GA)</i></td> </tr> <tr> <td><input type="checkbox"/> Option C – Cancer Only <i>(Not available in GA)</i></td> </tr> <tr> <td><input type="checkbox"/> Option B and C – Heart Attack, Stroke, and Cancer Only <i>(Not available in GA)</i></td> </tr> </table>			<input type="checkbox"/> Option A – Cancer, Heart Attack, Stroke, End Stage Renal Failure, and Major Organ Transplant	<input type="checkbox"/> Option B – Heart Attack and Stroke Only <i>(Not available in GA)</i>	<input type="checkbox"/> Option C – Cancer Only <i>(Not available in GA)</i>	<input type="checkbox"/> Option B and C – Heart Attack, Stroke, and Cancer Only <i>(Not available in GA)</i>
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<input type="checkbox"/> Identity Theft Protection – LifeLock® <i>Services provided by LifeLock, Inc.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
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<input type="checkbox"/> AmeriDoc <input type="checkbox"/> Healthiestyou	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
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<input type="checkbox"/> Group Limited Benefit Indemnity – TransConnect <i>Product not available in CT, GU, MN, MT, NH, NJ, PR, VI and WA. Large Employer Group Only (51+) in MA.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:															
Coverage: <input type="checkbox"/> TransConnect <input type="checkbox"/> HealthPak Do you continuously maintain a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Product only available while you continuously maintain an underlying medical plan)</i> How many plans are in force? _____ <i>(Attach a copy or plan summary of each plan and the most recent billing statement)</i>																	
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Hospital Inpatient Benefit Amount																	
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Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____																	

<input type="checkbox"/> Group Limited Benefit Outpatient-Only Indemnity – TransConnect II <i>Product not available in CA, CO, CT, GU, KS, MD, MA, MN, NH, NJ, PR, ND, RI, VI, WA</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:		
Coverage: <input type="checkbox"/> TransConnect II <input type="checkbox"/> HealthPak II Do you continuously maintain a medical plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Product only available while you continuously maintain an underlying medical plan)</i> How many plans are in force? _____ <i>(Attach a copy or plan summary of each plan and the most recent billing statement)</i>				
Benefit Amount	Class 1	Class 2	Class 3	Class 4
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____				

<input type="checkbox"/> Group Short-Term Disability – TransDI Plus IncomeSelect in FL Large Employer Group Only (51+). <i>Product not available in VT. Available as an individual policy in WA.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:		
Coverage: Accelerated Benefit For Terminal Illness Rider included in all states except CT.				
	Class 1	Class 2	Class 3	Class 4
Maximum Monthly Benefit is the lesser of: <i>(Cannot exceed 80% or \$5,000)</i>	%	%	%	%
Percentage of Salary	%	%	%	%
Dollar Amount	\$	\$	\$	\$
Maximum Benefit Period (3, 6, 12 or 24 Months)	Months	Months	Months	Months
Accident Elimination Period (0, 7, 14, 30, 60, 90 or 180 Days)	Days	Days	Days	Days
Sickness Elimination Period (7, 14, 30, 60, 90 or 180 Days)	Days	Days	Days	Days
Accept	Decline	Optional Riders/Benefits <i>(Optional Riders/Benefits are not available in FL)</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment Benefit Rider		
<input type="checkbox"/>	<input type="checkbox"/>	Hospital Indemnity Benefit Rider <i>(Not available in PR)</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Survivor Benefit Rider		
<input type="checkbox"/>	<input type="checkbox"/>	Limited Pre-existing Condition Benefit <i>(25% of the Disability Benefit for up to 6 weeks)</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy Rider <i>(Not available in CO, CT, MN, MT, NH, PR, WA)</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Portability Rider <i>(Not available in CO, MD, MN, MT, OH, RI, WA)</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Additional Income Benefit Rider <i>(Available in CA only)</i>		
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____ Workers' Compensation: Are all employees/members covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain below)</i>				

<input type="checkbox"/> Group Short-Term Disability – TransDI Elite <i>Product not available in CA, FL, VT or WA.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
Coverage:		
Maximum Monthly Benefit Amount	Guaranteed Issue up to \$2,500; Simplified Issue \$2,600 to \$5,000	
Not to exceed	60% of Salary	
Maximum Benefit Period	6 Months or 12 Months (Employee Option)	
Accident Elimination Period	0 Days	
Sickness Elimination Period	14 Days	
Accidental Death Benefit Rider	\$2,000 Benefit	
Occupational Benefit Rider <i>(Not available in WA)</i>	25% of the Disability Benefit Amount	
Limited Pre-existing Condition Benefit	50% of the Disability Benefit Amount for up to 12 Weeks of Disability	
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____ Workers' Compensation: Are all employees/members covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain below)</i>		

<input type="checkbox"/> Self-Administered Basic Short-Term Disability <i>Product not available in CA, CO, FL, MD, MN, NH, NJ, NY, PR, RI, UT, VI, VT, WA.</i>	Group Contribution? <input checked="" type="checkbox"/> Yes Policyholder pays 100% of Basic Disability Ins.	Requested Effective Date:		
Coverage: <input type="checkbox"/> Monthly Benefit <input type="checkbox"/> Weekly Benefit				
	Class 1	Class 2	Class 3	Class 4
Basic Benefit is the lesser of:	Percentage of Salary	%	%	%
<i>Cannot exceed 60%, 80% if pre-tax, or \$5,000</i>	Dollar Amount	\$	\$	\$
Supplemental Benefit <input type="checkbox"/> % of Salary <input type="checkbox"/> Dollar Amount	Minimum			
	Maximum			
	In Increments of			
Total Basic & Supplemental Benefits Can't Exceed <i>60 or 80% of Salary</i>	%	%	%	%
Maximum Benefit Period <i>(3, 6, 12 or 24 Months)</i>	Months	Months	Months	Months
Accident Elimination Period <i>(0, 7, 14, 30, 60, 90 or 180 Days)</i>	Days	Days	Days	Days
Sickness Elimination Period <i>(7, 14, 30, 60, 90 or 180 Days)</i>	Days	Days	Days	Days
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____ Workers' Compensation: Are all employees/members covered under Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain below)</i>				

<input type="checkbox"/> Hospital Indemnity – HospitalSelect II HSA Plan <i>Check with Account Management for current state approval information</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:		
Do you offer a medical plan with at least a \$1,000 deductible? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Product only available if you answer "Yes")</i>				
Coverage: (Attach Plan Design) Pre-Ex Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Class 1	Class 2	Class 3	Class 4
Base: Daily In-Hospital Indemnity Benefit	\$	\$	\$	\$
Maximum (choose one):	<input type="checkbox"/> 31 Days	<input type="checkbox"/> 31 Days	<input type="checkbox"/> 31 Days	<input type="checkbox"/> 31 Days
31 Days per Confinement	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Dollar Amount per Calendar Year				
<input type="checkbox"/> Hospital Confinement Indemnity Benefit Rider	\$	\$	\$	\$
Maximum of 1 Day per Confinement.	___ Days	___ Days	___ Days	___ Days
Calendar Year Maximum <i>(Not available in CO, KS, MO, NJ)</i>				
<input type="checkbox"/> Intensive Care Indemnity Benefit Rider <i>(Can't exceed 2 times the Base Benefit)</i>	\$	\$	\$	\$
Calendar Year Maximum <i>(Not available in NJ)</i>	___ Days	___ Days	___ Days	___ Days
<input type="checkbox"/> Inpatient Miscellaneous Indemnity Benefit Rider	\$	\$	\$	\$
Maximum of 31 Days per Confinement <i>(Not available in CO, MO, NJ)</i>				
<input type="checkbox"/> Off-The-Job Accidental Injury Indemnity Benefit Rider	\$	\$	\$	\$
Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days <i>(Not available in CO, NJ, PA)</i>				
<input type="checkbox"/> Critical Illness Indemnity Benefit Rider <i>(Not available in CA, CO, KS, NJ, PA)</i>	\$	\$	\$	\$
Dependent Benefit Percentage	%	%	%	%
<input type="checkbox"/> AmeriDoc <input type="checkbox"/> Healthiestyou	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Waiver of Preexisting Condition Rider <i>(Not available in NH, NJ)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Replacement: Are you replacing existing coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes IRS Type: <input type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____				

Hospital Indemnity – HospitalSelect II Non-HSA Plan

Check with Account Management for current state approval information

Group Contribution? Yes No
If yes, list amount or %:

Requested Effective Date:

Do you offer a medical plan with at least a \$1,000 deductible? Yes No *(Product only available if you answer "Yes")*

Coverage: (Attach Plan Design) Pre-Ex Waiver <input type="checkbox"/> Yes <input type="checkbox"/> No	Class 1	Class 2	Class 3	Class 4
Base: Daily In-Hospital Indemnity Benefit Maximum (choose one): 31 Days per Confinement Dollar Amount per Calendar Year	\$ <input type="checkbox"/> 31 Days <input type="checkbox"/> \$_____			
<input type="checkbox"/> Hospital Confinement Indemnity Benefit Rider Maximum of 1 Day per Confinement. Calendar Year Maximum <i>(Not available in CO, KS, MO, NJ)</i>	\$ ___ Days	\$ ___ Days	\$ ___ Days	\$ ___ Days
<input type="checkbox"/> Intensive Care Indemnity Benefit Rider <i>(Can't exceed 2 times the Base Benefit)</i> Calendar Year Maximum <i>(Not available in NJ)</i>	\$ ___ Days	\$ ___ Days	\$ ___ Days	\$ ___ Days
<input type="checkbox"/> Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement <i>(Not available in CO, MO, NJ)</i>	\$	\$	\$	\$
<input type="checkbox"/> Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days <i>(Not available in CO, NJ, PA)</i>	\$	\$	\$	\$
<input type="checkbox"/> Critical Illness Indemnity Benefit Rider Dependent Benefit Percentage <i>(Not available in CA, CO, KS, NJ, PA)</i>	\$ %	\$ %	\$ %	\$ %
<input type="checkbox"/> AmeriDoc <input type="checkbox"/> Healthiestyou	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Inpatient Surgical Indemnity Benefit Rider <i>(Requires confinement)</i> Calendar Year Maximum Anesthesia Benefit Percentage <i>(Not available in NJ)</i>	\$ ___ Days %	\$ ___ Days %	\$ ___ Days %	\$ ___ Days %
<input type="checkbox"/> Outpatient Surgical Indemnity Benefit Rider Calendar Year Maximum Anesthesia Benefit Percentage <i>(Not available in CO, KS, MO, NJ, PA)</i>	\$ ___ Days %	\$ ___ Days %	\$ ___ Days %	\$ ___ Days %
<input type="checkbox"/> Surgical and Anesthesia Indemnity Benefit Rider Daily Inpatient Surgical Benefit Amount: Daily Outpatient Surgical Benefit Amount: 50% of Inpatient Amount Daily Minor Outpatient Surgical Benefit Amount: 10% of Inpatient Amt. Calendar Year Maximum: 1 Day per category Anesthesia Benefit Percentage <i>(Not available in CO, NH, NJ)</i>	\$ %	\$ %	\$ %	\$ %
<input type="checkbox"/> Ambulance Indemnity Benefit Rider – Daily Ground Benefit Daily Air Ambulance pays 3 times the Daily Ground Benefit Calendar Year Maximum: 3 Days. Lifetime Maximum: 6 Days <i>(Not available in NJ)</i>	\$	\$	\$	\$
<input type="checkbox"/> Inpatient Drug & Alcohol Addiction Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days <i>(Not available in CO, KS, MO, NJ, PA)</i>	\$	\$	\$	\$
<input type="checkbox"/> Inpatient Mental & Nervous Disorder Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days <i>(Not available in CO, KS, MO, NJ, PA)</i>	\$	\$	\$	\$
<input type="checkbox"/> Skilled Nursing Indemnity Benefit Rider Calendar Year Maximum: 60 Days. Lifetime Maximum: 120 Days <i>(Not available in CO, KS, MO, NJ, PA)</i>	\$	\$	\$	\$
<input type="checkbox"/> Waiver of Preexisting Condition Rider <i>(Not available in NH, NJ)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Replacement: Are you replacing existing coverage? No Yes

IRS Type: Section 125 Welfare Benefit Plan ERISA 5500 Required Other *(please explain)* _____