Nippon Life Benefits

Nippon Life Insurance Company of America
PO Box 10310
Des Moines, IA 50306-0310

Employer Application for Small Group Insurance (2-50 Eligible Lives) - IN

This form is for: **New Case** **Amendment** Account number: ____________________

Requested effective date: ______________________________ Advanced premium received $ ____________________

Instructions for completing this agreement:

1) The employer or employer representative and agent must sign and date this agreement.
2) A current copy of the employer's quarterly state wage and tax must accompany this submission.
3) Note on your state quarterly each employee's current status (full-time, part-time, etc.) and hours worked/week.
4) A signed copy of the proposal/quote must accompany this submission.
5) The first month's premium made payable to Nippon Life Insurance Company of America must accompany this submission.

Employer Information

Legal name of company (include dba)

corporation partnership sole proprietorship other | Federal tax ID number

Street address	Billing address	
City	State	ZIP code
Contact	Telephone number	FAX number
E-mail address	Nature of business/SIC code	Number of years in business

Have you been insured by Nippon Life Insurance Company of America (Nippon Life Benefits) previously? yes no

If yes, when and under what name? ____

Has the company been denied credit within the past two years, ever filed for bankruptcy, or is the firm now in the process of (or considering) filing for bankruptcy? yes no (attach an explanation)

Employers with Participating Units

If employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) are to be covered, please list the affiliate or subsidiary below. Are there any participating units? yes no

Participating unit is an entity that is an affiliate or subsidiary related to the employer through common control or ownership.

Unit name/address/federal tax ID #	Nature of business	Relationship to company		Number of employees
1.			include unit exclude unit	
2.			include unit exclude unit	

Employee Eligibility

Employees actively working on a full-time basis (30 or more hours per week) are eligible for coverage.
Please complete the following as it represents your current employee composition for the group enrolling:

Total number of employees (full and part-time):	Total number of eligible employees:

Describe any class of employees excluded from coverage.	Number of employees

How many are full-time employees not on your payroll (contractors/1099/leased)? ______________________________

Small Employer Qualification

In order for us to issue and maintain your group health policy in accordance with state law, we need to know if you qualify as Small Employer. A small Employer means an employer that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year, and who employs at least two employees on the first day of the plan year.

Does your group meet the definition of Small Employer? yes no

I understand that a Qualification Statement may be required prior to each renewal as a condition of renewal as a small employer group. I understand that if our group qualifies as a Small Employer Group under Illinois law at the time of this qualification, the provisions of the law will continue to apply to our group until the next policy anniversary, even if our group ceases to qualify as a Small Employer Group prior to that date.

TEFRA 210

TEFRA eligibility is defined as employers who employed 20 or more full or part-time employees for 20 or more calendar weeks in the current or preceding year. If this requirement is met, the group is TEFRA eligible and Nippon Life Benefits will pay primary to Medicare.

Do you meet the eligibility definitions? yes no

Employer Group Size for Medical

Companies that are affiliated or file a combined tax return must be considered one employer. Count the employees of all affiliated companies (including those located abroad) when answering the following questions.

#1. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding year?

yes no If yes, you must also answer question #2. If no, skip question #2.

#2. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the previous calendar year? yes no

If 20 or 100 employees is reached mid-year, as of what date did you have 20 or 100 employees for the number of weeks required in the definition above? ______________________

Important Note: In the absence of employer-provided information, we may be required to administer your group health plan to pay Medicare claims as primary payer rather than as secondary payer. <u>This may impact the amount of claims paid under the plan, increasing the amount of claim benefits, and have a related effect on future premium increases for your health insurance coverage.</u>

This question is in reference to Mental Health benefits

Did you employ an average of 51 or more full-time equivalent employees on business days during the preceding calendar year?

yes no

The average number of full-time equivalent employees is calculated by adding:

(a) the number of full-time employees you employed for the entire calendar year; PLUS

(b) the total number of hours worked by all part-time employees and all full-time employees who were not employed full-time throughout the entire calendar year, divided by the number of annual hours typically worked by your full-time employees (not to exceed 2,080).

(c) Round the sum of (a) plus (b) down to the nearest whole number.

Waiting Period/Effective Date Provisions

Applies to:	only employees hired after the effective date all employees, including those hired before, on, or after the effective date
Waiting period:	30 days 90 days 180 days 1 month 3 months 6 months other ______________________
Employees will be eligible on the:	day immediately following the final day of the waiting period or change first of the insurance month coinciding with or next following the final day of the waiting period or change

On a separate piece of paper list all employees who are not actively at work and dependents in a period of limited activity.

Employer Request for Benefits and Contribution

Term Life Insurance (Proof of good health may be required before insurance can become effective.)

Employer Benefit Elections

Complete this table with the benefit elections

	Medical/ Prescription Drugs	Vision	Dental	Basic Term Life	Basic Accidental Death and Dismemberment	Short Term Disability	Long Term Disability
Employee	yes no	yes no	yes no	yes no	yes no	yes no	yes no
Dependent	yes no	yes no	yes no	yes no	N/A	N/A	N/A

Employer Contribution 210

Complete this table listing the percentage of premium the **employer** pays.

	Medical/ Prescription Drugs	Vision	Dental	Basic Term Life	Basic Accidental Death and Dismemberment	Short Term Disability	Long Term Disability
Employee	_______%	_______%	_______%	_______%	_______%	_______%	_______%
Dependent	_______%	_______%	_______%	_______%	N/A	N/A	N/A

Disability Insurance (Proof of good health may be required before insurance can become effective.)

State specific information (short term disability only)

Are there employees located in any of the states listed below (policies offered in these states are supplemental)?

yes no (If yes, indicate the number of employees for each state.)

California	Hawaii	New Jersey	New York	Rhode Island

* If employees contribute to the cost of STD or LTD insurance, are these contributions made on a pre-tax or post-tax basis?

Medical/Prescription Drugs Insurance

Do you offer HMO coverage? yes no

Do you have employees or their dependents residing or working in New York? yes no If yes, how many? _______________

Do you have employees located in Hawaii for whom medical expense coverage is intended? yes no

Number of employees	Department of Labor number

Note: Hawaii state law mandates special plan designs, eligibility, and waiting period requirements for employees located in Hawaii. Please contact the home office of Nippon Life Benefits regarding these special requirements.

Dental Insurance

Do you offer DMO coverage? yes no If yes, number of employees ___________________

Did your prior dental insurance include benefits for orthodontia treatment? yes no

Medical and Dental Insurance

PPO network(s) selected ____

Medical/Prescription Drugs/Mail Order Prescription Drugs/Dental/Vision (check continuation that applies)

COBRA eligibility is defined as employers who employed 20 or more full or part-time employees on at least 50% of the working days in the prior calendar year. Companies that are affiliated or file a combined tax return must be considered one employer. Count the employees of all affiliated companies (including those located abroad) when answering the following questions.

Do you meet the eligibility definition? yes no

Employee or dependent name	COBRA	USERRA	state cont.
Employee or dependent name	COBRA	USERRA	state cont.

Please attach separate sheet of paper if more space is needed.

All Coverages - Medical, Dental, Vision, Life

Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier		
	Effective date	Discontinue date	Coverage

If more than one carrier provided insurance in the past 12 months, provide carrier name, address, effective date and discontinue date(s) on a separate sheet of paper, and attach to application.

Do you offer medical insurance to your employees through another carrier? yes no

All Coverages 210

ERISA plan number _____________

The Employee Retirement Income Security Act of 1974 (ERISA) requires that each employee benefit plan subject to the Act designate a "Named Fiduciary who shall have authority to control and manage the operation and administration of the plan."

If this plan is subject to ERISA and the Named Fiduciary is other than the employer, fill in the information below. Nippon Life Benefits may not be designated as Named Fiduciary.

The "Named Fiduciary" shall be: ______________________________

Designation as Named Fiduciary is accepted. (Required only if the "Named Fiduciary" is an individual.)

By ______________________________ Title ______________________________

It is understood that Nippon Life Benefits shall not be responsible for any tax or legal aspects of the plan. The employer assumes responsibility for these matters. The employer acknowledges that they have counseled to the extent necessary with selected legal and tax advisors. The obligations of Nippon Life Benefits shall be governed solely by the provisions of its contracts and policies. Nippon Life Benefits shall not be required to look into any action taken by the named fiduciary or the employer and shall be fully protected in taking, permitting, or omitting any action on the basis of the employer's actions. Nippon Life Benefits shall incur no liability or responsibility for carrying out actions as directed by the named fiduciary or the employer.

It is further understood that by signing this application, the employer is purchasing insurance and not making an investment. No reserves, undeclared or unpaid experience premium refunds, or interest with respect to claim payments, nor claim proceeds themselves shall be considered plan assets under ERISA.

Agreement and Signatures

The employer has been informed of the minimum participation and contribution requirements. The employer agrees that coverage applied for shall not become or remain effective unless: a) participation and contribution requirements are met, and b) the employer is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code, and c) the application and any attached page(s) are received, accepted, and approved by Nippon Life Benefits.

The preexisting condition restrictions for medical and long term disability insurance have been explained to and understood by the employer. Actively at work and period of limited activity for other than medical coverage has been explained to and understood by the employer.

The employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If a policy is issued from this application and is accepted by the proposed policyholder, we will apply the premium deposit to the first premium due for such policy. If no policy is put into force, the premium deposit will be refunded. Premium payment will be monthly unless otherwise indicated.

Acceptance by the employer of any policy or policies issued with this application shall constitute approval of any corrections, additions, or changes specified in the space "For Nippon Life Benefits Use Only" or as otherwise indicated on this application.

Your agent or broker cannot change or waive any provision of this application or the policy or policies without the written approval of an officer of Nippon Life Benefits in the home office.

As a result of this sale and any subsequent renewal, your broker and marketing organization, if any, may receive commissions, other compensation including non-cash compensation, and bonuses based on factors such as volume of new sales, member and case counts, total premium volume, maintaining a certain percentage of business with Nippon Life Benefits, selling a certain mix of products, and/or the profitability of the business. The cost of this compensation may be directly or indirectly reflected in the premium for the product(s) you have applied for on this application form. This compensation is in addition to any compensation the broker may receive from you. Contact us at 1-800-937-6542 for further details on your case. We have placed a more detailed description of our compensation program on www.nlia.com.

The person signing this form for the employer has legal authority to bind the employer for whom application is being made.

The employer agrees to make timely notification of any employee termination, status change, or other material changes that may affect the eligibility of employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.

The employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The employer understands that coverage may also be terminated for other reasons as provided in the group policy.

I certify all information given on this application, and any attachments, are true and complete to the best of my knowledge and belief.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines. Fraud or misrepresentation may be grounds for nonrenewal or termination under the terms of the group policy.

Employer (company name)

Signed by (**must be an officer**)	Officer's title	Date signed
Licensed resident agent(s) (individual/firm)	Agent's license number	Date signed

Signature of soliciting agent(s) (If more than one, all must sign)

For Nippon Life Benefits Use Only