



Insurance Applied For

[The Premium Saver]

[Form AF-PSPGRP-P-25 (08/02) Supplemental Health Insurance (Premium Saver)]

[Are all Eligible Persons covered by a Major Medical Plan or Comprehensive Health Plan?  Yes  No

Who is the Major Medical Carrier? \_\_\_\_\_

What is the Major Medical Deductible Amount \$ \_\_\_\_\_

What is the Major Medical Co-Insurance Out of pocket Amount \_\_\_\_\_ % \_\_\_\_\_

**Important Note: Any person who is not insured by a Major Medical Plan or Comprehensive Health Plan is not eligible for insurance under this policy form**

**All persons (100 %) insured by this groups Major Medical or Comprehensive Health Plan must be covered by the Premium Saver Plan**

Employer will pay \_\_\_\_\_% of Employee Costs and \_\_\_\_\_% of Dependent Costs]

**Premium Saver Plan Design**

1. SUPPLEMENTAL DEDUCTIBLE (amount each insured pays each calendar year) \$ \_\_\_\_\_

2. SUPPLEMENTAL CO-INSURANCE (amount each insured pays each calendar year) \$ \_\_\_\_\_ OUT OF POCKET % \_\_\_\_\_

3. MAXIMUM TOTAL BENEFIT AMOUNT \$ \_\_\_\_\_

4. INDICATE HERE IF THE OUTPATIENT BENEFIT AMOUNT IS LIMITED \_\_\_\_\_ \$ \_\_\_\_\_

5. INDICATE HERE IF RIDERS ARE TO BE INCLUDED ( special rates apply - not available in all states)

A. CREDIT FOR PRIOR PLAN DEDUCTIBLE RIDER \_\_\_\_\_

B. ALLIED SERVICE RIDER \_\_\_\_\_

C. PRESCRIPTION DRUG RIDER B1 \_\_\_ B2 \_\_\_ G1 \_\_\_ G2 \_\_\_

7. COVERAGE \_\_\_ DEDUCTIBLE OR \_\_\_ DEDUCTIBLE AND CO-INSURANCE

8. COMMENTS \_\_\_\_\_

**Requested Effective Date** \_\_\_\_\_

**Payroll and Billing Information (Check All That Apply) For Normal Payday, Give Day of Week (Monday, Friday, etc.)**

<input type="checkbox"/> Weekly Normal Payday: _____	<input type="checkbox"/> Bi-Weekly (Every other Week) Normal Payday: _____
<input type="checkbox"/> Semi-Monthly (Twice per Month) Normal Pay Dates: _____ and _____ day of the month.	<input type="checkbox"/> Monthly Normal Pay Date: _____ day of the month.
<input type="checkbox"/> Other: _____	Billings must be: <input type="checkbox"/> Alphabetic <input type="checkbox"/> Numeric by Social Security Number <input type="checkbox"/> Numeric by Employee Number

**ALL PREMIUMS ARE PAYABLE IN ADVANCE OF THE EFFECTIVE DATE OF INSURANCE.**

On behalf of the Applicant, this Application for Group Insurance is signed by

X \_\_\_\_\_ Print Name \_\_\_\_\_  
Official Title \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_

Agent Name (print) \_\_\_\_\_ Signature \_\_\_\_\_