

**GROUP SUPPLEMENTAL MEDICAL EXPENSE REIMBURSEMENT INSURANCE APPLICATION**

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 Security Financial Life Insurance Co. before?  Yes  No

**FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

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

