HEALTH BENEFITS YOU CAN AFFORD

EXpected GI

Offered by:

PRIVATE HEALTH EXCHANGE℠
next HEALTH PLAN

Benefits & Availability Vary by State
Guaranteed Issue Health Benefits Subject to Group Size & Participation Requirements

21318-EGI

PRIVATE HEALTH EXCHANGE SM

next HEALTH PLAN

25+ Years Industry Experience

A+ Rating with Better Business Bureau BBB

Industry Leader in Plan Design & Pricing

Plans for Small Businesses, the Self-Employed & Individuals

PARTNERS

EXpectedGI Health Benefits partner with national networks, service providers, health care advocates & consumer programs to provide you with a large coverage footprint & the best price for your health care.

OUR PARTNERS PROVIDE ADDITIONAL UNLIMITED SERVICES AT NO COST

TELADOC

GoodRx

LabCorp Laboratory Corporation of America

thekarisgroup®

Access to the PHCS Network MultiPlan

EXpected Guaranteed Issue Health Benefits

Health Benefits help you…

- Attract and retain the most qualified employees
- Avoid health care reform penalties
- Get tax advantages
- Keep your employees healthy

Traditional Group Plans…

- High Premiums That Increase Every Year
- Large Deductibles & Co-Insurance
- Limited Provider Network

EXpectedGI…

- Premiums are both Affordable & Stable
- Access to Large, National Networks
- First Dollar Benefits make coverage accessible
- Partner Services Reduce out of pocket costs
- No Contribution Mandates
- Voluntary Health Plan
- Available Dental/Vision plan
- GAP Plan Available

Benefits & Availability Vary by State
Guaranteed Issue Health Benefits Subject to Group Size & Participation Requirements

3 Easy steps to save your business on health benefits

#1 Process Quote

#2 Review Rates

#3 Enroll Employees

Talk to an experienced, US board certified doctor in minutes.

TELADOC®

Imagine a world without waiting rooms.

Teladoc provides you with phone, video and mobile app access to licensed US physicians, 24 hours a day, 7 days a week. Need medical advice at 2 a.m. or a prescription while traveling? Teladoc delivers the finest physician care – anytime, anywhere, for anyone.

Quality, 24/7 care by phone, video or mobile app

8min
Average call-back time

92%
of calls resolved successfully

95%
Customer satisfaction

1MM
Consults provided in 2016

How it works:

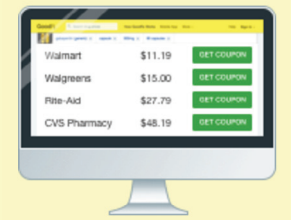
1. Complete your medical history
2. Request a phone of video consultation
3. Speak with a doctor about your issue
4. Receive treatment for your issue
5. Provide feedback on your experience

GoodRx

Stop paying too much for your prescriptions!

FIND THE LOWEST PRICE

1



Compare prices

GoodRx collects prices & discounts from over 60,000 U.S. pharmacies

2

Print free Coupons

Or send coupons to your phone by email or text message

3

Save up to 80%

Show the coupon to your pharmacist for massive savings on your meds

GoodRx Visit www.goodrx.com to search coupons or call us at 1-888-799-2553

LabCorp
Laboratory Corporation of America

Use LabCorp to save from 50% - 81% on over 400 tests.

LabCorp is a leading global life sciences company. With a mission to improve health and improve lives, LabCorp delivers world-class diagnostic solutions, brings innovative medicines to patients faster and uses technology to improve the delivery of care.

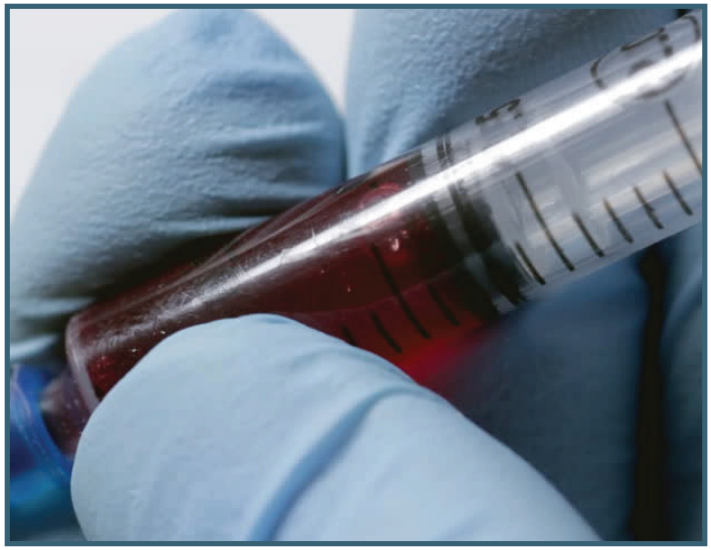
Using LabCorp is easier than ever!

1. Locate a lab most convenient to you and schedule an appointment for your test
2. Prepare for your lab test by following your Doctor's instructions on fasting or avoidance of certain medications
3. Arrive at the lab of your choice and submit your labwork for testing
4. Login to your LabCorp Patient Portal 7-10 days after your test to view your lab results

Research to Improve Lives

LabCorp and its subsidiaries are in the business of improving health. We have opportunities for our patients to participate in the research that can improve the quality of their lives and the lives of others. The research can take many forms, including clinical trials, medical device trials, and other types of research to develop new health care solutions. To learn more, please register for or login to your LabCorp Patient portal account.

Contact LabCorp at 888-522-2677



karis360

Services shop for better pricing on healthcare services including surgeries, procedures, and imaging as well as negotiate out-of-pocket expenses.

PATIENT ADVOCACY BEFORE, DURING AND AFTER A HEALTHCARE EVENT

Healthcare Navigator

Based on the policyholder's input and preference, an Advisor will search for doctors, hospitals and other healthcare services in the policyholder's area and schedule their appointments, if needed

Advisors will assist in finding the most affordable & convenient solution to their prescription drug needs

Karis360 Advisors will provide cost estimates for various outpatient procedures including X-rays, mammograms, colonoscopies, MRI, and lab testing

Advisors can help find alternative care in areas such as Acupuncture, Massage Therapy, Homeopathic and Naturopathic medicine

Advisors will schedule primary care and specialist visits, labs, imaging, flu shots and more at the policyholder's schedule and convenience

Karis Advisors can organize the transfer of a medical record between providers to ensure their care providers are working with accurate information while saving policyholders the time and effort of getting this done

thekarisgroup®

Services can be accessed via toll-free number 800-556-8452 or open an inquiry ("case") via the Karis' website.

Surgery Saver

Helps policyholders when a non-emergency surgical procedure is being considered

Karis' specialized Advisors provide a cost, quality and availability comparison of up to 5 healthcare facilities in the policyholder's area

Comparison includes the prescribing physician and their preferred facility

Bill Negotiator

The Karis team of experts focus on reducing the policyholder's out-of-pocket portion of medical bills after insurance benefits have been applied, if applicable

Policyholders can access Karis Bill Negotiator after a single, related medical incident where the combined total of medical bills exceeds the threshold of $2,500

The overall savings discount earned for the policyholder through negotiations of the out-of-pocket portion of medical bills typically ranges from 40% to 70%

PHCS
Limited Benefit Network

SAVE 43% OR MORE BY TAKING ADVANTAGE OF THE PPO NETWORK DISCOUNTS

PHCS NETWORK: MORE SAVINGS THROUGH YOUR BENEFIT PLAN!

While you are free to use any Doctor or Hospital you choose without penalty, you have the option of accessing the PHCS Network to take advantage of great savings averaging 43 percent for physicians and specialists — the types of services most typically use with these plans. With PHCS, you get more value for your benefit dollars.

Today more than ever, health plans with limited benefits are an ideal solution for consumers responsible for most or all of their healthcare costs. With the PHCS Network, you can offer them access to thousands of hospitals, practitioners and ancillary facilities who have agreed to significant discounts on their medical services.

SIGNIFICANT ACCESS AND SAVINGS

Accepted by over 900,000 healthcare professionals and at over 4,700 hospitals nationwide, PHCS is the largest primary PPO network in the nation, available at no additional costs!
Providers.ExpectedBenefits.com

To find providers in our area go to www.multiplan.com and select Patients, then search for the Doctor or Facility nearest and most convenient to you!

How EXpectedGI Works

- $5 Million in Total Coverage
- Spend up to $250,000 each year per covered employee
- $40,000 Critical Event Protection provides lump sum cash benefit for a critical event such as a cancer diagnosis or heart attack
  (Available to those who qualify medically - not Guaranteed Issue)
- Guaranteed Coverage for 10 or More Eligible Employees
- Additional Unlimited Services Provided at No Additional Cost

COVERAGE INCLUDES

Hospitalization
Surgical
Outpatient
Chemotherapy
Doctor Visits
Preventative
Prescriptions
& More

Major Illness

$100,000 CLAIM

- $43,000

Network Discount
(43% AVERAGE)

- $40,000

Critical Event Coverage*

$17,000

Funded by Policy

*Critical Event Coverage is only available to those who qualify medically and is not Guaranteed Issue

Benefits & Availability Vary by State
Guaranteed Issue Health Benefits Subject to Group Size & Participation Requirements

Health Benefits

A summary of benefits available to each employee

OUTPATIENT DAILY BENEFITS

Calendar Year Outpatient Benefits, Per Covered Person	$4,000
Outpatient Physician - 20 Visits Per Person, Per Year (6 Chiropractor visits)	$80
MRI, CAT Scan or Nuclear Testing (per covered person, per day)	$350
Other Diagnostic Testing or X-rays (per covered person, per day)	$80
Laboratory Testing (per covered person, per day)	$40
Brand Name Prescription (per covered person, per day)	$20
Generic Prescription (per covered person, per day)	$10
Injections (per covered person, per day)	$20
Emergency Room: Facility Fees ¦ Professional Services (limit 1 of each benefit per covered person per Calendar Year)	$150 ¦ $150
Urgent Care (limit 1 benefit per covered person per Calendar Year)	$125
Mammograms	$125
Colonoscopy (Colonoscopy benefits every 3 years, benefit doubles beginning 4th year)	$300 ¦ $600
All Other Preventive (Including Physicals)	$125
Emergency Ambulance (Ground) - 2 Benefits per person per Year	$500
Emergency Air Ambulance - 1 Benefit per person per Year	$1,500

HOSPITAL BENEFITS

	DAY 1	DAY 2+
Hospital Confinement due to Sickness, per Covered Person*	$600*	$3,000
Hospital Confinement due to Injury, per Covered Person*	$1,200*	$6,000
Hospital ICU (Sickness), per Covered Person* (20 day max per calendar year)	$900*	$4,500
Hospital ICU (Injury), per Covered Person* (20 day max per calendar year)	$1,200*	$6,000
Surgical Benefit per Covered Person, per Day for both inpatient & outpatient Surgery - percentage of Medicare RBRVS Schedule**	200%**	
Outpatient Hospital/Ambulatory Surgical, per Covered Person, per Day	$3,000	
Outpatient Radiation/Chemotherapy, per Covered Person, per Day	$1,500	
Rehabilitation or Skilled Nursing Facility, per Covered Person, per Day	$1,500	

*Hospital Confinement & Hospital ICU Benefits pay at 20% for the first day

**Coverage in TN pays a defined benefit rather than on an RBRVS Schedule

TERMINATION OF A COVERED PERSON'S INSURANCE

The insured person's insurance will cease on the earliest of; (a) the date of lapse at the end of the grace period for non-payment of premium; (b) the later of the date a written request to terminate the policy is received by the insurer or the date specified in the written request; (c) the premium due date following the date the covered person attains the limiting age.

The insurance on a dependent will cease on the earliest of; (s) the date the Insured's coverage terminates; (b) the premium due date following the date the dependent attains the limiting age for dependents; (c) the end of the last period for which premium payment has been made to the insurer, subject to the grace period; (d) the premium due date following the date the dependent no longer meets the definition of dependent, as defined in the policy; (e) the date the policy is modified so as to exclude dependent coverage; or (f) the date the policy terminates.

If the insurer accepts a premium for coverage for a covered person after the date on which the policy provides that a covered person will cease to be covered, the coverage for that covered person will continue in force until the end of the period for which such premium has been accepted.

TEN DAY FREE LOOK

You have 10 days after receiving the policy, and if you are not satisfied for any reason, you may return it to the insurer for a full refund of all premiums paid. Mail the policy with your written request for cancellation to the insurer. The insurer will promptly refund the premium paid and the insurance will be void.

NOTICE TO APPLICANTS

Your effective date will be assigned by the insurer. Insurance Coverage is Not Effective until the Coverage Applied for has been Accepted and Approved and Issued in Writing by the insurer. Completing the Application does not mean that coverage is in force. Please allow two to three weeks following approval for delivery of your policy.

GUARANTEED RENEWABLE TO AGE 65.

THE INSURER RESERVES THE RIGHT TO CHANGE PREMIUM RATES ON A CLASS BASIS.

You have the right to renew this policy until the first premium due date on or after your 65th birthday. The insurer reserves the right, subject to written notice within the time period your state allows, to establish a new schedule of premium rates; such schedule of rates will be effective on the following premium due date for all or any class of insured covered by the policy. Premiums may also change due to attained age. Please read the Premium Rate Change provision carefully that is contained in this policy.

GROUP SIZE & PARTICIPATION REQUIREMENTS

Guaranteed Issue Health Benefits are subject to the following Group Size and Participation Requirements: 10 - 15 Eligible employees require a minimum of 8 Participating employees, 16 - 24 Eligible employees require a minimum of 12 Participating employees, 25 - 36 Eligible employees require a minimum of 18 Participating employees, 37 - 50 Eligible employees require a minimum of 25 Participating employees. More than 50 Eligible employees requires Home Office Approval.

PRE-EXISTING CONDITION

means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.

Within this brochure you have been provided with a Summary of Benefits describing the Policy for which you have applied. Please verify that you understand the coverage as outlined as well as the following provisions:

1. The coverage for which you have applied will become effective only when the application is approved by the insurer and only on the Effective Date assigned by the insurer.

2. If you are approved and your Policy is issued, your coverage will begin immediately on the assigned Effective Date.

3. No benefits will be payable for any sickness or injury due to a Pre-Existing Condition. Pre-existing Condition means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.

4. A claim for benefits may not be payable under the new Policy due to the above-mentioned Pre-existing Condition waiting period; whereas, the same claim might have been payable under your present coverage, if any, had it remained in force.

5. Until the coverage has been approved and issued, the insurer has absolutely no liability to you other than to refund your initial premium if your Application is not approved. Any injury or sickness which may develop between now (today) and the date your coverage is effective will be a Pre-existing Condition, and depending on extent and severity, such injury or sickness may render you (or a dependent) ineligible for coverage.

6. Carefully read or have read to you and answer the questions on your Application on behalf of yourself and your dependents. Understand that disclosure of health in formation is important and any omission may bar the right to recover under the Policy if such answer materially affects the acceptance of the risk or hazard assumed. Your Policy, if issued, will contain a photocopy of all applicable documents along with the Application for Coverage.

An ExpectedGI plan is a limited benefit fixed indemnity plan and not a major medical insurance plan. Fixed indemnity benefits are provided for hospital confinement, specified medical, surgical and outpatient events. These benefits are paid in specific amounts and do not provide expense reimbursement or charges based on your healthcare provider's bill. Fixed indemnity insurance plans do not meet the Minimum Essential Coverage requirements under the Affordable Care Act and you may need to pay a tax penalty depending upon your income level and the cost of plans available.

Critical Event Coverage

Attained Age Pricing

After the first 12 months, the carrier reserves the right, subject to 30/45/60 days prior written notice (depending on state) to you at your last known address, to establish a new schedule of premium rates; such schedule of rates will be effective on the following renewal date for all or any class of Insured's covered by this Policy. Premiums are scheduled to change annually based upon Insured's attained age.

Waiting Period

The benefits of this Policy are payable for loss that begins more than 90 days after the Effective Date of coverage for each Insured person. If the Diagnosis is made within the first 90 days, the carrier will pay 25% of the benefit payable as listed in Category One and Two of the policy.

Reduced Benefits

During the first 90 days after the Effective Date of coverage, Reinstatment date or for a second date of occurrence resulting in a Diagnosis or procedure in a Multiple Condition instance, the carrier will pay 25% of the Percentage Benefit Payable listed in the Policy Schedule.

Reduction of Benefits Due to Age

Any benefits remaining at age 65 or older will reduce 50%.

Covered Events

Cancer (Internal Cancer)

This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, malignant melanoma that is Diagnosed as Clark's Level III or above or Breslow greater than .75mm and malignant tumors.

Non-Invasive Carcinoma In-Situ

A localized malignant tumor, which contains one or several cells that have the potential to invade or metastasize but have not yet done so. This excludes Skin Cancer.

Heart Attack

The death (infarction) of a portion of the heart muscle as a result of inadequate blood supply.

Stroke

A cerebrovascular event resulting in permanent neurological damage, including infarction of, hemorrhage of, or embolization to brain tissue from an extracranial source.

Coronary Artery Bypass Surgery (surgical treatment)

The first ever heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass frafts.

Angioplasty

The undergoing of angioplasty, atherectomy or laser treatment for coronary artery disease, which cannot be adequately controlled by medical therapy.

Pacemeker Implant

The procedure to insert an artificial pacemaker. A pacemaker is a device that sends small electrical impulses to the heart muscle to maintain a suitable heart rate or to stimulate the lower chambers of the heart.

Organ Transplant (heart, lung, liver, pancreas)

The actual undergoing, as a recipient, of a transplant due to failure of one of the following organs: heart, lung, liver or pancreas.

Organ Transplant (kidney)

The actual undergoing, as a recipient, of a transplant due to failure of the kidney.

End Stage Renal Failure

Diagnosis of End Stage Renal disease which: (1) results in chronic irreversible failure of both kidneys to function; and (2) requires an insured person to undergo regular renal dialysis at least weekly.

Medical Qualification

To obtain Critical Event Coverage, each insured person must qualify medically. Critical Event Coverage is a stand alone policy and is not Guaranteed Issue.

EXCLUSIONS AND LIMITATIONS

With respect to all of the benefits provided under the policy, no benefits will be payable as the result of: any service, supplies or treatment that is not a specified benefit described in the policy; suicide or any attempt thereat, while sane or insane; any intentionally self-inflicted injury or sickness; rest care; cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from an injury if initial treatment of the covered person is begun within 12 months of the date of the injury; immunization shots and routine examinations such as: health exams, periodic check-ups, pre-marital exams, and routine physicals, except as otherwise covered under the policy; routine newborn care, including routine nursery charges; voluntary abortion, except with respect to the insured or the insured's covered dependent spouse where such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion; pregnancy of a dependent child, unless required by law; a covered person's participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority; a covered person committing, attempting to commit or taking part in a felony, or engaging in an illegal occupation; a covered person's participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee-jumping, or hang gliding; air travel, except: (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or (2) as a passenger for transportation only and not as a pilot or crew member; any injury occurring directly or indirectly as a result of the voluntary use of intoxicants, narcotics or hallucinogens unless taken on the written advice of a physician except for treatment of Alcohol and / or Substance Abuse Dependency as provided in the policy; sex changes; any dental care, treatment or service to the teeth, gums or mouth; experimental treatments or surgery; the reversal of tubal ligation or vasectomies; artificial insemination, invitro fertilization, and test tube fertilization, including any related testing, medications, or physician's services, unless required by law; treatment of exogenous obesity or weight control; an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes injury sustained or sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro-rated unearned premium for any such period the covered person is not covered; Injury or sickness arising out of or as the result of any work for wage or profit when coverage is in force for the injury or sickness under Workers' Compensation, employer's liability or similar laws or coverage; any service, supplies or treatment that is not medically necessary; any facility charges for treatment at a hospital in excess of the indemnity amount specified in the policy; pregnancy, childbirth or voluntary abortion, except for complications of pregnancy as defined; Pre-Existing Conditions; any service or treatment rendered outside the territorial limits of the United States of America; treatment of jaw joint problems including temporomandibular joint syndrome and craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint; voluntary sterilization.

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

Acceptance of List Bill Program

This form must be signed by an authorized representative of the Employer/Organization named below. It is not an application for insurance. ***Please print.***

EMPLOYER INFORMATION:

Name of Company (Employer) or Organization _____ Type of Business _____ Company Phone Number _____

Send Billing Statement to: ☐ Company Administrator ☐ Outside Administrator

☐ Company Administrator ☐ Payroll Contact or ☐ Outside Administrator _____ Email Address _____

Billing Address – Line 1 _____ Line 2 _____ Line 3 _____

City _____ State _____ Zip _____ Fax Number _____

Number of Eligible Employees _____ Projected Number of Enrollees _____ Requested Effective Date _____

*Date of First Payroll Deduction _____ Start Date for Enrollment _____

*If deductions are made through payroll, allow 6 weeks from the end of the enrollment period in setting the effective date. This will allow the payroll administrator time to complete the deductions.

New employees are eligible for benefits in: ☐ 30 days ☐ 60 days ☐ 90 days ☐ _____ days

Payroll Frequency: ☐ *Weekly (52) ☐ *Bi-weekly (26) ☐ Semi-monthly (24) ☐ Monthly (12)

*Premium Holidays must be used.

Billing Frequency: ☐ Monthly ☐ *Other List Bill/Application Fee: $_____

***Payment mode other than monthly requires prior Home Office approval.**

Employer Contribution: ☐ Yes ☐ No If Yes-Amount (percentage or dollar): _____

AGENT INFORMATION:

Agent Name	Agent Number	Agent Phone Number	Agent Email Address	Percent
1.				
2.				
3.				
4.				

EMPLOYER'S ATTESTATION OF EACH EMPLOYEE'S WORK STATUS

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees to be enrolled in this program have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

_____ _____

SIGNATURE OF EMPLOYER / ADMINISTRATOR DATE

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

Acceptance of List Bill Program

PRODUCTS, UNDERWRITING CLASS AND UNIFORMITY OF PURCHASE

Select Individual Products and Underwriting Method

Requested Underwriting	SI		GI		TI
Hospital Indemnity	☐		☐		☐
GAP	☐		☐		☐
Accident	☐		☐		☐
Short-Term Medical	☐		NA		☐
Critical Illness	☐		NA		☐
Dental	☐		☐		☐

SI – Simplified Issue GI - Guaranteed Issue TI – Telephone Interview

Policy Delivery

Mail Policies To	
Insured	☐
Agent	☐
Employer	☐

ACCEPTANCE OF LIST BILL PROGRAM

We, the employer, wish to participate in Philadelphia American Life Insurance Company's (PALIC) List Bill Program. Our Payroll Department is prepared to: 1) honor the requests signed by our employees for benefits offered by PALIC, and 2) forward to PALIC the payroll-deducted premiums as stated on the list bill statement.

We understand that we or PALIC may, upon reasonable notice to the affected party, terminate this List Bill Program. In that case, the payment of premium will be a matter of accounting directly between the employee and PALIC. In addition, any employee may voluntarily discontinue their payroll deduction for this insurance. Written notice should be forwarded to PALIC. We also agree to honor all payroll deduction changes resulting from premium increases due to age changes, rate increase and dependent eligibility when presented.

We acknowledge that PALIC assumes no responsibility for compliance with the Employee Retirement Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirement contained therein. PALIC is not acting as a sponsor as defined in ERISA.

Please check the appropriate box:

☐ We hereby certify that the premium for the insurance coverage is paid by the company or that the company is making a contribution towards each employee's insurance premium.

☐ We hereby certify that the premium for the insurance coverage is being payroll deducted from each applicant's earning only as a convenience to the employee and that our only function will be to remit the premium payment to PALIC within the required 31 day grace period provided by the policy(ies).

Please indicate below whether a list of applicants will be provided by completing the attached List Bill New Business Transmittal form or by attaching an equivalent employee census.

☐ All applicants to be enrolled are listed in the attached PALIC's List Bill New Business Transmittal form.

☐ Attached is employee census data of all applicants to be considered for enrollment.

_____ _____

SIGNATURE OF EMPLOYER / ADMINISTRATOR DATE

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY®

List Bill New Business Transmittal
- Contingent Issue-

List Billing Plan: ☐ New Plan or ☐ Addition to Plan

Date

Name of Company | Company Phone # | List Bill #

Billing Address

City | State | Zip

Payroll Contact | Phone Number (Extension) | Email Address

Agent Name | Agent # | Agent Phone Number | Agent Email Address

Initial Premium ☐ Check Enclosed ☐ Bill Account Billing Frequency: ☐ Monthly ☐ Other

*Mode of payment other than monthly requires prior Home Office Approval

New employees are eligible for benefits in: ☐ 30 days ☐ 60 days ☐ 90 days ☐ days

Requested Effective Date | Date of 1st Payroll Deduction | Number of Eligible Employees

Send Policies to: ☐ Agent ☐ Employer ☐ Employee

List Bill/Application Fee $

Indicate the type of policy being applied for within this enrollment. List all applicants below or attach equivalent census:

Name of Applicant Last, First MI (Please Print)	Employment Date For New Employee Additions	Plan Type	Last 4 Digits of Employee's SS#	Monthly Deduction Amount	If employee did not elect to participate in the health insurance program please explain:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

We attest that during the past three (3) months, except for minor illness of one (1) week or less or pregnancy, that the employees listed above have not had any illness, injury or health related problem that has prohibited any proposed insured from working full time at his/her regular occupation or performing the normal activities of a person of the same age.

SIGNATURE OF ADMINISTRATOR

DATE