ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 434-9500 • (800) 573-9144 • FAX (402) 437-3634

Application for INSURANCE
PLEASE PRINT WITH BLACK INK

GROUP SUPPLEMENTAL MEDICAL EXPENSE REIMBURSEMENT INSURANCE APPLICATION

California Insurance Law requires that You, the Proposed Insured, are covered by an individual or group contract that arranges or provides comprehensive health insurance or HMO plan including medical, hospital and surgical coverage to be eligible to purchase a group supplemental medical expense reimbursement policy.

Are You, the Proposed Insured, currently insured for comprehensive health care? ..... ☐ Yes ☐ No
*(If your answer is **NO** you are not eligible to apply for this policy.)*

1. a. Name of group applicant _____

   Address _____
   Street *City* *State* *Zip Code*

   b. Federal I.D. no. _____ c. Phone no. *(including area code)* _____

2. Names and locations of any subsidiaries or affiliates to be insured _____

3. Requested effective date of insurance: First day of _____, 20____

4. Nature of business _____

5. Type of business: ☐ C Corporation ☐ Partnership ☐ S Corporation ☐ Sole Proprietor ☐ Other *(type)* _____

6. Name and title of applicant/employer contact _____

7. Amount of premium submitted with the application $ _____

8. a. Classes of eligible employees *(and any outside directors, retired employees or surviving spouses):*

   (1) _____ (4) _____
   (2) _____ (5) _____
   (3) _____ (6) _____

   b. Total number of employees *(including those ineligible for coverage)* _____

   c. Total number of eligible employees _____

   d. Total number of eligible outside directors *(if any)* _____

   e. Total number of eligible retired employees and surviving spouses *(if any)* _____

   (Individual enrollment cards must be completed and signed by all eligible persons.)

9. Plan: a. ☐ $100,000 b. ☐ $200,000

10. Carrier underwriting base health plan _____

11. Have you had group insurance with Assurity Life Insurance Company before? ☐ Yes ☐ No

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 civil penalties.

Signed at *(City, State)* _____ Date signed *(MM/DD/YYYY)* _____

Applicant signature _____ Printed name and title _____

Signature of witness _____ Witness's printed name _____

Agent name _____ Agent's state license no. _____

Taxpayer I.D. no. _____ Phone no. *(including area code)* _____

Agent's firm _____ Firm's address _____

Plan is administered by BeniComp, Inc. • Bus No. 800.837.7400 • Fax No. 260.483.6255
Send correspondence to: BeniComp, Inc., 8310 Clinton Park Drive, Ft. Wayne, IN 46825