EPIC SPECIALTY BENEFITS

Employer's Group Application

The EPIC Life Insurance Company
1717 W. Broadway
Madison, WI 53713

❑ New Group ❑ Change to Existing Group Number ____________________

(Please complete the Employer Information section and any other sections applicable to your requested change.)

Requested Effective Date__________ **Important**–coverage won't become effective until we notify you in writing.

Requested Anniversary Date ____________

1. Employer Information

Employer Name ____________________ Federal Tax ID Number__________

Address (Street, City, County, State, Zip)____________________

Telephone Number__________ FAX Number__________ Business Start Date __________

Name/Title of Contact Person ____________________

E-Mail Address ____________________ Telephone Number __________

Type of Ownership ❑ Association ❑ Corporation ❑ Partnership ❑ Proprietorship	Nature of Business *(please be specific)*	SIC
Will this coverage replace existing group insurance plan? ❑ Yes ❑ No	If yes, provide name of current carrier	Anticipated Termination Date

Please list the name of all subsidiaries and/or affiliated companies. | Are you requesting coverage for this group?

____________________ → ❑ Yes ❑ No Number of Eligible Employees __________

____________________ → ❑ Yes ❑ No Number of Eligible Employees __________

____________________ → ❑ Yes ❑ No Number of Eligible Employees __________

Is the firm applying for coverage eligible to file a tax return with the above-named subsidiaries and/or affiliated companies?
❑ Yes ❑ No

2. Eligibility and Enrollment

A. Total Number of Employees __________

Employees in ineligible classes __________

Part-time Employees __________

Seasonal Employees __________

Employees in Probationary Period __________

Others (please explain) __________

Total Number of *Ineligible* Employees __________

Total Number of *Eligible* Employees __________ (Subtract Ineligible Employees from Total Employees)

B. Please indicate minimum eligibility requirement below:

❑ 2-50 Full-Time Employees – Actively at Work Requirement is 30 hours per week

❑ 51 or More Full-Time Employees – Actively at Work Requirement: ________ hours per week

❑ Other ____________________

For Office Use Only	GN	DIV	Class	PP	ED	CC

2. Eligibility and Enrollment (cont.)

C. Payroll Deduction Schedule: ❑ Weekly ❑ 24 Wks ❑ 26 Wks ❑ 26 Wks, deductions taken on 24 weeks ❑ Other________

D. Employee Enrollment ❑ Paper ❑ Electronic File ❑ Online

E. Are domestic partners and their dependents eligible for coverage? ❑ Yes ❑ No
This question E. does not apply to local government units per Wis. Stat. 66.0137(1)(ae).

F. To the best of your knowledge, and belief, is any employee or dependent proposed for coverage now disabled, not at work, unable to work, confined to a hospital or contemplating a confinement, on a leave of absence, handicapped, or otherwise incapacitated as of the requested effective date? ❑ Yes ❑ No
If yes, please provide each person's name and status (For additional space, please use separate sheet) __________________
____

G. Are any employees or dependents (including spouses) proposed for coverage currently on group continuation coverage, including COBRA coverage? ❑ Yes ❑ No
If yes, date on which continuation coverage began______________ for how many months? ❑ 18 ❑ 29 ❑ 36
Employee's Name (For additional space, please use separate sheet) ____
____

H. Is each coverage applied for subject to or part of a union-negotiated collective bargaining agreement?
❑ Yes ❑ No (If yes, when does that agreement expire?) ____

I. Is this application being made on behalf of an Association, Chamber or Trust? ❑ Yes ❑ No (If yes, name of Association, Chamber or Trust) ____

J. Are any classes of eligible employees to be excluded from any coverage? ❑ Yes ❑ No (If yes, please explain and identify each coverage) ____

3. Probationary Period

Please provide the appropriate probationary period for each class.

A. Group Life/AD&D/STD/LTD Coverage(s)

Class 1 1st day of the calendar month following ______days ______months of full-time employment
Class 2 1st day of the calendar month following ______days ______months of full-time employment
Class 3 1st day of the calendar month following ______days ______months of full-time employment
Other ____

B. Group Dental/Vision Coverage(s)

Class 1 1st day of the calendar month following ______days ______months of full-time employment
Class 2 1st day of the calendar month following ______days ______months of full-time employment
Class 3 1st day of the calendar month following ______days ______months of full-time employment
Other ____

4. Premium/Billing Options

A. Premium

A check for $____________ made payable to EPIC is being submitted with this application as payment by this employer to be applied toward the initial month's premium if this application is approved by EPIC and the group policy(ies)/coverages is issued. The monthly premium billed by EPIC will be due and payable to EPIC on the first day of the coverage month. This does not apply if you select automatic withdrawal.

B. Payment Options

❑ **Automatic Withdrawal.** We electronically transfer your premium directly from your bank account monthly. If you select automatic withdrawal from your checking account, please complete the Authorization Agreement for Electronic Fund Transfer in Section 8 of this application.

❑ **Direct Bill.** We send a premium notice directly to your billing address monthly. You return the payment to EPIC by the premium due date. *An additional $5.00 fee will be added to your bill if you select this option.*

C. Billing Options

Bill Type: ❑ List Bill ❑ Self Bill (only available to groups with 100 or more enrolled employees)

Bill Frequency: ❑ Monthly ❑ Quarterly ❑ Other ____

5. Employer's Statement/Certification

EPIC may investigate the information on this application. Any findings may be used to deny coverage for one or more employees of the group or the entire group. Please indicate the name, title, and telephone number of an employee in your firm who can provide necessary clarification of the employee and group information provided on this application.

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been advised: (1) Not to terminate all existing coverage(s), whether on an insured or self-funded basis, unless and until EPIC notifies me in writing that coverage(s) has been approved; (2) EPIC doesn't guarantee approval of this application or issuance of coverage(s); (3) This application or any coverage may be declined by EPIC; (4) The agent represents the employer, not EPIC; and (5) Pre-existing conditions may be subject to waiting periods and other policy limitations and restrictions.

I understand that EPIC will rely, in part, on the information provided in this application to issue or deny coverage(s). If EPIC approves this application, I understand coverage(s) will become effective on the date assigned by EPIC; no coverage(s) will be in force until that date.

I understand no coverage(s) will become effective for an eligible employee (and his/her dependents, if any) if he/she is not actively at work with the employer on the assigned effective date. Such coverage(s) will become effective on the first day after he/she returns to work on a full-time basis performing all of the material tasks of his/her job.

I understand no agent or other person, other than the President &CEO or Chief Operating Officer of EPIC, has the authority to alter, bind EPIC, waive or change any terms, conditions, and/or provisions of the policy(ies) or any other requirement imposed by EPIC. I understand the employer represents its employees and their dependents, not EPIC. As the employer's authorized representative and acting on that employer's behalf, I understand, agree with, and approve each and every certification made by the writing agent in Section 6 (Agent Certification) of this application.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the insurer may rescind and void any coverage if it determines that you, the employer is listed on the SDN list or associated with an entity listed on the SDN list. Furthermore, EPIC may rescind and void any coverage if it determines that a covered employee, or a covered employee's spouse or named dependent, are either listed on the SDN list or associated with an entity listed on the SDN list.

If this application is approved, I understand that EPIC will not be, and is not, a plan sponsor, plan administrator, plan trustee, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any other state or federal law. I understand the employer is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies.

If EPIC approves this application, the actual benefit options for this employer's group coverage(s) will be contained in (1) the final, written and signed proposal; and (2) the EPIC Certificate of Insurance(s) which is part of the group insurance policy(ies) issued by EPIC to the employer as the EPIC group policyholder.

Name________________________________Position/Title____________________________Telephone Number ________________

Signature of Employer Representative____Date ________________

Signed at City ____ State _______________________________________

6. Agent Certification

I hereby certify and represent all of the following as being true: (1) I asked all questions accurately and fully recorded all information given by the Employer Representative in this application; (2) I advised the Employer Representative not to terminate existing coverage unless, and until, EPIC notifies him/her, in writing, that this application has been approved; (3) I used only advertising approved by EPIC to solicit this application; (4) I told the Employer Representative nothing inconsistent with, or contrary to, the approved advertising about the benefits, group policy(ies)/and or coverage(s); (5) I did not guarantee EPIC's approval of this application or EPIC's issuance of coverage(s); (6) I did not tell the Employer Representative that EPIC will cover any pre-existing condition(s) of any person proposed for coverage; and (7) I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and the marketing/sales standards maintained by EPIC.

I hereby certify and represent all of the following as being true: (1) I told the Employer Representative that EPIC has no liability for anything I said or failed to say before, during, or after the application process, that is not subsequently confirmed in writing by and EPIC authorized executive officer, including, but not limited to answers given by me in response to questions asked by that Representative or anyone else; (2) I told the Employer Representative that EPIC is not liable for any statement, representation, or other information provided to that Representative or anyone else that is not expressly contained in a written document provided to them and signed by an EPIC

authorized executive officer; (3) I understand that I am liable for my acts and omissions to the extent provided by law; and (4) I understand I have no authority to alter this application, bind EPIC by making promises and/or representations or to waive or change the terms, conditions, and/or provisions of the group insurance policy(ies) or any requirement imposed by EPIC.

6. Agent Certification (cont.)

Signature of Writing Agent ____ Date__________________

Please Print Writing Agent's Name ______________________Writing Agent's Social Security Number ______________

Agency____Tax ID Number ____________________

Business Address ________________________________City _____________________State _____ Zip ________

Agency Telephone Number _______________ Agency Number ______________ Agency FAX Number _____________

Agency Email ___________________________________ EPIC Representative Name _________________________

7. Issue Information

Initial issue of contract documents are to be sent to: ( ) District Office ( ) Agency ( ) Employer ( ) Other __________

IMPORTANT–DID YOU REMEMBER TO INCLUDE:

- ❑ A signed copy of the EPIC Proposal; and
- ❑ Completed and signed Employee's Application for Group Insurance Coverage for each eligible employee; and
- ❑ A check made payable to EPIC for the first month's premium; and
- ❑ A copy of the most recent bill from the prior carrier or administrator; or
- ❑ A copy of the group's most recent Quarterly Wage and Tax Report (groups with 51 or more eligible employees should include a census of all full and part-time employees).

8. Authorized Agreement for Electronic Transfer

Employer's Legal Name____Employer Number ______________________

I hereby authorize The EPIC Life Insurance Company, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my: (select one)

❑ Checking Account* ❑ Savings Account

indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name____Branch ________________________________

City____State_____________________Zip ____________

Transit Number____Account Number ____________________________

This authority is to remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Signature of Employer Representative____Date __________________

Name and Title of Employer Representative (please print) ____

Telephone Number ____

*IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.