



APPLICATION FOR GROUP INSURANCE

Please Type or Print All Information

17800 Royalton Road
Strongsville, Ohio 44136-5149

CONSUMERS LIFE
INSURANCE COMPANY
A MEDICAL MUTUAL OF OHIO COMPANY

Group Number

PART 1: APPLICANT INFORMATION

1. Policyholder (legal name)
2. Mailing Address (not P.O. Box)
Group Contact
Phone ( )
City
State
Zip
Fax ( )
3. Name of any Affiliates Subscribers to be covered
e-mail
4. Nature of Business
5. SIC Code
6. Effective Date
7. Initial Rates Guaranteed for months
8. Contributions: Employer will contribute:
Basic Life
Basic AD&D
Supplemental Life
Supplemental AD&D
Dependent Life
Short-Term Disability
Voluntary Life and AD&D
Voluntary Short-Term Disability
9. Waiting Period
10. Waiting Period applies to:
11. Total eligible employees
Total enrolled
12. Billing Method:
13. Premium Deposit: (approx. one month's Premium)
14. Premium Payable:
15. Premium is due on the 1st day of each billing period.
16. Is any other coverage in force or being applied for as of the effective date of coverage with Consumers Life Insurance Company?

PART 2: SCHEDULE OF BENEFITS

CLASS DEFINITIONS (Definitions must be specific)
Class 1
Class 2
Class 3
Class 4
Employees working less than 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.)
Table with columns: Class, Basic Life Insurance Amount of Insurance, Basic AD&D Principal Sum, Supplemental Life Amount of Insurance, Supplemental AD&D Principal Sum, Short-Term Disability Maximum Weekly Benefit.
1. Weekly STD benefit is subject to a maximum of % of employee's Basic Weekly Wage.
2. STD Benefits Payable: day of Accident; day of Sickness for a maximum benefit period of weeks.
3. 1st day Hospital? Yes No
4. 24 hour coverage? Yes No
5. STD Benefits payable for non-occupational disabilities only.
6. All benefits terminate at retirement unless otherwise noted in class definitions section.
7. STD Benefits not available for employees working in CA, HI, NJ, NY, PR or RI.

**SELECTION OF COVERAGE(S)** (continued) (check all that apply and fill in all applicable blanks.)

**Dependent Life Insurance** Spouse: \$ \_\_\_\_\_  
Child(ren):  
\$ \_\_\_\_\_ Live birth but less than 15 days \$ \_\_\_\_\_ Age 6 months but less than 19 year  
\$ \_\_\_\_\_ Age 15 days but less than 6 months \$ \_\_\_\_\_ Age 19 years but less than \_\_\_\_\_\*  
\*if a full time student(s) and dependent upon the insured for support

**Voluntary Life and AD&D Insurance**  
Increments of \$10,000 to a maximum of \$50,000

**Voluntary Short Term Disability** *Select one:*  
Increments of \$50; minimum of \$100 to a maximum of \$750, not to exceed 66⅔% of employee's Basic Weekly Wage  
 Voluntary STD benefits payable: 1<sup>st</sup> day of Accident; 8<sup>th</sup> day of Sickness for a maximum benefit period of 13 weeks  
 Voluntary STD benefits payable: 1<sup>st</sup> day of Accident; 8<sup>th</sup> date of Sickness for a maximum benefit period of 26 weeks

**GENERAL PROVISIONS** (check all that apply and fill in all applicable blanks.)

- Life or AD&D benefits include 24 hour coverage.
- If Life or AD&D benefits are based upon a multiple of salary, benefit amounts should be rounded to:  
 the next higher multiple of \$1,000  the nearest multiple of \$1,000  other \_\_\_\_\_
- Basic Life and AD&D benefits reduce by:  
 35% at age 65; and further reduces to 50% of the face amount at age 70.  
 35% at age 65; and further reduces 35% every 5 years thereafter.  
 \_\_\_% at age \_\_\_; and further reduces to \_\_\_% of the face amount at age \_\_\_; and further reduces to \_\_\_% of the face amount at age \_\_\_.
- Supplemental Life and AD&D benefits reduce by:  
 35% at age 65; and further reduces to 50% of the face amount at age 70.  
 35% at age 65; and further reduces 35% every 5 years thereafter.  
 \_\_\_% at age \_\_\_; and further reduces to \_\_\_% of the face amount at age \_\_\_; and further reduces to \_\_\_% of the face amount at age \_\_\_.
- Voluntary Life and AD&D benefits reduce by 35% at age 70 and terminate at age 75.

**NON-MEDICAL MAXIMUM** (amounts in excess of the amount stated are subject to satisfactory evidence of insurability)

Life: Basic \$ \_\_\_\_\_ Supplemental \$ \_\_\_\_\_ Combined Basic and Supplemental \$ \_\_\_\_\_  
STD: \$ \_\_\_\_\_ Voluntary Life and AD&D: (subject to answering "NO" to all eligibility questions.)

**PART 3: 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:

- 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 Material and Substantial Duties of his occupation; is working the number of hours specified in Part 2, Schedule of Benefits; and satisfies any other conditions required by the applicable group Policy.
- This insurance is subject to the approval of Consumers Life Insurance Company, and nothing contained herein shall be binding upon Consumers Life until this application is approved and accepted at Consumers Life's home office.
- No waiver or change will bind Consumers Life unless signed by an Executive Officer of Consumers Life.
- As of the proposed effective date (Item 6 above), are any of your employees **not Actively at Work** (as defined above) and **therefore not eligible for coverage**?  Yes  No If yes, please provide the following information: (attach a signed dated sheet if more space is needed)

A. Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Last Worked \_\_\_\_\_  
Reason not Actively at Work:  Disability  Family Leave  Other \_\_\_\_\_  
B. Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Last Worked \_\_\_\_\_  
Reason not Actively at Work:  Disability  Family Leave  Other \_\_\_\_\_

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 Consumers Life of any changes. I have relied upon no oral or written representations that contradict item (1) above.

\_\_\_\_\_  
Policyholder/Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Title \_\_\_\_\_ Licensed Resident Agent (if required)

**NOTE:** 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. (Ohio Revised Code Section 3999.21)