



**GROUP SUPPLEMENTAL MEDICAL EXPENSE
REIMBURSEMENT INSURANCE APPLICATION**

Please submit this form, the employee enrollment card and \$62.50 for the first quarter's premium for each eligible employee to:
Executive Edge, 5181 Utica Ridge Rd, Davenport, IA 52807
This application for use in AK, AZ, CA, CO, DC, DE, GA, IA, ID, IL, KS, KY, MI, MN, MO, NC, ND, NE, NV, OR, RI, SC, SD, TX, UT, VA, WY

1. a. Name of Group Applicant _____	4. Nature of Business _____
Street Address _____	_____
City State _____ Zip Code _____	5. Type of Business:
b. Federal I.D. No. _____	<input type="checkbox"/> C Corporation <input type="checkbox"/> Partnership
c. Phone Number () _____	<input type="checkbox"/> S Corporation <input type="checkbox"/> Sole Proprietor
2. Names and locations of any subsidiaries or affiliates to be insured _____	6. Name and Title of Applicant /Employer Contact _____
_____	_____
3. Requested effective date of insurance: First day of January ___ April ___ July ___ October ___ 200___	7. Amount of premium submitted with the application \$ _____

8. a. Classes of eligible employees (and any outside directors, retired employees or surviving spouses):	b. Total number of employees (including those ineligible for coverage) _____
(1) _____	c. Total number of eligible employees _____
(2) _____	d. Total number of eligible outside directors (if any) _____
(3) _____	e. Total number of eligible retired employees and surviving spouses (if any) _____
(4) _____	(Individual enrollment cards must be completed and signed by all eligible persons.)
(5) _____	

9. Plan: a. <input type="checkbox"/> \$100,000 b. <input type="checkbox"/> \$200,000	10. Carrier underwriting Base Health Plan _____
	Percent of Premium paid by ER for EEs _____; Dep _____

11. Have you had group insurance with Assurity Life Insurance Company before?..... Yes No

The employer authorizes the administrator to pay a service fee of \$50 per year, per employee covered to the indicated broker beginning on the effective date of coverage. These service fees are payable only as long as the indicated broker continues to service the employer and is considered to be the broker by the employer.

Signed at _____ Date _____ Signature (applicant) _____

Witnessed by: Agent _____ Applicant Title _____

Agent Name: _____	Agent's State License No. _____
Taxpayer ID No. _____	Phone: () _____
Agent's Firm: _____	Firm Address: _____