# GROUP INSURANCE MASTER APPLICATION

Application is hereby made for the Group Insurance benefits set forth below insuring the eligible Employees of the Employer or the Employees of Association Member Firms. If this Application is accepted by the Company, the policy will be issued to the Employer or Association named below in accordance with the following information:

| Employer or Association (Correct Legal Name) | Subsidiary or Affiliate Name(s) | | |
|---|---|---|---|
| Address: | City | State | Zip Code |
| Delivery Address (if different than above): | City | State | Zip Code |
| Group Contact Name: | Phone Number: | Fax Number: | |
| Nature of Business and SIC Code (if known) | All full-time, active employees are eligible for insurance except: | | |

**Basic Benefits & Employer Contributions:**

- ☐ Basic Term Life/AD&D _____%
- ☐ Supplemental Term Life _____%
- ☐ Supplemental AD&D _____%
- ☐ Dependent Term Life _____%
- ☐ Short-Term Disability _____%
- ☐ Long Term Disability _____%

**Voluntary Benefits & Employer Contributions:**

- ☐ Voluntary Life _____%
- ☐ Voluntary AD&D _____%
- ☐ Voluntary Short Term Disability _____%
- ☐ Voluntary Long Term Disability _____%

**Probationary Period for:**

Those employed on or before effective date _____ days.

Those employed after effective date _____ days.

Other (specify) _____

☐ First day for month following Probationary Period

☐ Other (specify) _____

CASH WITH APPLICATION $ _____

Premiums are to be paid monthly

Total # of Employees _____

Total # of Eligible Employees _____

Requested Effective Date / /

**Billing:**

☐ List

☐ Self-Bill

I understand and agree to the terms and responsibilities outlined in the Self Administration Manual provided by Greater Georgia Life Insurance Company

Are there Grand Fathered employees?

☐ Yes If Yes, how many? _____

☐ No

Are you requesting coverage for any non-active employees?

☐ Yes If Yes, attach completed Eligibility Information Form?

☐ No

The Policy is to become effective on the above date, except that, if the employees contribute to the cost, the Policy shall not become effective until at least 75% of the eligible employees have enrolled.

| SCHEDULE OF BENEFITS (Completion not required if submitting a signed proposal) | | |
|---|---|---|
| EMPLOYEE CLASS / ELIGIBILITY DESCRIPTION | REQUESTED BENEFIT | BENEFIT AMOUNT |
| | | |

**COMPLETE ONLY IF YOU ARE APPLYING FOR LIFE INSURANCE BENEFITS AND YOU HAVE NOT SIGNED A GREATER GEORGIA LIFE PROPOSAL**

LIFE/AD&D benefits reduce to _____ % at age _____ and further reduce to _____ % of the original amount at age _____ and terminate at retirement.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS ARE OCCUPATIONAL AND NON-OCCUPATIONAL.

**COMPLETE ONLY IF YOU ARE APPLYING FOR SHORT TERM DISABILITY BENEFITS AND YOU HAVE NOT SIGNED A GREATER GEORGIA LIFE PROPOSAL**

SHORT-TERM DISABILITY benefits begin on the _____ consecutive day of Accidental Disability or _____ consecutive day of Sickness Disability and continue for a maximum period of _____ weeks. Benefits are non-occupational and terminate at age 70 unless specified otherwise _____.

The Pre-existing Condition Limitation provision is 12/12 or Other ☐ (specify) _____.

THE INSURANCE APPLIED FOR is not in addition to, nor is it to replace, any such insurance now or previously in force within the past year in another company covering employees eligible for this insurance, except as follows:

Name of Insurance Company _____ Date to Which Premiums Paid _____ / _____ / _____

IT IS UNDERSTOOD AND AGREED that the Policy, if issued, shall include the premium rates and administrative provisions applicable to the insurance; that such premium rates and administrative provisions shall be binding upon the Applicant and the Company, subject to all of the provisions of the policy; and that this application shall form a part of the contract to be issued by the Company. IT IS HEREBY CERTIFIED that all persons to be insured hereunder are full-time, active employees working 30 or more hours per week, except as otherwise specified above.

Taken at _____

Date: _____

Applicant is a(n): ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Association

_____
Agent Name (Please Print) LICENSE #

_____
Agent Signature

_____
BCBSGA Representative Name LICENSE #

_____
Employer/Association Name (Please Print)

_____
Employer/Association Representative Name/Title (Please Print)

BY _____
Representative Signature