

Coverage(s) will be provided by the Company(ies) indicated above. Healthcare benefits will be provided by Consumers Life Insurance Company. Life/Disability Insurance benefits will be provided by Fort Dearborn Life Insurance Co. (FDL).

HealthPool

EMPLOYER/GROUP ENROLLMENT APPLICATION

THIS IS AN APPLICATION FOR COVERAGE, NOT A CONTRACT.

DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL YOU HAVE RECEIVED WRITTEN ACCEPTANCE FROM CONSUMERS LIFE

NOTE: If your group is accepted, Consumers Life cannot provide retroactive effective dates.

1. GROUP/COMPANY INFORMATION

GROUP NAME		EIN/FEDERAL TAX ID #	
HAS THIS GROUP EVER BEEN KNOWN BY ANOTHER NAME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT NAME(S)			DUN & BRADSTREET #
ADDRESS		EMAIL ADDRESS	
BILLING ADDRESS, IF DIFFERENT THAN GROUP LOCATION			
CITY	COUNTY	STATE	ZIP CODE
		PHONE NUMBER	
		Ext.	
CHIEF EXECUTIVE		BILLING CONTACT	
		RENEWAL CONTACT	
SIC CODE	TYPE OF BUSINESS (be specific)		HAS THIS GROUP EVER APPLIED TO CONSUMERS LIFE OR MEDICAL MUTUAL BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO
		WHEN?	YEARS IN BUSINESS
PROPOSED EFFECTIVE DATE FOR COVERAGE TO START: / /			

2. ENROLLMENT CRITERIA

ELIGIBLE EMPLOYEE PROFILE	Is the Minimum # of Hours Worked per week to be considered eligible for benefits equal to 30 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation Period for New Hire Benefits <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days following Date of Hire <input type="checkbox"/> 60 days following Date of Hire <input type="checkbox"/> 90 days following Date of Hire <input type="checkbox"/> 180 days following Date of Hire Probation Period for Rehires <input type="checkbox"/> Same as above <input type="checkbox"/> Other _____
Waive probation period for initial enrollment? <input type="checkbox"/> YES <input type="checkbox"/> NO		

IS THE EMPLOYER CONTRIBUTION AT LEAST 25% OF EACH CONTRACT? YES NO

DO YOU HAVE ANY AFFILIATIONS WITH OTHER COMPANIES OR UNIONS (include parent, subsidiary, joint venture, etc...)? YES NO
 IF YES, PLEASE DESCRIBE.

PARTICIPATION	Active*	COBRA	Retired*
Total Number of Current Employees (part time & full time)			
Total Number of Eligible Employees			
Number of Employees Applying for Coverage			

* Including Owners, Officers and Partners who receive compensation from the company, reported on a tax form other than a 1099.

DO YOU HAVE FACILITIES IN MULTIPLE LOCATIONS? YES NO IF YES, PLEASE LIST WHERE AND EMPLOYEES COUNTS

CITY AND STATE	TOTAL NUMBER OF EMPLOYEES	TOTAL NUMBER OF APPLICANTS

3. STANDARD BENEFIT OPTIONS - (check appropriate box(es))

GROUP SIZE ENROLLING	BENEFIT PROGRAMS	
2+	Please specify network(s): _____ SuperMed Plus: (May choose Two Plans including HSA Plans) <input type="checkbox"/> 15100 <input type="checkbox"/> 1580-250 <input type="checkbox"/> 2080-500 <input type="checkbox"/> 3070-500 <input type="checkbox"/> 3080-1000 <input type="checkbox"/> 1590 <input type="checkbox"/> 1580-500 <input type="checkbox"/> 2080-1000 <input type="checkbox"/> 3070-1000 <input type="checkbox"/> 3080-1500 <input type="checkbox"/> 1590-250 <input type="checkbox"/> 1580-1000 <input type="checkbox"/> 2560 <input type="checkbox"/> 3070-1500 <input type="checkbox"/> 3080-2000 <input type="checkbox"/> 1590-500 <input type="checkbox"/> 1580-1000-5000 <input type="checkbox"/> 2580-500 <input type="checkbox"/> 3080-2500 <input type="checkbox"/> 1590-1000 <input type="checkbox"/> 1580-1500 <input type="checkbox"/> 2580-1000 <input type="checkbox"/> 3080-5000 <input type="checkbox"/> Medical Plans _____ and _____	High Deductible Health Plan Options: (HSA Compatible Plans) <input type="checkbox"/> SMP 2200 <input type="checkbox"/> SMP 2500 <input type="checkbox"/> SMP 3000 <input type="checkbox"/> SMP 4000 <input type="checkbox"/> SMP 5000
2+	<input type="checkbox"/> SuperMed Vision	
2+	<input type="checkbox"/> SuperDental 180	
10+	<input type="checkbox"/> Traditional Dental Without Orthodontia <input type="checkbox"/> SuperDental 186 Without Orthodontia	
25+	<input type="checkbox"/> Traditional Dental With Orthodontia <input type="checkbox"/> SuperDental 186 With Orthodontia	
	<input type="checkbox"/> Medicare Carveout	

4. CURRENT and PRIOR CARRIER HISTORY (If more space is needed, attach an additional sheet in the same format.)

List all carriers used for all product lines offered to the employees for the past 5 years. If there are no carriers, indicate NONE.

CARRIER NAME (Current Carrier First)	CHECK IF CONTINUING COVERAGE	TYPE OF PLAN*	TYPE OF BENEFIT**	DATES		CURRENT RATES				RENEWAL RATES***				
				From	To	Single	2-Person	Family	Medicare	Single	2-Person	Family	Medicare	
1.	<input type="checkbox"/>													
2.	<input type="checkbox"/>													
3.	<input type="checkbox"/>													

* Examples: Traditional, HMO, PPO, etc... **Examples: Comp. Major Med., 1st Dollar, etc... *** For the current carrier and any continuing coverage.

5. LIFE, DEPENDENT LIFE AND SHORT TERM DISABILITY PLANS (check appropriate box(es))

LIFE AND AD&D INSURANCE (minimum \$15,000, maximum \$100,000 benefit amount):

All Eligible Employees \$ _____ each

All Eligible Employees _____ X Base Annual Earnings* to a maximum of \$ _____ (rounded to the next higher \$1,000)

Employees according to Class: Class Job Titles (as indicated on the employee enrollment form) Benefit Amount

1	_____	\$ _____
2	_____	\$ _____
3	_____	\$ _____

*excluding bonuses, overtime and other forms of extra pay

Life and AD&D benefits reduce by 35% at age 65, further reduce to 50% of the original amount at age 70, and terminate at retirement.

DEPENDENT LIFE INSURANCE (Only available if Life and AD&D is elected) Plan A Plan B Plan C

SHORT TERM DISABILITY INSURANCE - Benefits may not exceed 70% of basic weekly income (Only available if Life and AD&D is elected).
 Product Options (select one): 1-8-13* 1-8-26* *Benefits are payable for non-occupational disabilities only.
 Maximum Weekly Benefit (select one): (Choose benefit amount(s) in \$50 increments a maximum of \$600)
 \$ _____ per employee Employer Contribution: _____ %
 Benefits by same class designation as life insurance above: Class 1 \$ _____ Class 2 \$ _____ Class 3 \$ _____
 Percentage of weekly income: 60% 66 2/3% Other _____ % to a maximum of \$ _____ per employee.

6. VALIDATIONS (If more space is needed, attach an additional sheet in the same format.)

Groups completing the Employer Risk Assessment Form may skip 6A.

A • HAS ANY EMPLOYEE WITHIN THE PAST 24 MONTHS missed work due to a work related injury?
 ___Yes ___No If yes, provide below the employee name, the dates when work was missed and indicate if there was a Workers Comp claim.

B • IS ANYONE CURRENTLY COBRA Eligible/Enrolled? YES NO If Yes, provide details below.

NAME	SOCIAL SECURITY #	DATE OF QUALIFYING EVENT	EXPIRATION DATE	QUALIFYING EVENT

C • ARE THERE ANY RETIREES who meet the eligibility requirements? YES NO If Yes, provide details below.

NAME	SOCIAL SECURITY #	AGE AT RETIREMENT	DATE OF RETIREMENT	DATE OF HIRE	AVG. HRS. WORKED PER WEEK PRIOR TO RETIREMENT

7.

TERMS AND CONDITIONS

1. The group named herein, which is duly organized under the laws of the State of Indiana, hereby applies to Consumers Life Insurance Company and/or Fort Dearborn Life Insurance Co. (FDL) for the benefits selected herein. The group understands and acknowledges that the actual benefits will be specified in the group contract if this application is accepted by Consumers Life and/or FDL and that benefits will take effect as of the date specified in such group contract. **This Employer/Group Enrollment Application is not a contract for health care benefits. Continue your current coverage until you are notified in writing that Consumers Life has accepted this application.**
2. For all groups: Each employee not enrolling must complete the Waiver on the cover page of the employee application. Employees not enrolling are not required to complete the other sections. For groups with less than 51 employees: Each employee enrolling must complete all sections of the Employee Application, Change Form and Medical History Questionnaire (Sections 1 - 8).
3. To be eligible for coverage, an individual must be a full time employee of the group or company applying for coverage. Any individual who applies for insurance coverage from Consumers Life and/or FDL must be a full-time common law employee, drawing a regular paycheck and with compensation reported on IRS Form W-2. Independent contractors of the group or company are not eligible for coverage.
4. To be eligible for coverage by Consumers Life and/or FDL the group or company must be in compliance with all applicable laws of the State of Indiana.
5. Any untrue or incomplete information, statements or answers on this application (whether intentional or not) or engaging in any fraudulent conduct, deception or misrepresentation relating to any application, coverage, claim or usage of a Consumers Life identification card can result in denial of a claim or rescission of coverage for the group or any group member and may subject the group or any group member to legal action by Consumers Life or FDL.
6. Approval and acceptance of this Employer/Group Enrollment Application and individual Employee Applications are subject to Consumers Life and FDL underwriting guidelines.
7. It is agreed that this Employer/Group Enrollment Application supersedes any previous applications for this group coverage.
8. By signing this Employer/Group Enrollment Application, the authorized representative of the group or company represents that the group or company is not an entity that has been formed primarily to obtain health insurance coverage, and it does not permit membership in the group or company solely for the purpose of obtaining health insurance coverage.
9. The group hereby authorizes Consumers Life to obtain information from prior carriers to determine existence of pre-existing conditions. Prior carriers are authorized to release such information to Consumers Life and/or FDL upon receipt of a copy of this application.
10. I understand and agree that no agent or broker has the authority: (i) to bind Consumers Life and/or FDL by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information Consumers Life and/or FDL requests; (iii) approve coverage; (iv) make or alter any contract on behalf of Consumers Life and/or FDL; or (v) waive or alter any of Consumers Life Insurance Company's and/or FDL's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Consumers Life and/or FDL to be binding on Consumers Life and/or FDL.

8.

AUTHORIZED SIGNATURE

PRINT NAME and TITLE of the authorized representative who has full power and authority to legally bind and act on behalf of the group.	
SIGNATURE of the AUTHORIZED REPRESENTATIVE I certify that I understand the contents of this application and that the information stated herein is true and correct and that I will promptly notify Consumers Life and/or FDL of any changes.	DATE

9.

BROKER INFORMATION

BROKER (PLEASE PRINT)	TAX ID/SSN	BDS SALES REP
BROKER SIGNATURE	BROKER ADDRESS	

WARNING: 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 is guilty of insurance fraud.

