

APPLICANT SECTION		
FULL LEGAL NAME OF GROUP:		
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBER: ()	FAX NUMBER: ()	
GROUP CONTACT:	CONTACT'S TITLE:	
CONTACT'S PHONE NO. IF DIFFERENT: ()	CONTACT'S FAX NO. IF DIFFERENT: ()	
NATURE OF BUSINESS:	TAX I.D. NO.:	

REQUESTED EFFECTIVE DATE: _____ **This application must be submitted prior to the requested effective date. The actual effective date will be determined by Standard.**

INSURANCE COVERAGE REQUESTED	
<input type="checkbox"/> Long Term Disability (LTD)	<input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Dental EPO
OTHER INSURANCE	
Does this insurance supplement other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify for each line of coverage and insurance carrier:	
Does this insurance replace existing insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify for each existing line of coverage and submit a copy of each inforce policy, certificate or plan document.	
Effective date of Prior Plan:	Termination date of Prior Plan:
Note: A person must meet an Active Work requirement to become insured. Will all proposed insureds meet the Active Work requirement? <input type="checkbox"/> Yes <input type="checkbox"/> No	

AGREEMENT
<p>APPLICANT AGREES THAT:</p> <p>I hereby apply for group insurance as provided in the attached proposal, and I elect to participate in the applicable Standard Insurance Company Group Insurance Trust. I agree to be bound by the terms of the Trust Agreement and any amendments to it. I request participation under the Group Policy(ies) issued to the Trustee for the coverage I have elected. I agree to remit the required premium contributions. If this Application is not accepted, any premium advanced by me shall be refunded.</p> <p>Premium rate quotations were based on the data submitted to Standard Insurance Company. Final premium rates will be determined by the actual composition of the group.</p> <p>If this request is acceptable to Standard Insurance Company under its current rules and practices, coverage will be provided to me in the language customarily used by Standard Insurance Company. My participation under the Group Policy(ies) will be effective on the date determined by Standard Insurance Company, and coverage will be subject to Standard Insurance Company's usual underwriting requirements. No agent or broker has the authority to guarantee the acceptability of the requested coverage.</p> <p>It is my responsibility to comply with: Federal, state and local laws and regulations which govern employee relationships and the provision of employee benefits. No services are being requested of, or will be provided by, Standard Insurance Company in connection with my responsibilities as: Plan Sponsor, Administrator and Named Fiduciary under the Employee Retirement Income Security Act of 1974. I agree to indemnify and hold Standard Insurance Company, the Trustee, and their employees, agents and representatives, harmless from any liability which may arise because of my failure to comply with such laws.</p> <p>No material describing coverage will be distributed without receiving Standard Insurance Company's prior written consent. Standard Insurance Company may act as my agent under the Trust Agreement, but only to determine and authorize compensation to the Trustee for its services, and to name Successor Trustees. A copy of the Standard Insurance Company Group Insurance Trust Agreement will be made available to me at any time without charge.</p>

SIGNATURE
I hereby represent that all statements on this document are complete and true to the best of my knowledge and belief. I understand that Standard Insurance Company will rely on these statements as the basis for approving this Application. I have read and understand the information herein.
SIGNATURE OF AUTHORIZED COMPANY OFFICER
BY:
NAME AND TITLE:
DATE:

PRODUCER AND CO-PRODUCER INFORMATION

PRODUCER NAME—MUST BE LICENSED CORPORATION, PARTNERSHIP OR INDIVIDUAL: (Attach License Copy)		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBER: ()	% SPLIT:	TAX ID OR SOCIAL SECURITY NUMBER:
CO-PRODUCER INFORMATION (IF APPLICABLE) (Attach License Copy)		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBER: ()	% SPLIT:	TAX ID OR SOCIAL SECURITY NUMBER:

PRODUCER’S AND CO-PRODUCER’S (IF APPLICABLE) STATEMENT

I certify that I am licensed for life and health in the state of sale, where the Participating Employer is located. I warrant that I have reviewed all enrollment materials. I understand that I represent the interest of the applicant, not Standard Insurance Company. I have advised my client not to terminate any existing coverage until receiving notice that the coverage applied for is approved. I understand that I have no right to: bind this coverage, alter terms of the Group Policy(ies) or enrollment materials, or adjust any claim for benefits under the Group Policy(ies).	
SIGNATURE OF PRODUCER BY:	SIGNATURE OF CO-PRODUCER BY:

GROUP REPRESENTATIVE

YOUR STANDARD INSURANCE COMPANY GROUP REPRESENTATIVE:

KEEP A COPY FOR YOUR RECORDS.