

**Application for Group Accident Limited Benefit Insurance to:
Standard Life and Accident Insurance Company**

Administrative Office:

**5722 I-55 North Frontage Road • Jackson, MS 39211
or P.O. Box 14067 Jackson, MS 39236**

The Information provided by the Applicant in this Application will be the basis on which any insurance is issued. Incorrect information could void Insurance.

Legal Name of Employer (include d/b/a):		Employer Identification Number	
Principal Business or Activity		SIC Code	
Physical Address: (Street Number and Name)		Billing Address: (If bill is to be split and sent to more than one billing address please indicate here and give addresses on an attached sheet.)	
City		City	
State	Zip	State	Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:
Email Address:	Email Address:
Fax Number	Fax Number

Employer's Major Medical or Comprehensive Plan Data

Major Medical Plan Carrier _____
Major Medical Deductible Amount \$ _____
Major Medical Coinsurance % _____ to Maximum Out of pocket (Coinsurance Limit) Amount \$ _____
Are Major Medical Deductibles & Coinsurance per Plan Year or per Calendar Year? _____
Major Medical Plan Anniversary Date _____
Number of Covered: Employees _____ Dependent Spouses _____ Dependent Children _____

Eligibility

Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:

Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee)

[All active full time employees working 18 hours or more per week and who are under the age seventy will be eligible for coverage. Each insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the insured becomes eligible for insurance;
2. or The day the Insured acquires his or her first dependent]

Eligible Person - If employer participates in paying the premiums

1. [An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan.] Eligible new employees or dependents may be added subject to the terms of the Policy.

Eligibility/Waiting Period: _____

{Eligible Classes: _____}

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the Termination of Coverage Provisions of the Policy.

Insurance Applied For

Employer Contribution ___ {Premium Saver Plan} ___ {HSA Saver Plan} ___ {Med Bridge Plan}
Voluntary (Employee Paid Plans) ___ {Med Bridge Plan}

Requested Effective Date: _____

Employer will pay _____% or \$_____ of Employee Costs and _____% or \$_____ of Dependent Costs

{Important Note: All persons (100 % participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be covered on Employer Contribution plans listed above.

Plan Design Selection

ATTACH FLIER OR PROPOSAL THAT DESCRIBES THE SPECIFIC BENEFITS

Applicable to {all} {Accident}{Sickness}{Inpatient}{and}{Outpatient} Benefits {Only}

Deductible: \$_____ Coinsurance: _____% Out-of-Pocket Maximum (Coinsurance Limit) \$_____

Maximum Total Benefit Amount \$_____

Per Year Benefit Maximum Basis: Plan Year Calendar Year

Comments _____

This Section is for Office Use Only

ACCIDENT BENEFIT

{Co-payment Amount \$_____} {Per visit}

Maximum Benefit Amount All Covered Facilities per Year: \$_____

Maximum Benefit Amount for In-Hospital Confinement per Year \$_____

Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$_____

OPTIONAL RIDERS

{Sickness Benefit Rider:} Yes No

{Co-payment Amount \$_____} {Per visit}

{Maximum Benefit Amount All Covered Facilities per Year: \$_____}

{Maximum Benefit Amount for In-Hospital Confinement per Year \$_____}

{Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$_____}

{Hospital Indemnity Sickness Benefit Rider} Yes No

{Outpatient Physicians Expense Rider} Yes No

{Ambulance Benefit Rider} Yes No

{Generic Outpatient Prescription Drug Rider} Yes No

{Brand {and Generic} Prescription Drug Rider} Yes No

{Outpatient Physical and Wellness Examination Rider} Yes No

{Outpatient Diagnostic Test and Lab Rider} Yes No

{Allied Services Rider} Yes No

{Prior Plan Deductible Credit Rider} Yes No

Policy/Certificate Delivery

Send Policy & Certificate to? _____ Agent _____ Employer

Payroll and Billing Information

{Billing is alphabetical -12 monthly Premiums}
Effective date can be {the 1st or the 15th of the month}

Make check payable to Standard Life and Accident Insurance Company.
\$ _____ Amount of Attached Check.

ALL PREMIUMS ARE PAYABLE IN ADVANCE. THE FIRST PREMIUM MUST BE PAID PRIOR TO THE EFFECTIVE DATE OF INSURANCE.

Agreements, Representations and Understanding

I represent that all statements made herein are complete and true as of the date I signed this Application, and I understand that Standard Life and Accident Insurance Company (SLIC) will rely on these statements and this information as the basis for approving this Application.

I understand that the Group Accident Insurance Policy for which I have applied is a limited benefit Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy's limitations and exclusions, if any.

I understand that only those employees and dependents covered under our company's major medical or comprehensive health plan are eligible for coverage.

Check One

{I **represent** that {100%} of eligible employees and dependents will be enrolled in the plan}. _____

{I **represent** that this plan will be offered on a voluntary basis} _____

I understand that coverage is effective when: a) the Policy is issued by SLIC; b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by SLIC.

{**We agree** to make any necessary payroll deductions for any employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums and any applicable administrative fee due under the insurance Policy issued.}

I understand that **Policyholder may** terminate the Policy and any Rider(s) **by giving** written notice to the other party. The Policyholder is responsible for notifying the Insureds of the termination or non-renewal of the Policy.

I understand that SLIC and the Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

I represent that the information herein is true and complete, as of the date I signed this Application, and that I have read and understand this form.

{**I acknowledge and understand** that any misrepresentation on this Application by my agent or me may result in the cancellation or rescission of any Policy issued based on this Application.}

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

X _____ Print Name _____

Official Title _____ this _____ day of _____

Agent Name (print) _____
Signature _____

Agent's State License Identification Number _____

SLIC -GAP Grp App FL

Provider Questionnaire

MorganWhiteAdministrators, (TPA for the Group Accident Plan) wants to go the extra mile to insure that you and your customers are happy with their policy.

Please list below the hospitals that you feel your client will be using. MorganWhiteAdministrators will send a letter to each of these hospitals explaining: who we are, that you just wrote a group in their area, how the Plan works, how to file a claim and who to contact if they need help or have questions.

Name of Group _____
Agent's Name _____
Agent's phone # _____

Name of Hospital	Address	Phone #

Other providers you want us to contact
