

APPLICATION FOR GROUP SHORT TERM DISABILITY INCOME INSURANCE



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

1. Legal Name of Policyholder _____		() Corporation () Partnership () Sole Proprietor
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. Tax I.D. Number _____	
7. Effective date - 12:01 A.M. Month _____ Day _____ Year _____	8. Deposit of \$ _____ to apply on the First Premium.	
EMPLOYEE ELIGIBILITY:		
9. Eligible Classes _____	10. Eligible Employees Must Work at Least _____ Hours Per Week and be reported for Social Security Purposes.	
11. Employees will be Eligible after Working for the Policyholder: Present Employees _____ Months/Days New Employees _____ Months/Days	12. Prior Employment to Count for Persons Rehired () Yes () No If Yes, Must be Rehired Within _____ Months	
13. Number of Employees: _____ Eligible _____ Enrolled	14. Do you have Similar Group Coverage In-Force simultaneously with this plan? () Yes () No	
15. Insured Persons are required to contribute towards cost: () Yes () No If yes, the Insured Person will contribute _____		
POLICY FEATURES:		
16. Weekly Benefit: _____ % of Weekly Earnings to Maximum of \$ _____ Per Week.		
17. Elimination Period: Injury _____ Days; Sickness _____ Days; 0 Days, if Hospital Confined () Yes () No		
18. Maximum Payment Duration: _____ Weeks		
19. Weekly Earnings to Include: Commissions () Yes () No; Other _____		
20. Definition of Disability: () Extended with Residual, () Extended without Residual, or () Total		
21. Social Security Integration: () Primary or () Primary & Family		
CONTINUITY OF COVERAGE:		
22. Is this a Replacement of Similar Coverage? () Yes () No	23. Termination Date of Prior Plan _____	24. Previous Company _____

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

24. 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.

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

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

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application for insurance or files a claim containing a materially false or deceptive statement may be guilty of insurance fraud.

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

Witness _____ Applicant _____

By _____

Title _____