ASSURANT EMPLOYEE BENEFITS
EMPLOYER APPLICATION FOR GROUP INSURANCE
EDUCATOR BENEFITS SOLUTIONS®
Underwritten by Union Security Insurance Company, Kansas City, MO
☐ Group Short-Term Disability Income Coverage
☐ Group Long-Term Disability Income Coverage

I. APPLICANT INFORMATION

Full Corporate/Legal Name of Employer	Employer Tax ID No. (EIN)

Full Address of Employer **Note: If P.O. Box is used, a street address must also be included.**

Number/Street City State Zip

Names and Addresses of Subsidiaries, Divisions, or Affiliates to be Covered ☐ None
Name: Address:
1. _____
2. _____
3. _____
If additional space is needed, please use a separate sheet of paper and attach it to this form.

Employer Contact (Name/Title)	Telephone Number	Fax Number

E-mail address

Nature of Business	SIC Code

Business is organized as:

☒School Group If this is checked, it is: ☐ERISA ☐Non-ERISA
☐Other (*Specify)*_____

Financial Status (If you answer "Yes," please attach an explanation.)

☐ Yes ☐ No Have you opted out or do you anticipate opting out of Workers' Compensation, Social Security, PERS, STRS or any other state retirement system (if applicable)?

☐ To the best of my knowledge and belief, there are no 1099 Workers/Independent Contractors included in any eligible class.

Will the proposed insurance replace any existing group insurance? If "Yes," please provide a copy of the prior plan.

STD: ☐ Yes ☐ No If "Yes," list prior carrier name _____Prior Plan Termination Date_____

LTD: ☐ Yes ☐ No If "Yes," list prior carrier name _____Prior Plan Termination Date_____

Section 125 Plan Information
Will the proposed insurance be offered through a Section 125 Plan?
STD: ☐ Yes ☐ No
LTD: ☐ Yes ☐ No
Employee Contributions:
STD: ☐ Pre-tax ☐ Post-tax
LTD: ☐ Pre-tax ☐ Post-tax

Employer Contributions:
STD ☐ ____% LTD ☐ ____%

II. SCHEDULE OF BENEFITS – SHORT-TERM DISABILITY (STD)

STD Coverage Type: ☐ Non-occupational ☐ 24 hour coverage

Effective Date 12:01 a.m. Month Day Year	Total Number of Eligible Employees _____
Anniversary Date Month Day	Total Number of Employees Enrolled _____

STD Eligible Classes and Minimum Hours Requirement
An employee must be working at least _____ hours per week.

Standard option:
☐ All full-time employees in active employment in the United States with the Employer.

Alternate option: (Describe classes. Classes must pertain to conditions of employment and be approved by the Company.)
☐ Class 1: _____in active employment in the United States with the Employer.
☐ Class 2: _____in active employment in the United States with the Employer.

STD Waiting Period
A. For Employees in an eligible class on or before the policy effective date:
☐ None ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days Other _____

B. For Employees entering an eligible class after the policy effective date:
☐ None ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days Other _____

Note: Provided required premium is paid, and the employee is in active employment, coverage will begin on the first day of a month. (See plan for additional information.)

STD Maximum Period of Payment	**STD Elimination Periods Available:** (In Days of Injury/Sickness) *Check the box below for the plan requested:* 0/7	7/7	14/14	30/30
3 Months				
6 Months				
12 Months				

Deductible Sources of Income
☐ Immediate offset/all sources ☐ Including sick pay

Maximum Benefit Percentage	☐ 66 2/3%
Maximum Benefit Amount	☐ $7,500
Minimum Benefit Amount	☐ 25%
Pre-existing Condition Limitation	☐ 12/12 ☐ 3/12
Pre-existing Condition Benefit	☐ Yes
STD Portability	☐ Yes

III. SCHEDULE OF BENEFITS – LONG-TERM DISABILITY (LTD)

LTD Coverage Type: ☒ 24 hour coverage

Effective Date 12:01 a.m.
Month Day Year

Anniversary Date
Month Day

Total Number of Eligible Employees _____

Total Number of Employees Enrolled _____

LTD Eligible Classes and Minimum Hours Requirement:
An employee must be working at least _____ hours per week.
Standard option:
☐ All full-time employees in active employment in the United States with the Employer.
Alternate option: (Describe classes. Classes must pertain to conditions of employment and be approved by the Company.)
☐ Class 1: _____in active employment in the United States with the Employer.
☐ Class 2: _____in active employment in the United States with the Employer.

LTD Waiting Period

A. For Employees in an eligible class on or before the policy effective date:
☐ None ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days Other _____

B. For Employees entering an eligible class after the policy effective date:
☐ None ☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days Other _____

Note: Provided required premium is paid, and the employee is in active employment, coverage will begin on the first day of a month. (See plan for additional information.)

LTD Maximum Period of Payment	**LTD Elimination Periods Available:** (In Days of Injury/Sickness) *Check the box below for the plan requested:* 30/30	60/60	90/90	180/180	365/365
5 Years-SSNRA – Injury and Sickness					
SSNRA – Injury and Sickness					

Deductible Sources of Income
☐ Immediate offset/all sources ☐ Including sick pay

Regular Occupation Period	☐ 24 Months
Maximum Benefit Percentage	☐ 66 2/3%
Maximum Benefit Amount	☐ $7,500
Minimum Benefit Amount	☐ 25%
Pre-existing Condition Limitation	☐ 12/12 ☐ 3/12
Survivor Benefit	☐ Yes
Advanced Survivor Benefit	☐ Yes ☐ 3 months
Mental Illness Limitation	☐ 12 months
Drug & Alcohol Limitation	☐ 12 months
Special Condition Limitation	☐ 12 months
AD&D Benefit	☐ Yes
LTD Portability	☐ Yes
Workplace Modification Benefit	☐ Yes

IV. CERTIFICATE DELIVERY INFORMATION

Certificates are provided in electronic format for all coverages. Please review the following statement regarding your responsibilities in relation to electronic certificates.

Significance: Electronic Certificates ("e-certs") provide important information about insurance coverage and protection for insureds under the plan.

You must agree that you will: (1) Distribute e-certs to insureds under the plan; (2) not release or otherwise transfer e-certs to third parties (other than insureds) without the Company's prior written approval; (3) not alter, modify or otherwise change e-certs and will ensure that adequate security is in place to prevent insureds from doing the same; (4) take measures to ensure that the system furnishing e-certs results in actual receipt of the information by each insured (use return-receipt electronic mail features or periodic review/surveys to confirm receipt); and (5) convey to each insured the **significance** (see definition above) of e-certs, that the certificate is being furnished electronically and that the insured may request and receive a paper copy at no charge.

☐ If you are unable to comply with the above listed e-cert responsibilities, check here and paper certificates will be provided to you.

Contact (Name/Title) for Electronic Certificates: _____

Email Address:_____(E-certs will be sent to this Email Address)

V. SPECIAL INSTRUCTIONS:

Unless specific state language is provided below, and except for Virginia, the following general fraud notice applies: *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 subjects such person to criminal and civil penalties.*

Florida and Oklahoma: *Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.* Ohio: *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.* New Jersey: *Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.* New York: *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 act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.* Oregon: *Any person who knowingly, and with the 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 may be subject to prosecution for insurance fraud.*

VI. APPLICANT AGREEMENT

On behalf of the Applicant (Employer), I understand that the requested insurance will not be effective until this Application is approved and accepted by the Company.

I understand that no agent or broker has the authority to accept or guarantee acceptance of the requested insurance.

I understand that the plan for which I am applying includes minimum participation requirements. If a sufficient number or percentage of eligible employees fails to enroll and the minimum participation requirements for the plan are not met, the insurance will not become effective.

If the requested insurance is approved and accepted, that insurance will automatically terminate if the premiums are not paid before the end of the grace period following the due date. Payment of premiums for coverage during the grace period is required. Insurance coverage will terminate if the number or percentage of participants falls below that required by the group plan.

An employee who is not in active employment on the plan effective date or on the date the employee's coverage would otherwise take effect will not be covered until the employee returns to active employment.

Employees working outside the United States are not covered by the plan unless agreed to, in writing, by the Company.

1099 Workers/Independent Contractors are not covered by the plan unless agreed to, in writing, by the Company.

I agree to deduct premiums from the payroll and remit to the Company on a monthly basis. I agree to cooperate with the Company regarding premium collection and reconciliation.

I will indemnify the Company for any claims made by employees regarding our actions or inactions with respect to premiums.

Payroll deductions are scheduled to begin _____.

I have read and understand this entire application. The information provided is true, accurate and complete to the best of my knowledge and belief. I understand that the information on this application and any other information I provide shall serve as the basis for the insurance to be issued, and that I have a duty to notify the Company of any changes. If applying for insurance as a Participating Employer, it is understood and agreed that this application serves as an agreement to participate in the Charter Series Group Insurance Trust. It is understood and agreed that this application shall be made a part of the policy or plan.

☐ I am authorized to sign on behalf of the Applicant (Employer).

If this Application is being signed after the requested effective date, you must complete the following:
☐ To the best of my knowledge and belief, there have been no claims incurred since the requested effective date.

EMPLOYER
Name and Title (please print)
Authorized Signature
Date
Dated at (City, State)

AGENT OF RECORD – WRITING AGENT
Name (please print)
Telephone
License # State
I have met with the Employer submitting this application and I have fully explained the contents of this application. I have discussed coverage, eligibility, restrictions, limitations, exclusions, the effect of misrepresentations, and termination provisions. To the best of my knowledge and belief, all responses given on this application are true, accurate and complete. Signature Date