EPIC | SPECIALTY BENEFITS

Employee's 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. If you are waiving/declining coverage at this time you are still required to complete Sections 1.,2.,3., and 4.

1. General Information

Requested Action:
- ☐ Add coverage
- ☐ Reinstate coverage
- ☐ Terminate coverage
- ☐ Change coverage

Reason:
- ☐ New employee
- ☐ Return to work
- ☐ Birth or adoption
- ☐ Other (please specify)________________________________
- ☐ Late application
- ☐ Marital status change

Group Name ________________ Group Number ________ Requested Effective Date __________

Last Name ________________ First Name ________________ Middle Initial ________

Employee Address ________________ City ________ County ______ State ___ Zip ______

Date of Birth ________ Phone Number ____________ Social Security Number ________________

Employee Email ______________ Occupational Title ____________ Annual Earnings $__________

Date of Hire ________ Hrs. Worked/Week ________ Marital Status: ☐ Single ☐ Married Sex: ☐ Male ☐ Female

Have you ever applied for, been insured by, or are currently insured by The EPIC Life Insurance Company? ☐ Yes ☐ No

If yes, provide details: ____

List all family members to be insured including first and last name (For additional space, use separate sheet)	Relationship to Employee	Sex	Birth Date

2. Beneficiary Selection

Primary Beneficiary (if multiple, specify allocation to equal 100%)

Name and Relationship	Date of Birth	Address	% of Benefit

Contingent Beneficiary (optional)

Name and Relationship	Date of Birth	Address	% of Benefit

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent for Community Property States Only: If you live in a community property state – Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – then this Spousal Consent section should be completed if your spouse is not listed as the primary beneficiary in order for the above designation to be valid. This Spousal Consent allows your spouse to waive his or her rights to any community property interest in the benefit.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of the applicable group benefits under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this policy.

Signature of Employee's Spouse: ____ Date: _________________________

3. Coverage Selection

Please check the coverage(s) that you are applying for below. Availability of coverage(s) is based on your group's selected plan of insurance.

Coverage Type	Applying For	Waiving/Declining
Term Life Guarantee Issue___________________________	☐ Myself	☐ Myself
Accidental Death and Dismemberment Guarantee Issue___________________________	☐ Myself	☐ Myself
Dependent Term Life	☐ My Spouse ☐ My Dependents	☐ My Spouse ☐ My Dependents
Voluntary/Supplemental Term Life Guarantee Issue___________________________	☐ Myself $___________ or ____ x your annual earnings ☐ My Spouse $__________ ☐ My Dependents $_________	☐ Myself ☐ My Spouse ☐ My Dependents
Voluntary/Supplemental AD&D Guarantee Issue___________________________	☐ Myself $___________ or ____ x your annual earnings ☐ My Spouse $__________ ☐ My Dependents $__________	☐ Myself ☐ My Spouse ☐ My Dependents
Short-Term Disability Guarantee Issue___________________________	☐ Myself $___________	☐ Myself
Supplemental (Buy-Up) Short-Term Disability Guarantee Issue___________________________	☐ Myself $___________ * Base + supplemental can't exceed 60% of Pre-Disability Earnings	☐ Myself
Voluntary Short-Term Disability Guarantee Issue___________________________	☐ Myself $___________	☐ Myself
Long-Term Disability Guarantee Issue___________________________	☐ Myself $___________	☐ Myself
Supplemental (Buy-Up) Long-Term Disability Guarantee Issue___________________________	☐ Myself $___________ * Base + supplemental can't exceed 60% of Pre-Disability Earnings	☐ Myself
Voluntary Long-Term Disability Guarantee Issue___________________________	☐ Myself $___________	☐ Myself

Coverage Type	Applying For	Waiving/Declining
Dental ☐ Traditional ☐ Base ☐ Voluntary Traditional ☐ Buy-up	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents ☐ Coverage through my Spouse
Dental (Preferred Provider) ☐ Traditional PPO ☐ Voluntary PPO Preferred Provider Network_________________	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents ☐ Coverage through my Spouse
Vision Plan Identifier_________________	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents ☐ Coverage through my Spouse
Hospital Indemnity	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents

4. Agreement Authorization

I hereby request coverage for the group benefit(s) selected above in Section 3. I authorize my employer to take deductions from my pay if contributions are required for the coverage elected.

CERTIFICATION: I represent and certify all of the following: (1) I am employed by the employer named herein and am working the number of hours indicated in Section 1. above; (2) I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; (3) I entered each and every answer myself in response to each request for information and/or question; (4) no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); (5) such representations are true, accurate, and complete to the best of my knowledge; (6) I, and my spouse and dependent(s), have been given the opportunity to apply for the coverage(s) available to me (us) through my employer; and (7) and I was neither pressured nor forced by my employer, the agent, or EPIC into waiving/declining any coverage as shown in Section 3.

UNDERSTANDING: I understand: (1) the representations I make, together with any supplemental representations that I make, shall be the basis for EPIC to determine eligibility for issuing coverage; (2) that no person, except the President & CEO or Chief Operating Officer of EPIC, has the authority to: (a) determine whether any contract (s) of insurance shall be used on the basis of the application;(b) waive or modify any of the provisions of the application or any of EPIC's requirements or rights; (c) bind EPIC by any statement or promise pertaining to any insurance contract (s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained on the written application (3) that no coverage will be effective unless and until the date specified by EPIC after this application has been approved by EPIC; (4) any misrepresentation contained herein may be used to reduce or deny a claim, void coverage, or void the group contract(s) within the contestable period, if such misrepresentation materially affects EPIC's acceptance of the risk; including approving any person for coverage; (5) if I decline any coverage, future changes in coverage are NOT automatic and will be subject to EPIC approval; and (6) if my death occurs before EPIC has approved in writing any EPIC coverage, the only death benefit provided shall be the lesser of the maximum amount available without evidence of insurability or the maximum amount I am eligible for, under the coverage(s) for which I was eligible.

I understand that EPIC fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, EPIC may rescind and void any coverage if it determines that the employer, 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 any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer. An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I understand that EPIC is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that is not expressly contained in a written document provided to them and signed by an EPIC authorized executive officer.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

Has any person assisted you in the completion of this form? ☐ **Yes** ☐ **No**

If yes, please print name:____

Applicant's Signature:____ Date Signed:________________________