



GROUP LONG TERM DISABILITY INSURANCE APPLICATION

Type Or Print In Black Ink

P.O. Box 1650
Little Rock, Arkansas 72203

1. Legal Name of Policyholder, Taxpayer ID#, Home Office Use - Group #
2. Mailing Address of Policyholder, City, State, Zip+4
3. Street Address of Policyholder (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 of Policyholder
5. Name of Subsidiary or Affiliate Companies to be Covered, Email Address for Company Contact, Fax Number of Policyholder
6. Nature of Business, SIC Code, Billing Method
7. Effective Date as of 12:01 a.m., First Anniversary Date, Number of Employees
8. Do you have any employees located in states other than the policyholder's main address?
9a. Eligibility Waiting Period
9b. Eligibility Waiting Period Applies to:
9c. Employer Contribution
10. Class Definitions
11. AMOUNT OF INSURANCE
12. BENEFIT CALCULATION:
13. Elimination Period
14. Pre-Existing Conditions Exclusion
15. MAXIMUM DURATION OF BENEFIT PERIOD

