

APPLICATION/PARTICIPATION AGREEMENT

Group Number

PART 1: APPLICANT INFORMATION

1. Business Name		Check if applicable: <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Subchapter S Corp. <input type="checkbox"/> Sole Proprietorship	
2. Mailing Address (not P.O. Box)			
Group Contact	Phone ()		
City	State	Zip	Fax ()
3. Name of any <input type="checkbox"/> Affiliates <input type="checkbox"/> Subsidiaries 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: Life/AD&D <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Voluntary Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % STD <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Voluntary Short-Term Disability <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Dependent Life <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Long-Term Disability <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ % Other <input type="checkbox"/> 100% <input type="checkbox"/> Other _____ %		9. Waiting Period _____ _____ _____	
10. Waiting Period applies to: <input type="checkbox"/> All employees <input type="checkbox"/> New employees only			
11. Total eligible employees _____ Total enrolled _____	12. Billing Method: <input type="checkbox"/> List Billed <input type="checkbox"/> TPA Billed <input type="checkbox"/> Self Administered	13. Premium Deposit: (approx. one month's Premium) \$ _____	
14. Premium Payable: <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		15. <input type="checkbox"/> Premium is due on the 1 ST day of each billing period. <input type="checkbox"/> Other _____	
16. Is any other coverage in force or being applied for as of the effective date of coverage with Consumers Life Insurance Company? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____			

PART 2: SCHEDULE OF BENEFITS

CLASS DEFINITIONS (if more than one class, 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.)			
<input type="checkbox"/> Basic Life Insurance	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short-Term Disability	
<u>Class</u>	<u>Amount of Insurance</u>	<u>Principal Sum</u>	<u>Maximum Weekly Benefit</u>
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. STD Benefits payable for non-occupational disabilities only.			
5. All benefits terminate at retirement unless otherwise noted in class definitions section.			
6. 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.)

7. Life or AD&D benefits include 24 hour coverage.

8. If Life or AD&D benefits are based upon a multiple of salary, benefits amounts should be rounded to:

the next higher multiple of \$1,000 the nearest multiple of \$1,000 other _____

9. 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 65; and further reduces to ___% of the face amount at age ____; and further reduces to ___ % of the face amount at age ____.

10. Voluntary Life benefits terminate at retirement.

Group Long-Term Disability

*Employees must work a minimum of 30 hours per week

Select One Plan:

90 day elimination 180 day elimination Other _____

Dependent Life Insurance

Spouse: \$ _____

Child(ren):

\$ _____ Live birth but less than 14 days

\$ _____ Age 14 days but less than 6 months

\$ _____ Age 6 months but less than 21 years

\$ _____ Age 21 years but less than _____*

*if a full time student(s) and dependent upon the insured for support

Voluntary Life Insurance

Increments of \$10,000 to a maximum of \$300,000

Voluntary Short-Term Disability

Increments of \$50; minimum of \$100 to a maximum of \$500, not to exceed 70% of employee's Basic Weekly Wage.

Select One:

Voluntary STD benefits payable: 1st day of Accident; 8th day of Sickness for a maximum benefit period of 26 weeks.

Voluntary STD benefits payable: 15th day of Accident; 15th day of Sickness for a maximum benefit period of 26 weeks.

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

Life: Basic \$ _____ Voluntary \$ _____ Combined Basic and Voluntary \$ _____

STD: \$ _____ Other: _____ \$ _____

PART 3: ACTIVE WORK

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 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.
2. 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 _____

PART 4: TERMS AND CONDITIONS

I, as the undersigned employer or other eligible membership organization ("Participating Employer"), hereby apply for coverage in the Council of Smaller Enterprises (COSE), a division of Greater Cleveland Partnership (GCP), group association insurance policy offered by Consumers Life Insurance Company (CLIC). I acknowledge that a copy of the group insurance policy is available at COSE's office for review by Participating Employers and employees. I acknowledge that no coverage can commence unless I receive written notice of approval from CLIC's home office.

I agree that, upon acceptance and approval by CLIC, I will, so long as such participation continues, fully comply with all obligations applicable to Participating Employers under the COSE policy as set forth therein. I understand that the insurance coverages under the group insurance policy will be only as provided for under the policy issued to COSE as the Policyholder. I acknowledge that COSE is not an insurer, and has no obligations regarding payment of premiums or handling of claims for the insurance provided under the group insurance policy issued to it as policyholder.

I understand that this insurance is subject to the approval of CLIC, and nothing contained herein shall be binding upon CLIC until this application is approved and accepted at CLIC's home office. No waiver or change will bind CLIC unless signed by an Executive Officer of CLIC.

I certify that the information in this application is true and accurate to the best of my knowledge. I understand that the information in this application and any other information I provide shall serve as the basis for the coverage to be issued, and that I have a duty to notify CLIC of any changes. I have relied upon no oral or written representations that contradict the aforementioned active-work information.

Participating Employer Name and Title

Authorized Representative's Signature

Title

Date

WARNING: 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)

Licensed Resident Agent (if required)