



MEDMUTUAL LIFE™

A Medical Mutual Company

15885 W. Sprague Road
Strongsville, Ohio 44136-1772

APPLICATION FOR GROUP INSURANCE

Please Type or Print All Information

Group Number

PART 1: APPLICANT INFORMATION

1. Policyholder (legal name)		Check if applicable: <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Subchapter S Corp. <input type="checkbox"/> Sole Proprietorship	
2. Mailing Address (not P.O. Box)			
Group Contact	Phone ()		
City	State	Zip	Fax ()
3. Name of any <input type="checkbox"/> Affiliates <input type="checkbox"/> Subsidiaries to be covered			e-mail
4. Nature of Business			5. SIC Code

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, DEPENDENT LIFE AND SHORT-TERM DISABILITY

Yes I am electing life and/or short-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
 If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:
 _____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Participation-free coverage

Yes, I am electing participation-free Voluntary Life and AD&D
 Yes, I am electing participation-free Voluntary Life, AD&D and short-term disability.
 If participation-free, voluntary short-term disability is elected, indicate the plan: 1/8/13 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:

- None
- First of month following completion of _____ days
- Other _____

Employees working less than **20 hours** per week are not eligible for coverage. If different than 20 hours, please indicate number of hours: _____

Employer contribution percentages (%) for all products are as stated in the proposal, unless indicated below:

<u>Product</u>	<u>%</u>	<u>Product</u>	<u>%</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GROUP LONG-TERM DISABILITY

Yes, I am electing group long-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Prior carrier: _____
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _____.

Contribution:

Employer _____% Employee _____% Pre-tax dollars Post-tax dollars

GENERAL CONDITIONS

The above information is true and accurate to the best of my knowledge. I understand that the information on this application and any other information I provide shall serve as the basis for the Policy to be issued, and that I have a duty to notify MedMutual Life Insurance Company of any changes.

Policyholder/Authorized Signature

Date

Title

Licensed Resident Agent (if required)

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.