

# APPLICATION FOR GROUP LONG TERM DISABILITY INCOME INSURANCE



P.O. Box 7777; Meridian, ID 83680-7777

1. Legal Name of Policyholder <span style="float: right;">( ) Corporation ( ) Partnership ( ) Sole Proprietor</span>	
2. Address of Policyholder	3. Telephone
4. Name of Subsidiaries, Divisions or Affiliates to be Covered <u>Name</u> <span style="margin-left: 150px;"><u>Address</u></span>	Effective Date of Coverage <span style="margin-left: 50px;">Number of Employees</span>
5. Person Responsible for Administration	
6. Nature of Business	7. Tax ID Number
8. Effective date - 12:01 A.M.  Month _____ Day _____ Year _____	9. Deposit of \$ _____ to apply on the First Premium.
<b>EMPLOYEE ELIGIBILITY:</b>	
10. Eligible Classes	
11 . Waiting Period:  Present Employees _____  New Employees _____	12. Eligible Employees Must Work  at least _____ Hours per Week and be reported for social security purposes.
13. Number of Employees: A. _____ Eligible B. _____ Enrolled	14. Will Employees Contribute Towards Cost? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, employees will contribute _____
<b>POLICY FEATURES:</b>	
15. Amount of Insurance _____ % of Basic Monthly Earnings not to Exceed a Maximum Monthly Benefit of \$ _____	
16. Elimination Period  _____ Days or the end of sick leave, whichever is greater	17. Pre-Disability Earnings will include <input type="checkbox"/> Commissions <input type="checkbox"/> Bonuses <input type="checkbox"/> Other _____
18. Definition of Disability  A. <input type="checkbox"/> Own Occupation <input type="checkbox"/> _____ month Own Occupation <input type="checkbox"/> _____ month Reasonable Alternative <input type="checkbox"/> Any Occupation	19. <input type="checkbox"/> Continue coverage during temporary layoff or leave of absence for ( ) one ( ) two ( ) three ( ) four months.  <input type="checkbox"/> Continue coverage during family or medical leave.

**MAXIMUM BENEFIT DURATION**

20.  Reducing Benefit Duration  
 Reducing Benefit Duration with social security normal retirement age  
 2 Year - Reducing Benefit Duration  
 5 Year - Reducing Benefit Duration

21. Options:  
 Family Care Credit  
 Survivor Benefit  
 Lump Sum Benefit  
 Flat Benefit  
 Monthly Installment  
 Infectious and Contagious Disease Benefit

- Extended Earnings Protection Benefit  
 Accidental Dismemberment and Loss of Sight Benefit  
 Activities of Daily Living Benefit  
 Pension Contribution Benefit  
 Work Place Modification Benefit

**CONTINUITY OF COVERAGE:**

22. Is this a Replacement of Similar Coverage?  
 Yes  No

23. Previous Company

24. Termination Date of Prior Plan

25. Agent of Record (provided he is duly licensed as required by law):

Agent's Name \_\_\_\_\_ Agency Name \_\_\_\_\_

Pay commissions to:  Agent  Agency

26. W-2 Services Option

\_\_\_\_\_ Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.

\_\_\_\_\_ Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established standard procedures.

27. The Applicant agrees that in no case will the policy become effective if:

- (a) less than \_\_\_\_\_ persons are enrolled for insurance;
- (b) for non-contributory plans, less than 100% of the eligible persons enroll for insurance;
- (b) for contributory plans, less than 75% of the eligible persons enroll for insurance;
- (c) for voluntary plans, less than \_\_\_\_\_% of the eligible persons enroll for insurance.

All eligible persons will be given an opportunity to apply for insurance and to make the required premium contributions, if any.

28. The Applicant agrees that no insurance shall take effect unless this application is approved by the Home Office of United Heritage Life Company, Meridian, Idaho.

29. This Application supersedes any previous application for this insurance coverage.

*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, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties.*

Dated at \_\_\_\_\_, State of \_\_\_\_\_, the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Witness \_\_\_\_\_ Applicant \_\_\_\_\_

By \_\_\_\_\_

Title \_\_\_\_\_