CONSUMERS LIFE®
A MEDICAL MUTUAL COMPANY
15885 W. Sprague Road
Strongsville, Ohio 44136-1772

APPLICATION FOR GROUP INSURANCE

Please Type or Print All Information

Group Number

PART 1: APPLICANT INFORMATION

1. Policyholder (legal name)			Check if applicable: ☐ Partnership ☐ LLC ☐ Subchapter S Corp. ☐ Sole Proprietorship
2. Mailing Address (not P.O. Box)			
Group Contact		Phone ( )	
City	State	Zip	Fax ( )
3. Name of any ☐ Affiliates ☐ Subsidiaries to be covered			e-mail
4. Nature of Business			5. SIC Code

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, DEPENDENT LIFE AND SHORT-TERM DISABILITY

☐ Yes I am electing life and/or short-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Participation-free coverage
☐ Yes, I am electing participation-free Voluntary Life and AD&D
☐ Yes, I am electing participation-free Voluntary Life, AD&D and short-term disability.
If participation-free, voluntary short-term disability is elected, indicate the plan: ☐ 1/8/13 ☐ 1/8/26

Waiting period is identical to medical probationary period, unless indicated below:
☐ None
☐ First of month following completion of _____ days
☐ Other _____

Employees working less than **20 hours** per week are not eligible for coverage. If different than 20 hours, please indicate number of hours: _____

Employer contribution percentages (%) for all products are as stated in the proposal, unless indicated below:

Product	%	Product	%
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GROUP LONG-TERM DISABILITY

☐ Yes, I am electing group long-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Prior carrier: _____
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _____ .

Contribution:
Employer _____% Employee _____% ☐ Pre-tax dollars ☐ Post-tax dollars

GENERAL CONDITIONS

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.

_____ _____
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 may be guilty of insurance fraud.