

Please type or print

**REQUESTED EFFECTIVE DATE** \_\_\_\_\_

**APPLICANT**

**Full Legal Name of Group** (Exactly as it is to be shown in the policy.)  
\_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_ FAX Number ( \_\_\_\_\_ ) \_\_\_\_\_

Group Contact \_\_\_\_\_ Contact's Title \_\_\_\_\_

Contact's Phone No. if different ( \_\_\_\_\_ ) \_\_\_\_\_ Contact's FAX No. if different ( \_\_\_\_\_ ) \_\_\_\_\_

**Nature of Business** \_\_\_\_\_

**INSURANCE COVERAGE REQUESTED**

- |   |   |  |   |                                |
|---|---|--|---|--------------------------------|
| <input type="checkbox"/> Life Only      | <input type="checkbox"/> Supplemental Life        | <input type="checkbox"/> Dental/Employees            | <input type="checkbox"/> LTD                                  | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Life & AD&D    | <input type="checkbox"/> Additional/Optional Life | <input type="checkbox"/> Dental/Employees and Dep(s) | <input type="checkbox"/> STD                                  | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dependent Life | <input type="checkbox"/> Stand Alone AD&D         | <input type="checkbox"/> Dental/Orthodontia          | <input type="checkbox"/> LTD with Transitional Duty Agreement |                                |

**OTHER INSURANCE**

A. Does this insurance supplement other insurance?  Yes  No  
If yes, specify for each line of coverage and Insurance Carrier: \_\_\_\_\_

B. Does this insurance replace existing insurance?  Yes  No  
If yes, specify for each existing line of coverage: \_\_\_\_\_  
• Please submit a copy of each in force policy, certificate or plan document.  
Effective date of Prior Plan: \_\_\_\_\_ Termination date of Prior Plan: \_\_\_\_\_

**ACTIVE WORK REQUIREMENT:** A person must meet an Active Work requirement to become insured. Members who have not met an Active Work requirement are not insured until returning to work for one full day and meeting all other contractual requirements.

**Initial:** \_\_\_\_\_

*Note: Some members who do not meet an Active Work requirement may be eligible for Waiver of Premium with a prior carrier. The Active Work requirement does not apply to Dental coverage.*

**APPLICANT AGREES THAT: I hereby apply for Group Insurance as provided in the attached proposal.**

The above information is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. If the requested insurance is acceptable to Standard Insurance Company under its current rules and practices and is legally permissible, a Group Policy will be issued in the language customarily used by Standard. It will be effective on the date determined by Standard. No producer has the authority to guarantee the acceptability of the requested insurance.

Standard may issue separate Group Policies if more than one coverage is requested in this Application. The insurance, if approved, will be subject to Standard Insurance Company's usual underwriting requirements, including the exclusions and limitations in the Group Policy and, if applicable, Evidence Of Insurability. The effective date of insurance for which a person is required to submit satisfactory Evidence Of Insurability will be determined in accordance with the terms of the Group Policy, subject to the Active Work requirement. No premiums will be collected or paid by the Applicant for such insurance until notification of approval.

No material describing coverage under the Group Policy will be distributed by the Applicant to any person to be insured without the prior written consent of Standard Insurance Company.

Premium rate quotations were based on data submitted to Standard. Final premium rates will be determined by the actual composition of the group.

The consideration for any Group Policy which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the Group Policy is acceptance of the terms of the Group Policy.

This Application is made a part of the Group Policy.

Applicant authorizes the producer, broker of record, or consultant to receive information regarding the applicant's claims status and experience that the applicant has a right to receive and which is reasonably necessary to assist the applicant in conducting a review of the information.

\_\_\_\_\_  
Signature and Title of Applicant's Authorized Representative

\_\_\_\_\_  
Date  
(Must be signed or submitted prior to the requested effective date.)

Initial Deposit \$ \_\_\_\_\_

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Received from \_\_\_\_\_, an initial deposit of  
\$ \_\_\_\_\_\* in connection with the Application for Group Insurance bearing the same date as this conditional receipt.

Date \_\_\_\_\_

***This receipt is subject to the terms and conditions below.***

Received By

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Name	Title
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\*All premium checks must be made payable to Standard Insurance Company.

Do not make check payable to the producer or leave payee blank.

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***Terms of Receipt (Please read carefully.)***

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*No material describing coverage under the Group Policy will be distributed by the Applicant to any person to be insured without the prior written consent of Standard insurance Company*

*Premium rate quotations were based on data submitted to Standard. Final premium rates will be determined by the actual composition of the group.*

*The consideration for any Group Policy which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the Group Policy is acceptance of the terms of the Group Policy.*

*This Application is made a part of The Group Policy.*