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 Edge1501 50th Street, Suite 340, West Des Moines, IA 50266

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:

_____

Street Address:

_____

City: State: Zip Code:

_____

b. Federal I.D. #: _____

c. Phone Number: (____) _____

2. Names and locations of any subsidiaries or affiliates to be insured:

_____

_____

3. Requested effective date of insurance:

First day of _____, 19_____

4. Nature of Business:

_____

_____

_____

5. Type of Business:

☐ C Corporation ☐ Partnership

☐ S Corporation ☐ Sole Proprietor

☐ Other: type _____

6. Name and Title of Applicant /Employer Contact:

_____

_____

7. Amount of premium submitted with the application:

$_____

8. a. Classes of eligible employees (and any outside directors, retired employees or surviving spouses):

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

b. Total number of employees (including those ineligible for coverage): _____

c. Total number of eligible employees: _____

d. Total number of eligible outside directors (if any): _____

e. Total number of eligible retired employees and surviving spouses (if any): _____

(Individual enrollment cards must be completed and signed by all eligible persons.)

9. Plan: a. ☐ $100,000 b. ☐ $200,000

10. Carrier underwriting Base Health Plan:_____

Percent of Premium paid by ER for EEs_____; Dep_____

11. Have you had group insurance with Security Financial Life Insurance Co. 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:**_____

Security Financial Life Insurance Co.P.O. Box 82248Lincoln, Nebraska 68501-2248
(800) 284-8575