EPIC SPECIALTY BENEFITS

Employer Application for Group Insurance Coverage

The EPIC Life Insurance Company
1717 W. Broadway
Madison, WI 53713

Instructions: Please complete the entire form in black ink. **Important:** Coverage won't become effective until we notify you in writing.

1. Employer Information

Requested Action:
☐ New Group Enrollment
☐ Change to Existing Group Number_____
(Complete the Employer Information section and any other sections applicable to your change request.)

Employer Full Legal Name _____

Address _____ City _____ State _____

Zip Code _____ County_____ Federal Tax ID Number _____

Requested Effective Date _____ Requested Anniversary Date_____

Type of Ownership: ☐ Partnership ☐ Proprietorship ☐ Corporation
☐ Service Corporation (SC) ☐ Limited Liability Corporation (LLC)

Nature of Business (please be specific): _____ SIC code: _____

Business Start Date _____ Will this coverage replace existing group insurance plan? ☐ Yes ☐ No

If yes, provide name of current carrier_____ Anticipated Termination Date_____

Please list the name of all subsidiaries and/or affiliated companies	Are you requesting coverage for this group?	Number of Eligible Employees
	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____
	☐ Yes ☐ No	_____

Is the firm applying for coverage eligible to file a tax return with the above-named subsidiaries and/or affiliated? ☐ Yes ☐ No

2. Eligibility and Enrollment

A. 1. Total Number of Employees ..... _____
2a. Employees in ineligible classes ..... _____
2b. Part-time employees ..... _____
2c. Seasonal employees ..... _____
2d. Employees in probationary period ..... _____
2e. Others (please specify_____) ..... _____
2f. Total Number of *Ineligible* **Employees** (2a + 2b + 2c + 2d) ..... _____
3. Total Number of *Eligible* **Employees** (1 – 2f) ..... _____

B. Eligibility Requirement:

☐ Employees actively at work a minimum of 30 hours per week*

☐ Employees actively at work a minimum of _____ hours per week**

☐ Retirees**

☐ Other** (please specify) _____

* Standard eligibility requirement for groups with 50 or fewer eligible employees.

** Groups with at least 51 eligible employees may request a non-standard eligibility requirement, subject to underwriting approval.

C. Employee Enrollment: ☐ Applications ☐ Online enrollment ☐ Current census

D. Are domestic partners and their dependents eligible for coverage? ☐ Yes ☐ No

Wis. Stat. 66.0137(1)(ae) prohibits domestic partnership coverage for Wisconsin local government unit employees.

E. Are civil union spouses and their dependent(s) eligible for coverage? ☐ Yes ☐ No

F. Is any employee or dependent who would otherwise be eligible to enroll disabled, not at work, unable to work, confined to a hospital or contemplating a confinement, on a leave of absence, handicapped, or otherwise incapacitated as of the requested effective date? ☐ Yes (Please identify below.) ☐ No

Name	Relationship	Status	Date Last Worked	Expected Return to Work
Example: Heidi A. Johnson	*Employee*	*Hospitalized*	*07-01-2019*	*09-15-2019*

Attach a separate sheet if you need additional space.

G. Are any employees or dependents (including spouses) proposed for coverage currently on group continuation coverage, including COBRA coverage? ☐ Yes (Please identify below) ☐ No

Name	Relationship	Continuation Began	Duration
Example: John H. Smith	*Employee*	*12-15-2018*	*18 months*

Attach a separate sheet if you need additional space.

H. Is each coverage applied for subject to or part of a union-negotiated collect bargaining agreement? ☐ Yes ☐ No

If yes, when does that agreement expire? _____

I. Is this application being made on behalf on an Association, Chamber, or Trust? ☐ Yes ☐ No

If yes, please provide its name _____

J. Are any classes of employees to be excluded from any coverage? ☐ Yes ☐ No

If yes, please explain and identify each coverage_____

3. Probationary Period

A. Please provide the probationary period and eligibility date for each class.

Class	Coverage	Probationary Period	Eligibility Date
Example: Hourly Employees	*Base life and AD&D*	*90 days from date of hire*	*First day of the calendar month following satisfaction of the probationary period.*
Example: All Employees	*Long-term Disability*	*Three months from date of hire*	*Day following satisfaction of the probationary period.*

Attach a separate sheet if you need additional space.

B. Prior employment to count toward probationary period for employees rehired within:

☐ Three (3) Months ☐ Other – Rehire periods longer than three months require EPIC's approval.

Duration_____Reason_____

4. Premium Payment and Billing Options

A. Premium Payment Options

☐ Pay by Check: You agree to pay EPIC by check before the premium due date, which is the first day of the coverage period. A check for $_____payable to EPIC is being submitted with this application. EPIC will apply this payment toward the first month's premium if it approves this application and issues the group policy(ies)/coverages.

☐ Automatic Withdrawal: I hereby authorize The EPIC Life Insurance Company, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my: (select one)

☐ Checking Account – Please attach a voided check. ☐ Savings Account

indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same amount to such account.

Depository Name_____Branch_____

City_____State_____Zip Code_____

Transit Number_____ Account Number_____

This authority will remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Signature of Employer Representative_____ Date_____

Name and Title (please print) _____

Telephone Number _____Email Address_____

B. Billing Options

Bill Type: ☐ List Bill ☐ Self Bill (only available to groups with 100 or more enrolled employees)

Bill Frequency: ☐ Monthly ☐ Quarterly ☐ Other_____

Billing Contact Person _____ Title _____

Telephone Number _____ Email Address _____

5. Employer's Statement/Certification

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been advised: (1) Not to terminate all existing coverage(s), whether on an insured or self-funded basis, unless and until EPIC notifies me in writing that coverage(s) has been approved; (2) EPIC doesn't guarantee approval of this application or issuance of coverage(s); (3) This application or any coverage may be declined by EPIC; (4) The agent represents the employer, not EPIC; and (5) Pre-existing conditions may be subject to waiting periods and other policy limitations and restrictions.

I understand that EPIC will rely on the information I provided in and with this application and that EPIC may attempt to verify it. EPIC will issue or deny coverage(s) to the group and its employees based upon this information and its subsequent research. If EPIC approves this application, I understand coverage(s) will become effective on the date assigned by EPIC. No coverage(s) will be in force until that date.

I understand no coverage(s) will become effective for an employee and his/her dependents, if any, if he/she is not actively at work with the employer on the assigned effective date. Such coverage(s) will become effective on the first day after he/she returns to work performing all the material duties of his/her job and becomes a member of a class eligible for coverage.

I understand no agent or other person, other than the President & Chief Executive Officer or Chief Operating Officer of EPIC, has the authority to alter, bind EPIC, waive or change any terms, conditions, and/or provisions of the policy(ies) or any other requirement imposed by EPIC. I understand the employer represents its employees and their dependents, not EPIC. As the employer's authorized representative and acting on that employer's behalf, I understand, agree with, and approve all the writing agent's certifications in Section 6 (Agent Certification) of this application.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the insurer may rescind and void any coverage if it determines that you, the employer, is listed on the SDN list or associated with an entity listed on the SDN list. Furthermore, EPIC may rescind and void any coverage if it determines that a covered employee, or a covered employee's spouse or named dependent, are either listed on the SDN list or associated with an entity listed on the SDN list.

If this application is approved, I understand that EPIC will not be, and is not, a plan sponsor, plan administrator, plan trustee, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any other state or federal law. I understand the employer is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies.

If EPIC approves this application, the actual benefit options for this employer's group coverage(s) will be contained in (1) the final, written and signed proposal; and (2) the EPIC Certificate of Insurance(s) which is part of the group insurance policy(ies) issued by EPIC to the employer as the EPIC group policyholder.

Name_____Position/Title_____Telephone Number_____

Signature of Employer Representative_____Date_____

Signed at City_____ State_____

6. Agent Certification

I hereby certify and represent all of the following as being true: (1) I asked all questions accurately and fully recorded all information given by the Employer Representative in this application; (2) I advised the Employer Representative not to terminate existing coverage unless, and until, EPIC notifies him/her, in writing, that this application has been approved; (3) I used only advertising approved by EPIC to solicit this application; (4) I told the Employer Representative nothing inconsistent

with, or contrary to, the approved advertising about the benefits, group policy(ies)/and or coverage(s); (5) I did not guarantee EPIC's approval of this application or EPIC's issuance of coverage(s); (6) I did not tell the Employer Representative that EPIC will cover any pre-existing condition(s) of any person proposed for coverage; and (7) I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and the marketing/sales standards maintained by EPIC.

I hereby certify and represent all of the following as being true: (1) I told the Employer Representative that EPIC has no liability for anything I said or failed to say before, during, or after the application process, that is not subsequently confirmed in writing by an EPIC authorized executive officer, including, but not limited to answers given by me in response to questions asked by that Representative or anyone else; (2) I told the Employer Representative that EPIC is not liable for any statement, representation, or other information provided to that Representative or anyone else that is not expressly contained in a written document provided to them and signed by an EPIC authorized executive officer; (3) I understand that I am liable for my acts and omissions to the extent provided by law; and (4) I understand I have no authority to alter this application, bind EPIC by making promises and/or representations or to waive or change the terms, conditions, and/or provisions of the group insurance policy(ies) or any requirement imposed by EPIC.

Signature of Writing Agent_____Date_____

Writing Agent's Name_____ Writing Agent's Social Security Number_____

Agency Name _____Tax ID Number_____

Agency Address_____City_____State_____Zip_____

Agency Telephone Number_____ Agency Number_____ Fax_____

Agency Email _____EPIC Representative Name_____

7. Issue Information

Initial issue of contract documents are to be sent to: ☐ Agency ☐ Employer ☐ Other_____

IMPORTANT – PLEASE INCLUDE THE FOLLOWING:

☐ A signed copy of EPIC's Proposal; and
☐ A completed and signed Employee's Application for Group Insurance Coverage for each employee eligible for one or more coverages requiring he or she pay all or part of the premium; and
☐ A check payable to EPIC for the first month's premium if you will be paying premium by check; and
☐ A copy of your current plan documents for the coverage(s) EPIC will be providing; and
☐ A current census of all full and part-time employees if more than 50 employees are eligible for coverage; and
☐ A copy of 1) the most recent bill from your current carrier or administrator or 2) your most recent Quarterly Wage and Tax Report.