



P.O. Box 1650  
Little Rock, Arkansas 72203

# Employer Group Trust Participation Application & Agreement

Office Use Only	
Policy #	
Effective Date	

1. Legal Name			Taxpayer ID#		
2. Mailing Address		City	State	Zip+4	
3. Street Address (if different from above)		City	State	Zip+4	
4. Name of CEO, President or Owner of Company		Name of Insurance Contact at Company		Telephone Number	Fax Number
5. Nature of Business		SIC Code	Effective as of 12:01 a.m.	Premium Deposit	Billing Mode
6. Waiting Period <u>Life, AD&amp;D, Dependent Life and STD:</u> <input type="checkbox"/> First of the month following completion of _____ days (minimum 30 days for Life, AD&D, Dep Life, & STD) <u>Long Term Disability:</u> <input type="checkbox"/> First of the month following completion of _____ days (minimum 90 days for LTD) <i>All effective dates must be first of the month.</i>		Waiting Period applies to: <input type="checkbox"/> Future Employees Only <input type="checkbox"/> Present & Future Employees			Number of Employees Eligible _____ Enrolled _____
7. Life/AD&D <input type="checkbox"/> Flat Amount \$ _____ per employee (minimum \$15,000; maximum \$100,000, elected in \$5,000 increments) <input type="checkbox"/> Multiple of annual salary to a maximum of \$100,000: <input type="checkbox"/> 1 times <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times (rounded to the next higher \$1,000) <input type="checkbox"/> All employees according to the following occupational schedule:					
Class	Job title, as shown on enrollment form		Life/AD&D Amount	STD Amount (if elected)	
1.					
2.					
3.					
(No Class may have a benefit greater than 2 1/2 times the amount for the next lower class.)					
8. Dependent Life (available if Life/AD&D selected) <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2					
Spouse \$10,000 \$5,000					
Child (birth to 6 months) \$100 \$100					
Child (6 months to age 19*) \$5,000 \$5,000					
*to age 23 if full time student					
9. Short Term Disability (STD) (available if Life/AD&D or LTD selected) <input type="checkbox"/> Yes <input type="checkbox"/> No					
Elimination Period/Duration:		Benefit Amount:			
<input type="checkbox"/> 1-8-13 <input type="checkbox"/> 1-8-26		<input type="checkbox"/> Percentage of weekly income: <input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 66 2/3% to maximum of \$ _____ (\$50 – \$750)			
<input type="checkbox"/> 8-8-13 <input type="checkbox"/> 8-8-26		<input type="checkbox"/> Flat Amount of \$ _____ (\$50 increments to a maximum of \$250)			
<input type="checkbox"/> 15-15-13 <input type="checkbox"/> 15-15-26		<input type="checkbox"/> Class Defined Plan (fill in STD Amount column in number 7 above)			
Maximum: The maximum weekly STD benefit may not exceed 66 2/3% of an insured's weekly income.					
10. Long Term Disability (LTD) (available if Life/AD&D or STD selected) <input type="checkbox"/> Yes <input type="checkbox"/> No					
Elimination Period:		<input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days			
Maximum Benefit Period:		<input type="checkbox"/> Social Security Normal Retirement Age (Sickness or Accident)			
		<input type="checkbox"/> 5 years (Sickness or Accident)			
Amount of Insurance:		<input type="checkbox"/> 60% of monthly salary to a maximum of <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000			
Pre-existing Conditions Exclusions/Limitations: 12/6/24					
The Minimum Monthly Benefit is \$100.00 or 10% of the Monthly Disability Benefit, whichever is greater.					
Policy Features include: • 24 Month Own Occupation • Three month Survivor Benefit • Direct Integration with Return to Work Incentive					
• Rehabilitation • 24 Month Mental Illness & Substance Abuse • Family Care Credit • Workplace Modification • Waiver of Premium and					
• Primary and Family Social Security Integration					
Is this a replacement of similar coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Prior Carrier _____					
Date Terminated _____ Also if there was a prior carrier, a copy of prior plan is <b>required</b> for claims administration.					
Are premiums sheltered under a Section 125 Cafeteria plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
11. Contributions (Applies to all coverages unless otherwise stated. Employer must contribute at least 25% of cost.)					
<input type="checkbox"/> Non-contributory (employer pays 100% of cost) <input type="checkbox"/> Contributory, employer pays _____% of cost					

Legal Name		Taxpayer ID#	
12. <input type="checkbox"/> I certify that all employees are actively at work at their usual place of business today. <input type="checkbox"/> There are employees who are not actively at work at their usual place of business today. Please complete the following:			
Name	Date Last Worked	Expected Return to Work Date	Reason for Absence
13. General Conditions <ul style="list-style-type: none"> <li>• Eligibility: All full-time employees who work a minimum of 30 hours per week on a year round basis. Coverage does not include temporary, seasonal or retired employees.</li> <li>• Employees must be actively at work on their effective date for coverage to be effective.</li> <li>• Participation Requirement: 2 to 4 lives – 100%; 5 to 7 lives – All but 1 must enroll; 8 to 9 lives – All but 2 must enroll.</li> <li>• Evidence of Insurability (EOI) is required on Life and AD&amp;D and LTD amounts in excess of the guaranteed issue and on all late applications for contributory coverage.</li> <li>• Life and AD&amp;D insurance reduces to 65% at age 65; to 50% of the original amount at age 70; and to 25% of the original amount at age 75. All benefits terminate at retirement.</li> </ul>			
I hereby apply for the coverage noted above and certify that all responses are true, complete, and correctly recorded, and I have read and understand the <b>Notice to Applicants</b> below. <b>Warning</b> - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.			
Applicant's Signature	Print Name and Title	Date	
Representative's Signature (Must be resident licensed agent)	Print Representative's Name	Date	

### Notice to Applicants

1. USABLE Life coverage is not effective until this application is approved and accepted by the home office of USABLE Life. This application is to participate in the Trust policy covering the following eligible participants: A Massachusetts employer with at least two but less than ten eligible employees on the date of issue.
2. This application for participation will also be offered as an inducement for the issuance of group insurance. It will form a part of the group policy issued to the USABLE Life Group Insurance Trust.
3. The Participating Employer will furnish and maintain the records necessary for the administration of the plan and will report changes to USABLE Life.
4. The initial employee participation requirement must be satisfied and maintained or exceeded in order for coverage to remain in force.
5. If the application is not accepted, no insurance will become effective and any premium advanced will be refunded. No individual will be covered unless he or she is eligible under the terms of the policy.
6. Coverage will automatically terminate if the premiums are not paid before the end of the 31-day grace period following the due date. Payment of premiums for coverage provided during the grace period is required.

Remarks (Identify by number.)