ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (402) 437-3404

WORKSITE GROUP EMPLOYER APPLICATION

PLEASE PRINT WITH BLACK INK

EMPLOYER INFORMATION

Employer Name | Employer's Tax I.D. No.

Address
Street Address | *City* | *State* | *ZIP+4*

Contact Name | Contact Title

Contact Phone No. ( ) | Contact Fax No. ( ) | Contact Email

1. Details of any subsidiaries or affiliates to be insured _____

2. Name and nature of business _____

3. Type of business: ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other _____

4. Percent of premium paid by employer for employees _____%

5. Waiting period: For current employees _____ For new employees _____

6. How many eligible full-time employees? _____ Hours required for benefit eligibility _____

7. Does this insurance replace existing insurance with any company? If YES, provide details below.

Company Name	Group/Policy Number	Termination Date *(MM/DD/YYYY)*
		/ /
		/ /

8. Requested effective date of insurance ___/___/___ *(MM/DD/YYYY)*

9. Is this an ERISA Plan? ☐ Yes ☐ No

10. Third-party administrator *(TPA)* must be approved by and under contract with Assurity. If a TPA will be involved, please provide the information below.

Name _____

Address _____
Street Address | *City* | *State* | *ZIP+4*

Additional information or details _____

NOTE: There is an "actively employed" requirement for coverage to be in force. Any employee unable to perform the material and substantial duties of their regular occupation will not be insured until this requirement is satisfied.

ENROLLMENT INFORMATION

ACCIDENT EXPENSE— Policy and rider availability, features and rates may vary by state

Plans	Riders
☐ 24-hour Accident Expense ☐ Off-the-job Accident Expense Premium paid by: ☐ pre-tax deduction ☐ after-tax deduction	☐ Accident-only Disability Income Rider ☐ Wellness Benefit Rider ☐ Other *(specify)* _____

CRITICAL ILLNESS—Policy and rider availability, features and rates may vary by state

Plan	Riders
☐ Critical Illness	☐ Cancer Benefit Rider ☐ Cancer Benefit Rider with Recurrence Benefit ☐ Health Screening Benefit Rider ☐ Recurrence Benefit Rider ☐ Other *(specify)* _____

DISABILITY INCOME— Policy and rider availability, features and rates may vary by state

Plans	Riders
☐ Off-the-job Accident-only Disability Income ☐ Off-the-job Accident and Sickness Disability Income Premium paid by: ☐ pre-tax deduction ☐ after-tax deduction	☐ Emergency Accident Rider ☐ On-the-job Disability Income Rider ☐ Retroactive Injury Benefit Rider ☐ Spouse Accident-only Disability Income Rider ☐ Other *(specify)* _____

HOSPITAL INDEMNITY—Policy and rider availability, features and rates may vary by state

Plan	Riders	
■ Hospital Indemnity	☐ AD & D Rider	■ Critical Illness Rider
	■ Diagnostic Rider	■ Emergency Accident Rider
	■ First Hospital Admission Rider	☐ Initial Hospitalization Lump Sum Rider
	☐ Intensive Care Unit Rider	☐ Outpatient Sickness Rider
	☐ Private Duty Nurse Rider	☐ Surgical/Anesthesia Rider
	■ Wellness Rider	
	☐ Other *(specify)* _____	

TERM LIFE—Policy and rider availability, features and rates may vary by state

Plan	Riders	
☐ 5-year	☐ Spouse Term Insurance Rider	☐ Waiver of Premium Rider
☐ 10-year	☐ Children's Term Insurance Rider	☐ Accident-only Disability Income Rider
☐ 20-year	☐ Accidental Death Rider	☐ Critical Illness Rider
☐ 30-year	☐ Other *(specify)* _____	

WHOLE LIFE—Policy and rider availability, features and rates may vary by state

Plan	Riders	
☐ Whole Life	☐ Level Term Insurance Rider	☐ Waiver of Premium Rider
	☐ Spouse Term Insurance Rider	☐ Accident-only Disability Income Rider
	☐ Children's Term Insurance Rider	☐ Critical Illness Rider
	☐ Accidental Death Rider	
	☐ Other *(specify)* _____	

UNIVERSAL LIFE—Policy and rider availability, features and rates may vary by state

Plan	Riders	
☐ Universal Life	☐ Level Term Insurance Rider	☐ Waiver of Monthly Deductions
	☐ Spouse Term Insurance Rider	☐ Face Amount Increase
	☐ Children's Term Insurance Rider	☐ Accident-only Disability Income Rider
	☐ Accidental Death Rider	☐ Critical Illness Rider
	☐ Other *(specify)* _____	

AUTHORIZATION AND AGREEMENT

Assurity Life Insurance Company reserves the right to withdraw the policy if participation during the initial enrollment is less than 10 covered Certificate holders or any other state-specific participation requirements. It is understood and agreed that this application shall be made a part of the policy applied for and that no insurance shall be effective until approved by the Company at its home office. The Employer acknowledges that compliance with federal and state employment laws is solely the responsibility of the Employer.

Any person who knowingly, and with intent to defraud any insurance company or other person, 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 substantial civil penalty where and to the extent allowed by state law.

Signed at _____ on _____ / _____ / _____

City *State* *Date (MM/DD/YYYY)*

_____ _____

Employer Signature *Title*

_____ _____

Signature of Licensed Agent *Print Agent Name and Agent No.*