



417 Washington Street  
Columbus, IN 47201  
800-443-2980

# INSURANCE APPLICATION EMPLOYER APPLICATION FORM

GROUP #: \_\_\_\_\_

Effective Date: \_\_\_\_\_

## Employer Information

Legal name of Business: \_\_\_\_\_

Billing/Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Administrative Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Would you like to receive Invoices via email? Yes  No

Type of Business: \_\_\_\_\_

Standard Industry Code (SIC): \_\_\_\_\_ Tax ID/FEIN: \_\_\_\_\_

Affiliates/ subsidiaries/ divisions to be included under coverage (list names, locations, number employed at each location):  
\_\_\_\_\_

Total number of employees: \_\_\_\_\_ Total number of ELIGIBLE (Actively Working) employees: \_\_\_\_\_

Total number of employees on COBRA: \_\_\_\_\_ List employees/ dependents on Continuation of Coverage/ COBRA:  
\_\_\_\_\_

**COBRA:** Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.  
**Medicare:** Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact their legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine Medicare status.

Do you offer coverage to early retirees under age 65?: \_\_\_\_\_ Do you currently have early retirees under age 65 covered?: \_\_\_\_\_

Total number of early retirees under age 65 covered?: \_\_\_\_\_

Does group have a cafeteria plan under IRS Section 125:  Yes  No

Name of prior health and/ or life carriers within the last five years (if more than one carrier, include length of time covered by each):  
\_\_\_\_\_

**Please provide a copy of Quarterly Tax and Wage Statement or Participation Affidavit (if you do not file Quarterly Tax and Wage Statements).** Please indicate which employees are full-time, part-time, terminated and add new hire names. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligibility waiting period.

Do you have more than one business location? Yes  No  If "yes" list physical and billing/ mailing address for each.

Billing/Mailing address (Location 2): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Physical Address (Location 2): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Administrative Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

## Plan Section

Please circle one choice in each column:

Select Product	Landmark Combined		Deductible Amount
Prime Care Choice	Yes	No	\$500
HSA	Yes	No	\$1,000
HRA	Yes	No	\$1,500
SIHO Secure	Yes	No	\$2,000
Care Plus	N/A		\$2,500
			\$3,500
			\$5,000
			\$7,500
			\$10,000

**Enrollment status for which you are Applying/Enrolling.** Please indicate Coverage Type for each Plan you are eligible for:

Coverage Type	Plan
E Employee Only	Medical _____
ES Employee & Spouse	Dental _____
EC Employee & Children	Vision _____
F Employee & Family	

**Voluntary Plan(s) Selected:**

Choose one Dental Plan:	Choose one Vision Plan:
_____ Preferred	_____ 12 months/12 months
_____ Standard	_____ 12 months/24 months
_____ Value	

Life Insurance Amount: (Please Circle All that Apply)

\$15,000	\$20,000	\$25,000
\$30,000	\$40,000	\$50,000

Would you like to offer Dependent Life Insurance?: \_\_\_\_\_

**Waiting Period for New Employees**

- Option 1: First of the month following  0  30  60  90 ... days of employment  
 Option 2:  0  30  60  90 ... days from the date of hire  
 Other: \_\_\_\_\_

## Employer Contribution

Employer's declaration of contribution toward monthly premium (*indicate the amount—either in dollars or percentage in premium—employer is committing to; please make this as complete and as thorough as possible, particularly relative to the different enrollment/status tiers if there is some contribution toward them*):

## Agreement

As the representative of the above Company, I acknowledge and declare that I have been made aware of the requirements for the above total replacement coverage including a continuous minimum employer contribution or payment of premium, and a continuous minimum eligible employee participation requirement for this to be considered an eligible group. I understand that in calculating the participation percentage of total full-time employees that ultimately elect coverage, that employees covered under spousal coverage do not count but that under no circumstances will coverage be available if less than 50% of all full-time employees do not elect to participate. Also, I understand that two employees who are husband and wife, or otherwise related in such a way that they can be combined for personal tax purposes under the code of the Internal Revenue Service will be considered as one employee for determining participation compliance for this group to be considered eligible for coverage.

I further certify that I have read the above statements and I declare and agree that the above responses/ answers are, to the best of my knowledge and belief, complete and true and, together with any supplements thereto, shall be the basis for any policy of coverage issued. I understand and agree that no agent has the authority to waive a complete answer to any question of this application or any other which is involved in this acquisition of coverage process, nor to pass on coverage/ insurability, make or alter any contract, or waive any of the rights or requirements of SIHO. I hereby agree that no coverage will be effective until the date specified by SIHO on the policy of coverage after this application has been accepted. I understand that any misrepresentation contained herein or within the related application which is relied on by SIHO may be used to modify or void the contract within the contestable period if such misrepresentation materially affects the acceptance or the evaluation of the risk.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I understand that any claims for benefits or disputes relative to any coverage placed with SIHO will be resolved according to Group Policy.

Are you a member of the Chamber of Commerce?  Yes  No

If yes, which one? \_\_\_\_\_

Date: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

Employee's Position with Company: \_\_\_\_\_

Employer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's Name: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_

Agent's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Agent's email address: \_\_\_\_\_

For Dental and Vision Coverage (if selected): The Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-39160 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

For Dental and Vision, as an agent are you appointed by Security Life? Yes  No

## SIHO Dental and Vision Plan Election

### SIHO Dental

If employer group has fewer than 50 eligible employees, group must select one plan option. If group has 50 or more eligible employees the group MAY offer 2 plan options.

Plan Selection: Preferred  Standard  Value

Increase to Annual Maximum: Increase by \$500  Increase by \$1,000   
(Available for Preferred and Standard Plans only)

There are initially \_\_\_\_\_ employees enrolled in the Dental Plan

### Current Dental Plan

Is the Group currently enrolled under another group dental program? Yes  No

Is Credit for Previous Time (CPT) requested? Yes  No

If Yes, please include a copy of the current plan benefits and last billing.

### Agreement

The undersigned Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under Group Dental Policy GH-1112-39160 insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.

Employer agrees to make such benefits available to all present employees and all employees becoming eligible in the future and to make payroll deductions as required by the plan as applicable to the employees. The employer agrees that at least two (2) employees must be enrolled in the plan to prevent cancellation of coverage. The plan does not require any premium contribution from the employer.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Employees Position with Company \_\_\_\_\_

### SIHO Vision

If employer group has fewer than 50 eligible employees, group must select one plan option. If group has 50 or more eligible employees the group MAY offer 2 plan options.

Plan Selection:  12/12 Plan (9657966)  12/24 Plan (9657974)

There are initially \_\_\_\_\_ employees enrolled in the Vision Plan

### Agreement

Employers agrees to make such benefits available to all present employees and all employees becoming eligible in the future and to make payroll deductions as required by the plan as applicable to the employees. The employer agrees that at least two (2) employees must be enrolled in the plan to prevent cancellation of coverage. The plan does not require any premium contribution from the employer.

Employer declares that to the best of their knowledge and belief that statements and answers are complete and true. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Employees Position with Company \_\_\_\_\_

