

APPLICATION FOR GROUP LIFE INSURANCE



P.O. BOX 7777, MERIDIAN, IDAHO 83680-7777

1. Legal Name of Policyholder																	
2. Address of Policyholder	Telephone																
3. Name of Subsidiaries, Divisions or Affiliates to be Covered	4. Person Responsible for Administration of the Plan:																
5. Nature of Business																	
6. Effective date - 12:01 A.M. Month _____ Day _____ Year _____	7. Deposit of \$ _____ to apply on the First Premium.																
EMPLOYEE ELIGIBILITY:																	
8. Eligible Classes	9. Eligible Employees Must Work at Least _____ hrs. Per Week and be reported for Social Security Purposes.																
10. Employees will be Eligible after Working for the Policyholder: Present Employees _____ Months/Days New Employees _____ Months/Days	11. Waiting Period waived if Rehired in _____ months. () Yes () No																
12. Number of Employees: _____ Eligible _____ Enrolled If dependent benefits are included, number of eligible employees with eligible dependents: _____ Eligible _____ Enrolled																	
13. Employees are required to contribute towards cost: Employee Insurance: () Yes () No If yes, the Employee will contribute _____. Dependent Insurance: () Yes () No If yes, the Employee will contribute _____.																	
POLICY FEATURES: (enter information from proposal)																	
14. Employee Classification	<table style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center; border-bottom: 1px solid black;">Amount of Insurance</th> </tr> <tr> <th style="width: 50%; text-align: center; border-bottom: 1px solid black;">Life</th> <th style="width: 50%; text-align: center; border-bottom: 1px solid black;">AD & D</th> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> <tr> <td style="border-bottom: 1px solid black;"> </td> <td style="border-bottom: 1px solid black;"> </td> </tr> </table>	Amount of Insurance		Life	AD & D												
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15. Dependent Group Life Insurance: () Yes () No If yes, complete this section.																	
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Spouse	_____	Children: _____	_____														
	_____	_____	_____														
	_____	_____	_____														
16. Accelerated Death Benefit: () Yes () No If yes, () Employee only () Employee & Dependents																	

17. Accidental Death & Dismemberment Benefits (AD&D):
 24-Hour or Non-Occupational
 Additional AD&D Benefits:
 Common Carrier Seat Belt/Air Bag Day Care Felonious Assault
 Education Repatriation Rehabilitation Spouse Education
 Adaptive Home and Vehicle Coma Critical Burn Therapeutic Counseling

18. Employee Supplemental Life Insurance Yes No If yes, complete this section.

Employee Classification	Amount of Supplemental Insurance	
	Life	AD & D
_____	_____	_____
_____	_____	_____
_____	_____	_____

19. Dependent Supplemental Life Insurance: Yes No If yes, complete this section.

Classification	Amount of Insurance	Classification	Amount of Insurance
Spouse	_____	Children: _____	_____
		_____	_____
		_____	_____

20. Does coverage continue for retired employees? Yes No If yes, complete the Retiree Specification sheet.

21. Is this a Replacement of Similar coverage? Yes No If yes, termination date of prior plan _____
 Previous Company _____

22. Agent of Record (must be licensed as required by law): _____

23. The Applicant agrees that if the entire premium is paid for by the applicant, all eligible employees and dependents will be enrolled and reported to the Company as they become eligible.

24. The Applicant agrees that if eligible employees are required to contribute towards the cost, all eligible employees will be given an opportunity to enroll for insurance and to make the required premium contribution; and at least _____% of the eligible persons will be enrolled, for contributory coverage; and/or at least _____% of the eligible persons will be enrolled for voluntary coverage.

25. The Applicant agrees that no insurance shall take effect unless this application is approved by United Heritage Life Insurance Company, Meridian, Idaho.

26. This Application supercedes any previous application for this insurance coverage.

Dated at _____ on _____
 (City & State) (Date)

Witness _____ Applicant _____

By _____

Title _____