MASTER APPLICATION FOR EMPLOYEE BENEFITS

AIG Life Insurance Company*
Wilmington, Delaware
A member company of American International Group, Inc.
Administrative Office: P.O. Box 30083, Tampa, FL 33630-3083

*This company does not solicit business in New York.

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust, or will be issued a group policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

Applicant Data (A group proposal is required as part of this application)

1. Full Name of Applicant (Company): ____________________
2. Group Contact Name: ____________________
3. Street Address: ____________________
   City: __________ State: ______ Zip: ______ Telephone: (____) __________
   Mailing Address (if different) __________ Fax: (____) __________
   City: __________ State: ______ Zip: ______
   E-Mail Address: __________ SIC Code: __________
4. Applicant is a: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Union
   ☐ Other (Explain): ____________________
5. Nature of Business: ____________________
6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? ☐ Yes ☐ No
   If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	*Nature of Business*	*Full Address*	*# of Full-Time Employees*

7. Have you ever applied for, or been insured for, group insurance with any member company of AIG Inc., including United States Life? ☐ Yes ☐ No
   If yes, give details: Group Policy Number(s) ____________________
   Date Insurance Ended/Declined __________ Effective Date (if still insured) __________
8. Please complete the information below for those coverages being replaced:

Current Coverage Employer		*Voluntary*		*Replacing with the Company's Plans?**	*Prior Plan Name & Effective Date*	*Proposed Termination Date*
Life**	☐	Life**	☐	☐ Yes ☐ No		
Dental	☐	Dental	☐	☐ Yes ☐ No		
Vision	☐	Vision	☐	☐ Yes ☐ No		
STD	☐	STD	☐	☐ Yes ☐ No		
LTD	☐	LTD	☐	☐ Yes ☐ No		

* **Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).**
** Are there other Group Life Insurance plans in force which you are not replacing or currently applying for with another carrier? ☐ Yes ☐ No If yes, please indicate the highest benefit amount of each plan.

____
____

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number:	Division Number: __________

Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least * 30 hours (20 hours for Voluntary Life only) per week, or _____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

9. Do you want to exclude any classes of full-time employees from coverage? ☐ Yes ☐ No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** ______________________________
______________________________ Total # of excluded employees ____________

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees ☐ ____________months OR ☐ First of the month following ____________months*
Future Employees ☐ ____________months OR ☐ First of the month following ____________months*

*Only option available for Voluntary Coverages. Available on Group coverages with the 1st of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued) .... __________
b. Number of Full-Time Employees **waiving all coverages** .... __________

12. Do you employ 20 or more employees? (Include part-time, union, etc.) ☐ Yes ☐ No

Contribution Data – Not applicable to Voluntary Coverages

13. Will the employees be required to contribute toward the cost of the insurance? ☐ Yes ☐ No
If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.

Coverage	*Life/AD&D*	*Dep Life*	*EE Dental**	*Dep Dental**	*EE Vision**	*Dep Vision**	*STD*	*LTD*
Employer %								

The employer must contribute a minimum of 35% of the total dental and vision premiums.

14. Premiums will be paid: ☐ Annually ☐ Semi-annually ☐ Quarterly ☐ Monthly ☐ EFT

Employee/Dependent Data

15. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? ☐ **Yes** ☐ **No**
If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **NOTE: This question does not need to be answered for Life and AD&D groups with more than 50 employees insured, Dental coverages, for Disability coverages with ten (10) or more employees insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.**

Name of Employee	*Date Disability Began*	*Current Amount of Group Life Insurance In Force*	*Describe Nature of Injury/Sickness*	*Date Return To Full-Time Work*

Requested Effective Date

I request that the coverage(s) chosen take effect on:

☐ the date the application is approved in writing by the Company; or

☐ ___________________ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For Voluntary Plans, the effective date must be the first of the month.

Applicant's Declaration

1. I verify that all employees applying for coverage listed on the census form are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all employees meet the eligibility requirements as listed on the application.
2. I verify that the Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s). Note: Changes in the Census data may affect previously quoted rates.
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are):____.
5. I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund.
   A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.
6. I understand and agree that:
   - no agent may change or waive any of the provisions of this application or of any plan of insurance;
   - any change or waiver may be made only by an officer of the Company; and
   - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
   - If the insurance contract compromises a part of an employee benefit plan, the Company is granted **sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
7. It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.

DATE	*PRINT NAME OF OFFICER, PARTNER, PROPRIETOR*
WITNESS	*SIGNATURE OF OFFICER, PARTNER, OR PROPRIETOR*

* Amount of hours may vary by state law

** May not be applicable in all states, and may vary by state law.

The Policyholder/Participant Employer hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.

Note: *If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

Producing Agent's Declaration

Please Print — PRODUCING AGENT

Producer #	**Tax ID # / SS #**	**% Commissions split with other agents**
Name ***As Licensed***		**License #**
Mailing Address		
City/State/Zip		
Phone	Fax	E-Mail
Signature	***Date***	***City and State Where Signed***

Please Print — GENERAL AGENT

General Agent #	**Name**	**Tax ID # / SS #**
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	**Premium Deposit $**	**Underwriter**
Mode	**Coverages**	
Group Contact	**Producer**	**GA**

Census Information *(This form may be photocopied if additional supply is needed)* **–** Not applicable for Voluntary Coverages.

For H.O. Use Only Class/Div.	Employee's Soc. Security#	Name (Last, First, MI)	Sex M/F	City/State of Residence	Current Salary***	Date of Birth			Occupation/ Title*	Date of Hire			Marital Status**	# of Dependents	Coverage Election E - Employee S - Spouse, C - Child	Coverage Selected					
						M	D	Y		M	D	Y				Life	LTD	STD	INT. DIS	Dental	Vision
1.	- -																				
2.	- -																				
3.	- -																				
4.	- -																				
5.	- -																				
6.	- -																				
7.	- -																				
8.	- -																				
9.	- -																				
10.	- -																				
11.	- -																				
12.	- -																				
13.	- -																				
14.	- -																				
15.	- -																				
16.	- -																				
17.	- -																				
18.	- -																				
19.	- -																				
20.	- -																				

**Please indicate state or federal coverage continuation here. Mark column with "C" along with date continuation began.*
***Marital Status Codes: S-Single, M-Married, W-Widowed, D-Divorced*
****Please state if salary is per hour, per week, per month or per year.*

For H.O. only:
Group Number: ____________________

For H.O. use only: Group Number: ____________
Class ________________ Division __________

DEPENDENTS' INFORMATION AND BENEFICIARY DESIGNATION FORM

This form may be used only in conjunction with a Group Enrollment Census form for initial enrollment. This form is not an employee application and should not be used for the addition of new employees.

Employee Information

To be completed by each employee

Employee's Name: ____
LAST FIRST MI

Name of Employer: ____

Group #: ____________________ Social Security # ____________________

Dependent Information for Life Coverage

To insure your dependents, please complete the following: (Employee is the beneficiary for all insured dependents)

Spouse's Name* ______________________________ Birthdate _______/ _____/ _______
LAST FIRST MI

Social Security No. ____________________ ☐ Male ☐ Female

*A notarized affidavit is required for Domestic Partners.

Applicant's Signature: ____________________ Date: ____________________

Beneficiary Designation

If applying for Life Coverage, enter the Beneficiary information.

Beneficiary Name: ______________________________ Relationship ____________________
LAST FIRST MI

Contingent Beneficiary: ______________________________ Relationship ____________________
LAST FIRST MI

Applicant's Signature: ____________________ Date: ____________________

REFUSAL OF COVERAGE

Employee Information (Please Print)

Employee's Name: ____
LAST FIRST MI

Name of Employer: ____

I was given the opportunity to enroll in this plan for group insurance offered by my employer. I am refusing: ____________________

	Dental	Vision
☐ LTD	☐ Employee & Dependents	☐ Employee & Dependents
☐ STD	☐ Spouse	☐ Spouse
☐ Life/AD&D	☐ Child(ren)	☐ Child(ren)
☐ Dependent Life	☐ All Dependents	☐ All Dependents
☐ Supplemental Life/AD&D		
☐ All Coverages Offered		

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:
Are you or your dependents now covered by another group plan? ☐ YES ☐ NO
(Your dependent(s) may be insured by this plan even if they are insured elsewhere.)
If Yes: Policyholder's Name ____________________ Carrier ____________________

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of other applicable insurance plan. If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage. I must furnish, at my expense, evidence of insurability satisfactory to the carrier if I wish to enroll in any other coverage that is now being refused.

____/____/ ____ ______________________________
DATE OF REFUSAL APPLICANT'S SIGNATURE

For H.O. use only: Group Number: ______________
Division Number: ______________

Life/AD&D

Group Name ____

- Waiver of Premium included
- Reduction Formula: Life Insurance and AD&D insurance reduce by 35% at age 65 and 50% at age 70.
- For 2-9, AD&D insurance terminates at age 70.
- BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

INSURANCE SCHEDULE

- Life and AD&D insurance will be written subject to the published maximum guidelines.

Class of Employees List by salary, job title, union membership or other employment conditions.	*Life / AD&D Schedule*	*Life / AD&D Amounts Subject to EOI*	*Total Amount Requested Per Life* *Life* *AD&D*
1.			
2.			
3.			
4.			
5.			

CHANGE IN AMOUNT OF INSURANCE: A change in the amount of Life and AD&D insurance will take effect on:

☐ the date of change ☐ other ________________________________

ISSUE ☐ Trust ☐ True Group

BENEFIT OPTIONS - See Proposal

DEPENDENT LIFE INSURANCE ☐ Yes ☐ No

Amounts: Spouse/Child ☐ $10,000/2,000 ☐ $5,000/1,000 ☐ Domestic Partners included

ADDITIONAL OPTIONS

- Not all options are available for 2-9

Check all that apply

☐ BTA
☐ Life only/No AD&D
☐ Work and Family Benefits
☐ Supplemental Life (Indicate Schedule Below)
☐ Without Waiver of Premium
☐ Upgrade AD&D - Tier One
☐ Upgrade AD&D - Tier Two
☐ Critical Illness

☐ Dependent Life Insurance Selections:

☐ legal spouse of employee ☐ children to ______ years, ______ if student

Amount: Spouse $______________ Children $______________

☐ Reduction Formula: Please specify if different from above.

Life ________________________________

AD&D ________________________________

☐ Special Requests: ________________________________

____

____

____

____

For H.O. use only: Group Number: ____________
Division Number: ____________________

Disability

Group Name ____

- Is the business run from the home? ☐ Yes ☐ No How long has business been in existence? __________ years
- Are there any employees who do **not** participate in Social Security or Worker's Compensation? ☐ Yes ☐ No

  If yes, explain ____

Issue ☐ Trust ☐ True Group

LONG TERM DISABILITY BENEFITS

	2-9 Lives	10+ lives
Elimination Period	☐ 90 or 180 days	______ days
Benefit per Month of Disability	___% of Basic Monthly Pay, up to a maximum of $_________ ($1,000 to $6,000 in $1,000 increments)	______% of Basic Monthly Pay, up to a maximum of $____________
Integration	☒ Family	☐ Family ☐ Primary ☐ 70% All Sources
Regular Occupation Period	☒ 2 Years	☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 5 Years ☐ Unlimited
Minimum Benefit of gross monthly benefit	The greater of $100 or 10% GMB	$_________
Maternity as any other sickness	☒ Yes	☒ Yes
Pre-Existing Conditions Limit	3/12 (or as mandated by state)	☐ 3/12 ☐ Other __________________________
Survivor Benefit	3X monthly report	☐ 3X ☐ 6X
Mental, Nervous, Drug & Alcohol Limitation	☒ 24 Months	☐ 24 Months ☐ See Quote
Benefit Duration	☒ Age 65 ADEAI	☐ Age 65 ADEAI ☐ 5 Year RBD ☐ NSSRA ☐ 2 year RBD
Partial Deefinition	☒ Proportionate Loss	☐ Proportionate Loss ☐ Dollar for Dollar ☐ 50% Offset
Conversion Option	Not available	☐ Yes ☐ No
COLA	Not availvable	☐ Yes ☐ No _________% ______Adjustments

SHORT TERM BENEFITS

	2-9 Lives	10+ lives
Benefit per Week of Disability	______ % of Basic Weekly Pay, not to exceed $___________	☐ ____% of Basic Weekly Pay, not to exceed $_______
	☐ Flat Amount $___________ Not to exceed 60% of Basic Weekly Pay	☐ Flat Amount $______________ Not to exceed 60% of Basic Weekly Pay
Elimination Period Waived if Hospitalized	Not available	☐ Yes ☐ No
Elimination Period	____ days for injury ____ days for sickness	____ days for injury ____ days for sickness
Maximum Weeks per Disability	☐ 13 ☐ 26 Weeks	_____ Weeks
Maternity as any other sickness	☐ Yes ☐ No	☐ Yes ☐ No
Pre-Existing Conditions Limit	3/12 Standard 12/12 w/Maternity	☐ No ☐ 3/12 ☐ 3/6/12
Minimum Benefit	$25/week	$25/week

INTEGRATED DISABILITY BENEFITS

100+ lives

Integrated Disability Management ☐ Yes ☐ No

Billing ☐ American General ☐ Other ______________________________
☐ USL
☐ AIG
☐ AIN

☐ Special Requests ____

____

For H.O. use only: Group Number: ____________
Division Number: ____________________________

Dental and Vision

Group Name ______________________________ ☐ Employee Only ☐ Employee and Dependents
Issue ☐ Trust ☐ True Group

Reasonable and Customary Plans:

☐ *2-9 lives*

	Deductible	*Coinsurance*	*Deductible Waived for Preventive*	*Annual Maximum*
☐ Plan 1	$50	100%/80%/50%	☐ Yes ☐ No	☐ $1,000 ☐ $1,500
☐ Plan 2	$100	100%/80%/50%	No	☐ $1,000 ☐ $1,500
☐ Plan 3	$50	100%/80%/0%	☐ Yes ☐ No	$1,000

☐ *10+ lives*

Annual Deductible: $__________ Family Limit: ☐ 3X ☐ 2X
☐ Lifetime ☐ None
Coinsurance: Preventive _________%
Basic _________%
Major _________%
Annual Maximum: ☐ $1000 ☐ $1500 or ☐ $2000
Enhanced Benefits Package ☐ Yes ☐ No
Deductible waived for preventive: ☐ Yes ☐ No
All dental waiting periods waived ☐ Yes ☐ No
Supplemental Accident ☐ Yes ☐ No

Orthodontia: ☐ Yes; Lifetime Deductible: $0 ☐ No
50% Coinsurance
Lifetime Maximum: ☐ $1000
☐ Other _____________
Adult (Age 19+) Orthodontia: ☐ Yes ☐ No

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child-only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

Point-of-Service PPO Plans:

MAC (Maximum Allowable Charge) – ☐ **2-9 lives** ☐ **10 or more lives**

Annual Deductible: $_____________ ☐ Lifetime
* ☐ Deductible waived for preventive (out of network)

		IN		OUT
Coinsurance:	* Preventive	_____________	/	100%
	Basic	_____________	/	80%
	Major	_____________	/	50%
Annual Maximum:	$	_____________	/	$ _____________

☐ Waiting periods waived
Orthodontia: ☐ Yes, Lifetime Deductible: $0 ☐ No
Coinsurance: __________%
Lifetime Maximum: ☐ $1000 ☐ Other __________
Adult Orthodontia: ☐ Yes ☐ No
(Age 19+)

Networks Available:
(Check network applicable to your area)
☐ AIG National Dental Network
☐ Delta Dental of New Jersey

Family Limit: ☐ 3x ☐ 2x ☐ None
Enhanced Benefits Package: ☐ Yes ☐ No
Supplemental Accident: ☐ Yes ☐ No
Sealants: ☐ Yes Age ___________ ☐ No

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child-only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

R & C (Reasonable & Customary) – ☐ **2-9 lives** ☐ **10 or more lives**

Annual Deductible: $_____________ ☐ Lifetime
☐ Deductible waived for preventive (out of network)

		IN		OUT
Coinsurance:	Preventive	_____________	/	_____________
	Basic	_____________	/	_____________
	Major	_____________	/	_____________
Annual Maximum:	$	_____________	/	$ _____________

☐ Waiting periods waived
Orthodontia: ☐ Yes, Lifetime Deductible: $0 ☐ No
Coinsurance: 50%
Lifetime Maximum: ☐ $1000 ☐ Other __________
Adult Orthodontia: ☐ Yes ☐ No
(Age 19+)

Networks Available:
(Check network applicable to your area)
☐ AIG National Dental Network
☐ Delta Dental of New Jersey Premier

Family Limit: ☐ 3x ☐ 2x ☐ None
Enhanced Benefits Package: ☐ Yes ☐ No
Supplemental Accident: ☐ Yes ☐ No
Sealants: ☐ Yes Age ___________ ☐ No
☐ HIAA 90th percentage out of network

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child-only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

Scheduled Plan:

☐ Reimbursement Dental Plan *(Available 5+ lives)*

Annual Deductible: ☐ $0 ☐ $25 ☐ $50 ☐ $100

Conversion Factor ($10-$20): $____________

Annual Maximum: ☐ $500 ☐ $750 ☐ $1000 ☐ $1500 *(10+ lives only)*

Preventive dentistry covered at 100% of Reasonable and Customary with deductible waived: ☐ Yes ☐ No

Orthodontia: ☐ Yes; Lifetime Deductible $50 ☐ No
50% Coinsurance
Lifetime Maximum: $1000

NOTE: Orthodontia is available only to groups of 10 or more lives and is paid at Reasonable and Customary.

Voluntary Plan:

☐ Voluntary Dental (Discount Dental Service Plan) - Careington Network

DHMO Dual Option Programs (Nationwide):

☐ Informal Dual Option/ Indemnity *(Available 10+ lives. Group Indemnity plan sold alongside another Company's prepaid plan.)*

☐ Plan I

$50 annual deductible - Coinsurance:

Preventive	100%
Basic	80%
Major	50%

Annual Maximum: ☐ $1000 ☐ $ 1500

Deductible waived for preventive: ☐ Yes ☐ No

☐ Plan II

$50 annual deductible - Coinsurance:

Preventive	80%
Basic	80%
Major	50%

Annual Maximum: ☐ $1000 ☐ $ 1500

Annual Enrollment Period ___________________________

☐ Informal Dual Option/PPO Dental *(Available 10+ lives in specific areas. Consult your agent for information. Group PPO Plan sold alongside another company's prepaid plan. MAC plans only.)*

Annual Deductible: $50 - Coinsurance: In and out; MAC

Preventive	100%
Basic	80%
Major	50%

Annual Maximum: ☐ $1000 ☐ $ 1500

Annual Enrollment Period:_____________________________

Vision Insurance:

See proposal for benefits **Issue** ☐ Trust ☐ True Group

One exam covered annually

Lenses and Contacts covered annually

☐ Plan A, Annual Frames Frequency

☐ Plan B, Biennial Frames Frequency

☐ Special Requests for Dental and/or Vision

____

____

____

____

____

____

____

____

____

____

____

____

____

____

For H.O. use only: Group Number: ____________
Division Number: ____________

Voluntary Coverages

1. Correspondent's full name and address: (If different than indicated on page 1) ____________

NOTE: Person named above is required to communicate individual coverage status to the employee.

2. Number of payroll deductions per year____________
3. Annual Enrollment/Solicitation dates ____________to____________
4. Individual Age bracket changes and increase in amounts of insurance will take effect:
   ☐ Plan Anniversary ☐ First of the month following the change

LIFE INSURANCE: ☐ Yes ☐ No

BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

2-199 LIVES

A. Premium rate schedule:
   ☐ Unismoke **OR** ☐ Smoker/Non-smoker
B. Waiver of premium: standard, terminates at age 65
C. Requested benefit schedule: standard
   Employee: $10,000 to $300,000 available in $10,000 increments, not to exceed 5X the employee's basic annual salary.
   Spouse: $10,000 to $200,000 available in $5,000 increments, not to exceed 5X the employee's basic annual salary.
   Children: $5,000

$300,000 maximum available to groups with 10-199 eligible lives.

200+ LIVES

A. Premium rate schedule:
   ☐ Unismoke **OR** ☐ Smoker/Non-smoker
B. Waiver of premium (if proposed) ☐ Yes ☐ No
C. Requested benefit schedule:
   Employee: ____________
   Spouse: ____________
   Children: ____________
   Please advise if any of the above are excluded.

Please note: Completing medical questions is not necessary for guarantee issue coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D): ☐ Yes ☐ No

BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay or other special compensation such as commissions.

2-199 LIVES

A. Requested benefit schedule: standard
   Employee: $10,000 to $300,000, available in $10,000 increments, not to exceed 5X the employee's basic annual salary.
   Spouse: $10,000 to $200,000, available in $5,000 increments, not to exceed 5X the employee's basic annual salary.

* $300,000 maximum available to groups with 10-199 eligible lives.

200+ LIVES

A. Requested benefit schedule:
   Employee: ____________
   Spouse: ____________

LONG-TERM DISABILITY: ☐ Yes ☐ No

A. Industry classification (2-199 eligible lives only): ____________ (Proposal must be included)
B. $100 increments available? ☐ Yes ☐ No
C. Benefit Percentage: ☐ 40% ☐ 50% ☐ 60%
D. Benefit Maximum ☐ $6,000 ☐ Other: ____________
E. Benefit Duration: ☐ Age 65 "ADEA I" (after age 65)
F. Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

A copy of the final group proposal must be included for groups of 200 eligible lives or more.

☐ Special Requests: ____________

SHORT-TERM DISABILITY: ☐ Yes ☐ No

A. Female Percentage (2-199 eligible lives only) ____________ (Proposal must be included)
B. $10 increments available? ☐ Yes ☐ No
C. Benefit Percentage: ☐ 40% ☐ 50% ☐ 60%
D. Benefit Maximum ☐ $500 ☐ $1,000 (for select industries) ☐ Other: ____________
E. Benefit Duration: ☐ 13 weeks ☐ 26 weeks
F. Elimination Period: ☐ 0 days injury/7 days sickness ☐ 7 days injury or sickness ☐ 14 days injury or sickness ☐ 29 days injury or sickness ☐ 7 days injury / 14 days sickness
G. Pre-existing conditions limitations: ☐ 3/12 ☐ 12/12 with maternity

A copy of the final group proposal must be included for groups of 200 eligible lives or more.

☐ Special Requests: ____________

Voluntary Coverages (cont'd)

☐ Discount Dental Plan (Careington Network)

OR

☐ Indemnity Plan [minimum 25 eligible employees with 10 enrolled] **OR** ☐ Point-of-Service PPO Plan
Annual Deductible ☐ $50 **OR** ☐ $100 Lifetime ☐ Waived for Preventive
Annual Maximum (Non-Orthodontic) benefit: ☐ $1000 per insured person or ☐ $1500 per insured person
Coinsurance

Indemnity:	☐ 100/80/50	☐ 100/50/50
PPO:	☐ 100/80/50 in & out	☐ 100/50/50 in & out
Out of Network:	☐ MAC	☐ R & C

☐ Orthodontia ☐ Yes: Adult/Child ☐ Yes: Child-only ☐ No
$0 deductible, 50% to $1,000 lifetime maximum

☐ $300 Supplemental Accident ☐ Endo / Perio in Basic
☐ Reduced Premium Option

VISION (minimum 10 eligible employees with 5 enrolled): ☐ Yes ☐ No

In-Network Copay – $10 Exam / $20 Lenses
One Exam covered annually
Lenses and Contacts covered annually
☐ Plan A, Annual Frames Frequency
☐ Plan B, Biennial Frames Frequency

☐ Special Requests: ______________________________
____
____

AIG AMERICAN GENERAL

AIG Life Insurance Company*
Wilmington, Delaware
A member company of American International Group, Inc.
Administrative Office: PO Box 30066, Tampa, FL 33630-3066
Phone: 1-877-672-1648, Fax: 1-877-672-1650

Group Employee Enrollment Form

*This company does not solicit business in New York.

Completing Your **GROUP ENROLLMENT FORM** 1. **Fully complete** each section 2. **Sign and date** Refusal/Authorization Section, as needed.	Group Policy No.(s)	☐ **NEW ENROLLMENT** ☐ **CHANGE IN ENROLLMENT**

1. PERSONAL DATA: (Must always be completed)

Billing Location	Class	Social Security No.	Last Name	First Name	Initial

Sex ☐ Male ☐ Female	Date of Birth MM DD YY	Street Address	City	State	Zip Code

Name of Employer	Location	Salary $ ____ Per ____

Occupation	Title	Date of Full-Time Employment MM DD YY	No. Hours Worked Per Week ____ ☐ Union ☐ NonUnion

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Dependent Children No ☐ Yes ☐ If Yes, # ____

2. ENROLLMENT

If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured.
PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.

Name	Relationship Self	Sp.	Ch.	Date of Birth MM/DD/YY	Sex	Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured. Indicate your effective and termination dates of coverage also.	If high/low dental, please select one.
SELF	X						☐ High ☐ Low

3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate

Life Amount for: Employee $ ____ **Spouse $** ____ **Dependent $** ____

4. Supplemental AD&D Benefit: If this benefit is a plan option and you wish to enroll for Supplemental AD&D coverage, please indicate

AD&D Amount for: Employee $____

5. Beneficiary Designation: as is

EX: MARY A. JONES, WIFE NOT MRS. JOHN JONES	First Name	Initial	Last Name	Relationship

6. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)

I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by AIG Life Insurance Company.

I am refusing:

	Dental:	**Vision:**
☐ LTD	☐ Employee & Dependents	☐ Employee & Dependents
☐ STD	☐ Spouse	☐ Spouse
☐ Life/AD&D	☐ Child(ren)	☐ Child(ren)
☐ Dependent Life	☐ All Dependents	☐ All Dependents
☐ All coverages offered		

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:

Are you or your dependents now covered by any other group plan? ☐ YES ☐ NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)

If Yes: Policyholder's Name ____ Carrier ____

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.
I must furnish, at my expense, **evidence of insurability** satisfactory to AIG Life Insurance Company if I later wish to enroll in any other coverage that is now being refused.

____ | ____ | ____ ____________________

DATE OF REFUSAL ***SIGNATURE IF REFUSING ANY COVERAGE***

***IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.**

7. AUTHORIZATION:

- I hereby certify that all information furnished is true to the best of my knowledge.
- I request group insurance for which I am or may become eligible.
- If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to AIG Life Insurance Company.
- I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.
- If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by AIG Life Insurance Company.
- I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to AIG Life Insurance Company information about me. Such information will pertain to my employment or other insurance coverage.

____ | ____ | ____ ____________________

DATE SIGNED ***APPLICANT'S SIGNATURE***