



Employer Application for Group Insurance for Life, AD&D, Short-Term Disability and Dependent Life

Healthy Alliance Life Insurance Company
1831 Chestnut Street, St. Louis, MO 63103

Please type or print all information.

Part 1: Applicant Information

1. Policyholder (correct legal name): _____

2. Mailing Address (not P.O. Box): _____

3. Group Contact: _____ Phone: () _____
Name of any: Affiliates Subsidiaries to be covered Fax: () _____

Check if applicable:
 Partnership
 Subchapter S Corp.
 Sole Proprietorship

If separate bills are desired, list addresses of subsidiaries on a separate sheet.

4. Nature of Business _____ 5. SIC Code _____ 6. Effective Date _____ 7. First Anniversary _____

8. Contributions – Employer will contribute:
Life/AD&D 100% Other _____%
STD 100% Other _____%
Dependent Life 100% Other _____%

9. Waiting Period:
 None
 First of the month following completion of ____ Days
 Premium due date following completion of ____ Days
 Other _____

10. Waiting Period applies to:
 All employees New employees only

11. Total eligible* employees: _____ *i.e., working a minimum of
Total enrolled: _____ hours per _____

12. As of the proposed effective date (Item 6 above) are any of your employees not "Actively at Work" (defined in Part 2 below)?
 Yes No If "Yes," please provide the following information (attach a signed date sheet if more space is needed):

A. Name _____ Sex Male Female Date of Birth _____
Benefit Amount \$ _____ Date Last Worked _____
Reason Not Actively at Work: Disability Family Leave Other _____

B. Name _____ Sex Male Female Date of Birth _____
Benefit Amount \$ _____ Date Last Worked _____
Reason Not Actively at Work: Disability Family Leave Other _____

13. Initial Rates Guaranteed for _____ months.

14. Billing Method:
 List Billed TPA Billed
 Self Administered

15. Premium Deposit \$ _____
(approx. one-month premium)

16. Does this policy replace an existing policy?
 Yes No If "Yes," list name of
prior carrier: _____

Part 2: General Conditions

It is understood and agreed that this application shall be made part of the Policy for which application is made. It is further understood:

1. Being Actively at Work is a requirement for coverage. If an employee is not Actively at Work on the day his coverage would otherwise be effective, the effective date of his coverage will be the date of his return to Active Work. If an employee does not return to Active Work, he will not be covered. The terms "Actively at Work" and "Active Work" mean that an employee is performing the normal duties of his occupation; is working the number of hours specified in Part 3, Schedule

of Benefits; and satisfies any other conditions required by the applicable group Policy.

2. This insurance is subject to the approval of Healthy Alliance Life Insurance Company, (HALIC) and nothing contained therein shall be binding upon HALIC until this application is approved and accepted at HALIC's home office.

3. No waiver or change will bind HALIC unless signed by an Executive Officer of the Company. The above information is true and accurate to the best of my knowledge. I understand that the information on this application

and any other information I provide shall serve as the basis for the Policy to be issued, and that I have a duty to notify HALIC of any changes. I have relied upon no oral or written representations that contradict item (1) above.

NOTE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information, or who 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.

Policyholder / Authorized Signature

Date

Title

Licensed Resident Agent (if required)

Part 3: Schedule of Benefits

Class Definitions (if more than one class, definition 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.

Selection of Coverage(s) (check all that apply and fill in all applicable blanks):

Class	<input type="checkbox"/> Life Insurance Amount of Insurance	<input type="checkbox"/> AD&D Principal Sum	<input type="checkbox"/> Short-Term Disability Maximum Weekly Benefit
1	\$ _____	\$ _____	\$ _____
2	\$ _____	\$ _____	\$ _____
3	\$ _____	\$ _____	\$ _____
4	\$ _____	\$ _____	\$ _____

Dependent Life Insurance:

Spouse \$ _____
Child(ren) 8 days to 6 months \$ _____
6 months to 19 years* \$ _____
**23 years for full-time students*

STD Benefit Payable: ____ day of Accident
____ day of Sickness for a maximum of ____ weeks
1st day of Hospital? Yes No

Refer to General Provisions 5, 6, and 7 below.

General Provisions (fill in all applicable blanks):

- Life and AD&D benefits include 24-hour coverage.
- If the 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 \$ _____
- Salary does not include bonuses, overtime or any form of extra pay. If salary is based on whole or in part on commissions, the benefit amount will include the amount paid in commissions during the preceding 12-month period.
- Basic Life and AD&D benefits reduce to ____% of the original amount at age ____, further reduce to ____% of the original amount at age ____ and further reduce to ____% of the original amount at age ____.
- Weekly STD benefit is subject to a maximum of ____% of employee's basic weekly wage.
- Basic weekly wage does not include bonuses, overtime, or any form of extra pay. If weekly wage is based in whole or in part on commissions, the weekly benefit amount will include the average of the amount paid in commissions during the preceding 12-month period. Benefit payment is based on a 7-day work week.
- STD Benefits payable for non-occupational disabilities only.
- All benefits terminate at retirement.

Guarantee Issue (amounts in excess of the amount stated are subject to satisfactory evidence of insurability):

Basic Life \$ _____ STD \$ _____ Other: _____

For Group Use Only:

Federal Tax ID: _____

Form 5500, Schedule A: Yes No If "Yes," benefit plan year is _____ Insured Benefit Amount Yes No

Information should be sent to: _____

Blue Cross Blue Shield of Missouri is the name RightCHOICE® Managed Care, Inc. (RIT) uses to do business in most of Missouri. RIT and certain affiliates administer benefits underwritten by Healthy Alliance® Life Insurance Company (HALIC). RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association.