LifeMap Assurance Company™
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Portland, OR 97207-1271
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Home Office Use Only
Group Number: ID03289I
SIC/NAICS Code:

Group Insurance Employer Application
(10 or More Employees)

Applicant Information **(Please complete using dark ink)**

Legal Name of Policyholder **City of Kimberly**		**Requested Effective Date** **September 1, 2013**	
Street Address	City	State	Zip
Years In Business	Nature of Business	Telephone Number	

Check one: ☐ C Corporation ☐ LLC ☐ LLP ☐ Subchapter S Corp. ☐ Partnership
☐ Sole Proprietorship ☐ Government Entity ☐ Other ______________________________________

Application is being made for the following coverage(s):

Basic		**Voluntary**		
☒ Short Term Disability	☐ Life	☐ Vol Short Term Disability	☐ Vol Life	☐ Vol Vision
☐ Long Term Disability	☐ AD&D	☐ Vol Long Term Disability	☐ Vol AD&D	☐ Vol Dental
☒ Vision	☐ Dependent Life	☐ Vol Critical Illness	☐ Vol Dependent Life	
☐ Dental		☐ Vol Accident Only		

Rates Below Are Initial Rates For Groups of **10 or More** Employees

Basic Life Rate per $1,000

Basic Life Rate of $________ /$1000 of Benefit Volume
Basic AD&D Rate of $_______/ $1,000 of Benefit Volume
Dependent Life Rate of $___________________ ☐ Per Employee - or - ☐ Per Family Unit
Life and AD&D Rates Guaranteed Until (month/day/year) ________________

Short Term Disability Rate of $ _0.492_______/ $10 of Covered Benefit STD Rate Guaranteed Until 9 1/15_____

[Long Term Disability Rate of _____________/ % of Covered Payroll LTD Rate Guaranteed Until ________________]

[Dental [Managed Care] Per Covered Employee $______________ Employee and Child $________________
Employee & Spouse[or Domestic Partner] $______________ Family $________________
Dental Rates Guaranteed Until (month/day/year) ______________________________________]

[Dental [Managed Care] Per Covered Employee $______________ Employee and Child $________________
Employee & Spouse[or Domestic Partner] $______________ Family $________________
Dental Rates Guaranteed Until (month/day/year) ______________________________________]

[Orthodontic Benefits Rider: ☐ Yes ☐ No] [TMJ Rider for Washington Residents Only: ☐ Yes ☐ No]

Vision Per Covered Employee $_7.36____________ Employee and Child $__15.77_________
Employee & Spouse $_14.75____________ Family $_25.21_____________
Vision Rates Guaranteed Until (month/day/year) __09/01/14________________

Rates for Voluntary coverage, if elected, are shown in the Benefit Proposal.

Name of Policyholder: City of Kimberly

The Plan Benefits Will be Those Shown in the Benefit Proposal

Agreement

The Applicant hereby applies for the group insurance coverage(s) shown on page one. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Any statement by the Applicant to obtain coverage for any Policy issued will be a representation and not a warranty. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will **(a)** be issued only if the requested insurance is acceptable to LifeMap Assurance Company (the Company) and is legally permissible; **(b)** be issued under a group Policy or Policies in the language customarily used by the Company; **(c)** be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable); **(d)** be subject to all exclusions and limitations of the Policy; and **(e)** take effect on the date determined by the Company.

The Applicant understands that no insurance producer has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an Employee is required to submit satisfactory Evidence of Insurability will be determined in accordance with the Policy's terms, and will be subject to the Actively at Work requirement. The Applicant agrees not to **(a)** collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or **(b)** distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This Application and the payment of premium constitutes the consideration for any Policy issued. After receipt of the Policy, payment of premium is deemed acceptance of the Policy's terms. This Application shall be attached to any Policy issued.

Disclosure

If you have an insurance producer, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from LifeMap Assurance Company. Incentives may be based on any of several factors including the size of group business, the products you buy, your insurance producer's volume of business with LifeMap Assurance Company and the other services your insurance producer provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your insurance producer.

Insurance Fraud Warning

Unless specific state language is provided below, the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I have read and understand this entire Application. The information provided is 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 insurance to be issued, and that I have a duty to notify the Company of any changes. It is understood and agreed that no insurance shall be effective until approved by the Company at its home office.

Note: The Accidental Death and Dismemberment (AD&D), Critical Illness and Accident Only Insurance Policies provide limited benefits. Review your policy carefully.

Name and Title of Authorized Group Executive or Administrator (please print)	Binder Payment Amount $ ________ (to be applied to initial premium payment)
Signature of Group Executive or Administrator	Date
Insurance Producer	Dated at (City, State)
LifeMap Insurance Producer Appointment Number	Insurance Producer E-Mail: **Required**