Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

5011 GATE PARKWAY, BLDG. 200
JACKSONVILLE, FLORIDA 32256

GROUP TERM LIFE INSURANCE APPLICATION

Type or Print In Black Ink

1. Legal Name of Policyholder		Taxpayer ID#	Home Office Use – Group #
2. Mailing Address of Policyholder	City	State	Zip+4
3. Street Address of Policyholder (if different from above)	City	State	Zip+4
4. Name of CEO, President or Owner of Company	Telephone Number of Policyholder		
5. Name of Insurance Contact at Company	Email Address of Insurance Contact	Fax Number of Policyholder	
6. Name of Subsidiary or Affiliate Companies to be Covered			

7. Nature of Business	Effective Date as of 12:01 a.m.	First Renewal Date	Number of Employees Eligible Enrolled ___	SIC Code

8. Do you have any employees located in states other than the policyholder's street address? ☐Yes ☐No
If yes, please list states.

9a. Waiting Period (applies to present and future employees)
☐ Premium Due Date following completion of ___ days
☐ Day following completion of _____ days

9b. Employer Contribution: Life and AD&D ___%
Dep. Life ___%
Other ___%

9c. Premiums are to be paid: ☐ Monthly ☐ Other Due Date: ☐ 1st of the month ☐ 15th of the month ☐ _____ of the month

10. Class Definitions for Basic Coverage(s): If more than one class, definitions must be specific.

Class 1 _____
Class 2 _____
Class 3 _____
Class 4 _____

Employees working less than 30 hours per week are not eligible for coverage unless otherwise noted above and approval received.

11. Selection of Coverage: Check all that apply and fill in all applicable blanks.

AMOUNTS OF INSURANCE

Class	☐ Life	☐ AD&D Principal Sum ☐ Supp AD&D	☐ Supp Life	☐ Dependent Life	☐ Hospital Indemnity Benefit
1	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____
Initial Rates					**EE $** _____ **EE/Sp $** _____ **EE/Child(ren) $** ____ **EE/Family $** _____

12. If the Life and AD&D benefit is a multiple of salary amount should be rounded to:
☐ the next higher ☐ the next lower ☐ the nearest Multiple of $ _____, if not already a multiple.
Not to exceed a maximum of $ _____.

13. Hospital Indemnity Benefit: ☐ **Yes** ☐ **No** **Daily Benefit:** _____/ **day** **Employer Contribution:** ____
Coverage Available: ☐ **Employee** ☐ **Employee/Spouse** ☐ **Employee/Child(ren)** ☐ **Employee/Family**

Information on Page 2 must be completed.

Please complete and sign this page.

Legal Name of Policyholder	Taxpayer ID#

14. Waiver of Premium:
☐ 5 Year Waiver ☐ Other _____

15. Guaranteed Issue	Changes in benefit amounts in accordance with the Schedule shown above will become effective on:
$ (Life and AD&D amounts over Guaranteed Issue are subject to evidence of insurability.)	☐ the first day of the policy month following the date of change; or ☐ the policy anniversary date coincident with or next following the date of change; or ☐ on the date of change; or ☐ other (give details): _____

16. Dependent Life Insurance (Not more than 50% of employee life amount)
☐ Yes ☐ No Spouse $ _____
Children: (select one age range) ☐ from birth to 6 months ☐ from 14 days to 6 months $ _____
(select one age range) ☐ 6 months to 25 years ☐ 26 years to 30 years $ _____

17. Reductions and Termination (Benefit reduction due to age will be effective on the insured's birthday.)
☐ Life and AD&D reduce 35% at age 65, reduce to 50% at age 70, and to 25% at age 75.
☐ Life and AD&D reduce 33% at age 70, and 33% of the previously reduced amount every five years thereafter (rounded to nearest $250).
☐ Other _____

18. Is this a Replacement of Similar Coverage? ☐ Yes ☐ No (If yes, a copy of prior carrier's plan is required.)

Previous Carrier: _____ Termination Date of Prior Plan: _____

REMARKS OR SPECIAL PROVISIONS

It is understood and agreed that this application shall be made a part of the policy or applied for and that no insurance shall be effective until approved by the Company at its Home Office.

COMPLIANCE NOTICE: Florida Combined Life does not provide legal or tax advice. Based upon information you have provided us about your group, we will notify you if we perceive any obvious deficiency in your plan, but you must consult your own legal counsel for definitive advice and opinions regarding your plan's compliance.

FRAUD NOTICE - Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

The applicant hereby certifies that the information contained in this application, including any attachment to it, is true and complete. The applicant understands that Florida Combined Life Insurance Company, Inc. (FCL), relies upon such information in considering or accepting this application, which will become part of the contract. If the policy is issued, it will be binding on you and us. It is also agreed that no insurance will become effective until approved by FCL. **(Please print, except where signature is requested.)**

For (Name of Applicant):	Group Representative:	Licensed Agent (FL) (If none put N/A)
By and Title:	Group Representative Code and License #:	License # (Social Security #/Federal Tax ID):
Signature:	Group Representative Signature:	Licensed Agent Signature:
Group Representative Email		
Licensed Agent Email		
Signature of Witness:	Dated at:	Date:

Agent/Marketing Representative:
Will this replace any existing coverage? ☐ No ☐ Yes If yes, indicate the product(s):

_____