FIRST RELIANCE STANDARD
Life Insurance Company
a DELPHI company

APPLICATION FOR GROUP INSURANCE

(See reverse side for additional information)

1. Applicant's Legal Name____________________

2. Doing Business As

3. ____________________
P.O. BOX / ZIP CODE
____
STREET ADDRESS
____
CITY / STATE / ZIP
____
PHONE NO. FAX NO.
____
E-MAIL ADDRESS TAX I.D. NO.

4. What is the nature of your business or industry?
____
____

5. Are any classes or locations excluded? ☐Yes ☐No
(If yes, please use reverse side for explanation.)

6. Are any subsidiary and/or affiliated companies to be insured? ☐Yes ☐No
(If yes, please use reverse side to list name and location.)

7. How many hours per week equals full time employment?_____

8. Employee Participation
Employer contributes ______% of employee premium.
☐ **Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)
☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)
☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)
☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

9. Dependent Participation
Employer contributes ______% of dependent premium.
☐ **Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)
☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)
☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)
☐ **Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. Section 125 Plan:
Election Period:____________________
Plan Year: ____________________

11. Waiting Period
_____ for those employed on or before the policy effective date.
_____ for those employed after the new policy effective date.
☐ month(s) ☐calendar days ☐working days

12. Effective Date and Termination Date
☐Immediate
☐First of Month Effective date/End of Month Termination date
☐Other____________________
____

13. Premium Payment Mode (In advance):
☐ Monthly ☐Quarterly ☐Semi-Annual ☐Annual
☐ **Payroll Deduction** (Coverage must be 100% employee paid for employee and dependent premium to choose this option.)
If policy effective date is other than first of the month, is a first of the month premium due date desired? ☐Yes ☐No

Billing Options
☐Home Office ☐Third-Party Administration
____
CONTACT NAME
____
TITLE
____
STREET ADDRESS
____
CITY / STATE / ZIP
____
PHONE NO. FAX NO.
____
E-MAIL ADDRESS

14. The following coverages are applied for:
Employee & Dependents Benefits:
☐ Dental ☐Orthodontia ☐Eye Care ☐Other__________
Employee Only Benefits:
☐ Dental ☐Orthodontia ☐Eye Care ☐Other__________
This insurance shall be effective on:__________
(Premiums due prior to the coverage period.)

15. **Insurance requested on this application will replace the coverage(s) checked.**
Coverages: ☐Dental ☐Ortho ☐Eye Care ☐Other__________
____
NAME OF CURRENT CARRIER
____
POLICY NO.
☐ Coverage applied for is replacing comparable coverage now or previously in force with another carrier.
☐ It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.
____
TERMINATION DATE ORIGINAL EFFECTIVE DATE

Item 5: Exclusions:

a. Classes, include reason for exclusion.

____

____

b. Locations, if location is different from applicant's, list city and state.

____

____

Item 6: Subsidiary and/or affiliated companies to be insured:

List names and locations: ____

____

____

Plan Design and Proposed Rates: ____

____

____

Additional Remarks: ____

____

____

Agreements

This application will be subject to review and approval by the Home Office of First Reliance Standard Life Insurance Company. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of First Reliance Standard Life Insurance Company, group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

Signed at: City: ______________________ State: ______________ Date: ______________

Soliciting Agent: Printed name: ______________________ Signature: ______________________

Signed by (Policyholder Representative): Printed name and title: ______________________

Signature: ______________________

Was a binder check received? ☐ YES ☐ NO If yes, then amount $______________.

Check received by: (agent) ______________________ Authorized by: (policyholder) ______________

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO FIRST RELIANCE STANDARD LIFE INSURANCE COMPANY.

DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.