

# APPLICATION FOR GROUP INSURANCE

(See reverse side for additional information)

1. Applicant's Legal Name \_\_\_\_\_

2. Doing Business As \_\_\_\_\_

3. \_\_\_\_\_

P.O. BOX / ZIP CODE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY / STATE / ZIP \_\_\_\_\_

PHONE NO. \_\_\_\_\_ FAX NO. \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ TAX I.D. NO. \_\_\_\_\_

4. What is the nature of your business or industry?  
\_\_\_\_\_  
\_\_\_\_\_

5. Are any classes or locations excluded?  Yes  No  
(If yes, please use reverse side for explanation.)

6. Are any subsidiary and/or affiliated companies to be insured?  Yes  No  
(If yes, please use reverse side to list name and location.)

7. How many hours per week equals full time employment? \_\_\_\_\_

8. **Employee Participation**  
Employer contributes \_\_\_\_\_% of employee premium.

**Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

**Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

**Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

**Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

9. **Dependent Participation**  
Employer contributes \_\_\_\_\_% of dependent premium.

**Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

**Non-Contributory** (Policyholder contributes 100% of premiums. All eligible dependents must be insured, except those listed under excluded classes or locations.)

**Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

**Voluntary** (Policyholder does not contribute towards premium, 100% contribution by employee.)

10. **Section 125 Plan:**  
Election Period: \_\_\_\_\_  
Plan Year: \_\_\_\_\_

11. **Waiting Period**  
\_\_\_\_\_ for those employed on or before the policy effective date.  
\_\_\_\_\_ for those employed after the new policy effective date.  
 month(s)  calendar days  working days

12. **Effective Date and Termination Date**  
 Immediate  
 First of Month Effective date/End of Month Termination date  
 Other: \_\_\_\_\_

13. **Premium Payment Mode (In advance):**  
 Monthly  Quarterly  Semi-Annual  Annual  
 **Payroll Deduction** (Coverage must be 100% employee paid for employee and dependent premium to choose this option.)  
If policy effective date is other than first of the month, is a first of the month premium due date desired?  Yes  No

**Billing Options**  
 Home Office  Third-Party Administration

CONTACT NAME \_\_\_\_\_

TITLE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY / STATE / ZIP \_\_\_\_\_

PHONE NO. \_\_\_\_\_ FAX NO. \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

14. **The following coverages are applied for:**  
Employee & Dependents Benefits:  
 Dental  Orthodontia  Eye Care  Other \_\_\_\_\_  
Employee Only Benefits:  
 Dental  Orthodontia  Eye Care  Other \_\_\_\_\_  
**This insurance shall be effective on:** \_\_\_\_\_  
(Premiums due prior to the coverage period.)

15. **Insurance requested on this application will replace the coverage(s) checked.**  
Coverages:  Dental  Ortho  Eye Care  Other \_\_\_\_\_

NAME OF CURRENT CARRIER \_\_\_\_\_

POLICY NO. \_\_\_\_\_

Coverage applied for is replacing comparable coverage now or previously in force with another carrier.  
 It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.

TERMINATION DATE \_\_\_\_\_ ORIGINAL EFFECTIVE DATE \_\_\_\_\_

**Item 5: Exclusions:**

a. Classes, include reason for exclusion.

\_\_\_\_\_  
\_\_\_\_\_

b. Locations, if location is different from applicant's, list city and state.

\_\_\_\_\_  
\_\_\_\_\_

**Item 6: Subsidiary and/or affiliated companies to be insured:**

List names and locations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Plan Design and Proposed Rates:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Additional Remarks:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Agreements**

This application will be subject to review and approval by the Home Office of First Ameritas Life Insurance Corp. of New York. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of First Ameritas Life Insurance Corp. of New York., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Any person who knowingly and with intent to defraud any insurance company or other reason files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

**If you do not want your company name used by First Ameritas Life Insurance Corp. of New York in our effort to recruit PPO providers, check this box.**

**Signed at:** City: \_\_\_\_\_ State: \_\_\_\_\_ Date: \_\_\_\_\_

**Soliciting Agent:** Printed name: \_\_\_\_\_ Signature: \_\_\_\_\_

**Signed by** (Policyholder Representative): Printed name and title: \_\_\_\_\_

Signature: \_\_\_\_\_

**Was a binder check received?**  YES  NO If yes, then amount \$ \_\_\_\_\_.

**Check received by:** (agent) \_\_\_\_\_ Authorized by: (policyholder) \_\_\_\_\_

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO FIRST AMERITAS LIFE INSURANCE CORP. OF NEW YORK.  
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.