AIG

AIG Benefit Solutions

Underwritten by
American General Life Insurance Company*
Houston, Texas
* This company does not solicit business in New York

MASTER APPLICATION FOR EMPLOYEE BENEFITS

Administrative Office: PO Box 30083, Tampa, FL 33630-3083

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.

(A group proposal is required as part of this application. If any of the data on this application conflicts with the data in the group proposal, the data in the group proposal will supercede.)

Applicant Data

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: _____ & Number of years in 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 affiliated American General Companies, 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				***Replacing with the Company's Plans?****	***Prior Plan Name & Effective Date***	***Proposed Termination Date***
Employer		***Employee Pay All***				
Life**	☐	Life**	☐	☐ Yes ☐ No		
ADD	☐	ADD	☐	☐ Yes ☐ No		
Dental	☐	Dental	☐	☐ Yes ☐ No		
Vision	☐	Vision	☐	☐ Yes ☐ No		
STD	☐	STD	☐	☐ Yes ☐ No		
LTD	☐	LTD	☐	☐ Yes ☐ No		
Critical Illness	☐	Critical Illness	☐	☐ Yes ☐ No		
Hospital Indemnity	☐	Hospital Indemnity	☐	☐ Yes ☐ No		
Accident	☐	Accident	☐	☐ Yes ☐ No		

* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).
** Are there other Employer Sponsored 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 Employee Pay All 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 Employee Pay All 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 Employee Pay All 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	Critical Illness	Hospital Indemnity	Accident
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 Employee Pay All 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 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.
8. It is understood and agreed that the group employer will pay, in advance, the required premium for these coverages.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

DATE	PRINT NAME & TITLE OF OFFICER, PARTNER, PROPRIETOR
WITNESS	SIGNATURE OF OFFICER, PARTNER, PROPRIETOR

* Amount of hours my 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

Important Notice

For residents of Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of 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.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

The following statement does not apply to an application for life insurance in New York:

For residents of 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 insurance 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.

For residents of 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.

For residents of Oklahoma: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: 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.

Disclosure Regarding Compensation

Your insurance or benefits advisor can offer you advice and guidance as you select the policy and provider most appropriate for your needs. At American General Life Insurance Company we recognize the important role these professionals play in the sale of our products and services and offer them a variety of compensation programs. Your advisor can provide you with information about these programs. We support disclosure of broker compensation so that customers can make an informed buying decision.

Brokers may be eligible to receive Base Commissions and Supplemental Compensation from American General Life Insurance Company.

Unless you have agreed in writing to compensate the broker differently, American General Life Insurance Company provides Base Commissions to all producers in connection with the sale of an insurance policy. Base Commissions area fixed percentage of the policy premium, and include a one time, first year flat amount for each policy sold. Base Commissions are paid by American General Life Insurance Company to your producer as long as they remain the broker of record on your policy.

A producer may also qualify for Supplemental Compensation paid by American General Life Insurance Company. For group insurance products, Supplemental Compensation may be paid in an amount equal to a fixed percentage of total group insurance premiums. The Supplemental Compensation percentage may range from 0% to 7% of total premiums paid. The exact Supplemental Compensation percentage payable to any producer is based upon the total dollar amount of all group insurance premiums or number of policies that the broker had in force with American General Life Insurance Company and affiliated American General Companies in the prior calendar year. Supplemental Compensation may be calculated differently for other insurance products. The premium you pay is not impacted whether or not your broker receives Supplemental Compensation.

If you would like additional information about the range of compensation programs our company offers for your group insurance policy or any other AIG Benefits Solutions product, you can find more details at www.AmericanGeneral.com/employeebenefits. Should you have other questions not addressed by the website, including Supplemental Compensation, please contact your Benefits Solutions representative.

CENSUS INFORMATION (This form may be photocopied if additional supply is needed) – Not applicable for Employee Pay All 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 M D Y	Date of Hire	Marital Status**	# of dependents	Coverage Election E-Employee S-Spouse****, C-Child	Coverage Selected – Please check									
											Life	LTD	STD	INT. DIS	Dental	Vision	Critical Ill.	Cancer	HIP	Accident
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**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, D-Divorced, P-Civil Union Partner, Domestic Partner*

****Please state if salary is per hour, per week, per month or per year.*

*****Note: The term "spouse" includes New Jersey civil union partners as well as partners in relationships from other jurisdictions (whatever they may be called) that provide substantially all of the rights and benefits of marriage, and will be treated as civil unions under New Jersey Law. In addition, the term includes domestic partners (or whatever they may be called) formed in other jurisdictions that provide some, but not all of the rights and obligations of marriage, and will be treated as domestic partnerships under New Jersey Law.*

For H.O. only:
Group Number: _____

IMPORTANT NOTICE – For Hospital Indemnity Plan Applicants

The American General Life Insurance Company ("AGL") believes that the Hospital Indemnity Plan that you are applying for qualifies as a supplemental excepted benefit under the Affordable Care Act ("ACA"), provided that you also maintain major medical or other required minimum essential coverage. It does not qualify as an excepted benefit if you do not maintain major medical or other minimum essential coverage. Therefore, AGL is providing you with this important Disclosure Statement about the Hospital Indemnity Plan.

THE HOSPITAL INDEMNITY POLICY AND THE ASSOCIATED CERTIFICATES ARE SUPPLEMENTAL TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE.

_____ _____

Applicant's Signature Date