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

NOTICE: This Supplemental Only Policy may only be issued if a comprehensive major medical or comprehensive medical plan is in force. The company should be notified immediately if your comprehensive coverage is terminated.

A. Do you have a comprehensive medical policy? *(If you answer **NO** to this question you are not eligible for a Supplemental Only Policy.)* .... ☐ Yes ☐ No

B. Do you understand most supplemental only policies may not pay full benefits if the comprehensive major medical or comprehensive medical plan is **not** in force? ..... ☐ Yes ☐ No

C. Do you understand that this is a supplemental only policy and that the benefits provided under this policy may be limited? ..... ☐ Yes ☐ No

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 no. of employees *(including those ineligible for coverage)* _____ c. Total no. of eligible employees _____

   d. Total no. of eligible outside directors *(if any)* _____ e. Total no. 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

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