Enrollment Checklist

Group Accident Protection Plan

Employer Name:_____
Employer Address:_____
City:_____State:_____ Zip:_____

Mailing Address:_____
City:_____State:_____ Zip:_____

Contact Person:_____ Phone: ( )_____
Email:_____

Primary Producer / Agent Name:_____ Commission %:_____
Address:_____ Tax ID#_____
City:_____State:_____ Zip:_____
Email:_____

Co-Producer / Agent Name:_____ Commission %:_____
Address:_____ Tax ID#_____
City:_____State:_____ Zip:_____
Email:_____

General Agent's Name:_____ Commission %:_____
Address:_____ Tax ID#_____
City:_____State:_____ Zip:_____
Email:_____

Effective Date:_____ Date Submitted:_____

Special Instructions:_____
_____

Included Are:
- _____ Employer Application for Coverage
- _____ Proposal
- _____ Producer / Agent Licensing Madison National Life - Occupational Accident
- _____ Producer / Agent Licensing Independence American - Employer Liability, if applicable
- _____ Premium Check in the amount of $_____
- _____ Owner Waiver, Contract Labor and Employee Census Form
- _____ ERISA Plan Worksheet
- _____ Agreement for Electronic Funds Transfer

Please Note: For electronic ACH premium payments, please submit one full month's premium with your application. This payment will be pro-rated to the first of the following month. An adjustment, if applicable, will be made on the next month's billing statement. ACH payments are drafted on the 5th of each month.

Marketed By: George W. Evans & Associates, Inc.
Send Completed Enrollment Material to: 5904 Dolores, Houston, TX 77057-5604
(800) 580-3826 or (713) 780-1116 Fax: (713) 782-1113 gapp@gwevans.com

Administered by: North American Benefits Company (NABCO)
20 Valley Stream Parkway, Suite 310, Malvern, PA 19355 (800) 994-GAPP (4277)

GROUP ACCIDENT PROTECTION PLAN
APPLICATION FOR COVERAGE – GAPP II

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
1241 John Q. Hammons Dr., Madison, WI 53717

1. Legal Name of Applicant: _____

   DBA: _____ Federal Tax ID Number: _____
2. Contact Person: _____ Title: _____
3. Physical Address: _____

   City: _____ State: _____ Zip: _____
4. Mailing Address: _____

   City: _____ State: _____ Zip: _____
5. Email Address: _____ Business Phone: _____
6. Nature of Organization: ☐ Corporation ☐ LLC ☐ Sole Proprietorship ☐ Other (explain): _____
7. How long has the organization been in business? _____ What are the hours of operation? _____
8. Type of workers to be covered: W-2 Employees: ☐ Yes ☐ No 1099 Labor: ☐ Yes ☐ No
9. What date was the Worker's Compensation Act rejected? _____
10. Has insurance of this type (Occupational Accident and/ or Employer Liability) been canceled, refused or non-renewed by any company during the past three (3) years? ☐ Yes ☐ No If Yes, please provide details:

    _____
11. Does the Applicant manufacture, store, distribute, sell, handle or transport any of the following?

Chemicals	☐ Yes	☐ No	Details: _____
Pharmaceuticals	☐ Yes	☐ No	Details: _____
Fuel Oils	☐ Yes	☐ No	Details: _____
Hazardous Materials	☐ Yes	☐ No	Details: _____
Nuclear Materials	☐ Yes	☐ No	Details: _____
Asbestos Materials	☐ Yes	☐ No	Details: _____

12. Does the Applicant currently have an ERISA Plan they wish to continue? ☐ Yes ☐ No If Yes, please provide a copy of the complete plan document, including the Summary Plan Description. It must be approved in writing by the Company prior to use.
13. Are any affiliated entities to be covered? ☐ Yes ☐ No If Yes, please provide Legal Names and Addresses:

    _____

    _____

    Please specify the number of employees at each location: _____

    _____
14. Are owners, officers or partners to be covered? ☐ Yes ☐ No If Yes, do they appear on the State Employment Commission Report? ☐ Yes ☐ No

    Please list the owners, officers or partners that are to be excluded from coverage: _____

    _____

15. Policy Elections:

- Deductible (per covered employee per occurrence):
  - Indicate amount ($1,000 min/ $50,000 max): $_____
- Combined Single Limit (per covered employee per occurrence):
  - Indicate amount ($100,000 min/ $2 mill max): $_____
- Aggregate Limit of Liability (per occurrence):
  ☑ $3 mill
- Accumulation Period (weeks):
  ☐ 52 ☐ 110 ☐ 156
- Weekly Indemnity:
  - Elimination Period (days): ☐ 7 min ☐ 28 max ☐ Other, please list: _____
  - Benefit Amount (% of weekly wage): ☐ 75% ☐ Other, please list (50% min/ 90% max): _____%
  - Maximum Weekly Indemnity: ☐ $750 ☐ Other, please list ($200 min/ $800 max): $_____
  - Maximum Weeks Duration (weeks): ☐ 52 ☐ 110 ☐ 156
- Accidental Death, Dismemberment and Loss of Use:
  ☐ $150,000 ☐ Other, please list ($100,000 min/ $500,000 max): $_____
- Occupational Disease, Cumulative Trauma and Occupational Hernia (subject to policy limits):
  ☑ Included
- Include Waiver of Subrogation: ☐ Yes ☐ No
- Include Alternate Employer Endorsement: ☐ Yes ☐ No

16. Premium Calculation and Payment Mode: ☑ Monthly Bill

NCCI Code	Payroll	Payroll Rate	Total for Class
Total Payroll			
	Composite Rate		
		Premium Subtotal:	
		Monthly Admin Fee:	
		Annual Policy Fee:	
		Initial Payment:	

(Please make premium check payable to NABCO)

THE INFORMATION ABOVE ACCURATELY REPRESENTS: 1) THE GAPP II PLAN DESIGN FOR WHICH WE ARE APPLYING, AND 2) THE REQUIRED EMPLOYEE INFORMATION.

_____ _____
Employer Authorized Signature Date

_____
Broker or Agent Name (please print)

_____ _____
Broker or Agent Signature Date

THE EMPLOYER CERTIFICATION (FORM # OCC ACC APP CERT 1016) OF THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE APPLICATION FOR THE COMPANY TO ISSUE A POLICY.

EMPLOYER CERTIFICATION
TO GROUP ACCIDENT PROTECTION PLAN APPLICATION

THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS CERTIFICATION IS COMPLETED AND SUBMITTED WITH THE APPLICATION

We, the undersigned Employer, hereby certify the following:

1. We are applying to Madison National Life Insurance Company, Inc. (the Company) for Accident Insurance. We fully acknowledge and understand that acceptance of this request is subject to all of the Company's requirements and verification of quoted premium. The insurance applied for shall not be effective until the application has been approved and accepted by the Company in writing and the Coverage Effective Date has been assigned. A Policy and Schedule of Benefits will be issued.

2. We understand that 100% of all eligible employees must be covered and that this will be verified using quarterly employment tax statements.

3. In order for employee insurance to take effect, each employee must satisfy the eligibility requirements of the Policy.

4. We agree to pay the required premiums to the Company when due.

5. We have reviewed the sales material and the application. These materials, taken together, describe the coverage terms explained to us by the broker/agent whose signature appears below.

6. We understand the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying.

7. WE ACKNOWLEDGE AND FULLY UNDERSTAND EACH OF THE FOLLOWING ITEMS:

   a. The coverage for which application being made is an employee benefit and does not insure any casualty or general liability risk of the Employer. This coverage is not intended to nor will it provide the Employer with any protection or defense against any suit which may be brought by an employee or anyone else.

   b. Neither the Company nor the undersigned broker/agent has represented the coverage as anything other than an employee benefit which offers no indemnity for the Employers' liability.

   c. THIS IS NOT A PROGRAM OF WORKERS' COMPENSATION INSURANCE. WE DO NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS COVERAGE. AND IF WE ARE A NONSUBSCRIBER, WE LOSE CERTAIN COMMON LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATIONS ON LIABILITY THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. WE MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

8. I am authorized by the Employer to review and to sign this Certification.

9. Madison National Life Insurance Company, Inc. and its representative are authorized to contact me by mail or telephone to discuss this certification.

THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.

Employer Authorized Signature	Title	Date

Broker or Agent Signature	Printed Name of Agent	Date

GAPP I. GAPP II. TAPP. **Group Accident Protection Plan**

Check One: ☐ GAPP I ☐ GAPP II ☐ TAPP

Owner/ Officer Waiver, Contract Labor and Employee Census Form

Employer Name:____

Prepared By: ____ Date:_________________

Are Officers, Owners and/ or Partners to be covered?: ☐ Yes ☐ No

If No, please list individuals to be excluded from coverage:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Census

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages	NCCI Class	W2	1099
				$		☐	☐

Job Titles/Duties	Termination Date

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages	NCCI Class	W2	1099
				$		☐	☐

Job Titles/Duties	Termination Date

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages	NCCI Class	W2	1099
				$		☐	☐

Job Titles/Duties	Termination Date

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages	NCCI Class	W2	1099
				$		☐	☐

Job Titles/Duties	Termination Date

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages	NCCI Class	W2	1099
				$		☐	☐

Job Titles/Duties	Termination Date

If additional space is needed, please use the Employee Census Supplemental Form.

I certify___________________________________the above information is accurate and agree that wages are subject to verification and audit.

(Signature of Employer Representative)

Please complete this form when any new additions or terminations occur with your statement.

Return to: NABCO
Attn: GAPP
20 Valley Stream Parkway, Suite 310
Malvern, PA 19355

Recurring Credit Card Payments

Procedures

- Any policyholder who elects Recurring Credit Card payments is required to complete an Authorization Form (See attached).
- The policy will have a 1st of the month billing date.
  - If the effective date of the policy does not fall on the first of the month, the initial credit card payment will be pro-rated to the first of the month.
    - Example:
      - Effective date 1/15/17.
      - Initial credit card payment will be for the billing period of 1/15/17 through 2/28/17.
      - The next payment due date will be 3/1/17.
- The policyholder will receive the attached instructions with each subsequent invoice.
- The subsequent invoices will be mailed the 15th day of each month prior to the group's next 1st of the month due date.
- The policyholder will be instructed to complete their monthly invoices by reflecting any changes to the number of lives, payroll, and premium.
- The completed invoice must be emailed to Nabco by the 5th day of each month.
  - Example:
    - The 2/1 invoice will be mailed to the policyholder on 1/15.
    - The policyholder must update the number of lives, payroll, and premium due and email the completed invoice by 2/5 to Nabco.
    - Email Address: gappptd@nabenefits.com

The completed invoice will authorize Nabco to charge the updated premium due to the credit card maintained on file.

- If the invoice is not received, Nabco will process the current monthly premium based on the prior months reported lives, payroll, and paid premium.
- NABCO will charge the credit card maintained on file on the 10th calendar day of each month for the premium due.
- A payment receipt will be emailed to the policyholder.
- If payment is rejected, Nabco will contact the policyholder for payment.
- If a replacement credit card is not available, a check payment will be required and the group will be removed from the automatic credit card billing.

NORTH AMERICAN BENEFITS COMPANY
20 Valley Stream Parkway, Suite 310
Malvern, PA 19355
800-994-4277

Credit Card Recurring Payment Authorization Form For Occupational Accident Policy

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town)

Here's How Recurring Payments Work:

- You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card.
- You will be charged each billing period for the total amount due for that period.
- You agree to email the completed billing statement to NABCO @ gappptd@nabenefits.com by the 5th of each month. This billing statement notification will authorize NABCO to charge the premium amount due to your credit card.
- Once your payment is submitted, a receipt will be emailed to you and the charge will appear on your credit card statement.

Please complete the information below:

I _____ authorize North American
(Please Print Full Name & Title)
Benefits Company to charge the credit card indicated below on the **10th** calendar day of each month for payment of my assigned Occupational Accident Policy.

Policyholder Name _____ Policy # _____

Credit Card Billing Address_____ Phone#_____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next following business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

North American Benefits Company
20 Valley Stream Parkway
Suite 310
Malvern, PA 19355
1-800-994-4277

TO OUR OCCUPATIONAL ACCIDENT PROTECTION PLAN POLICYHOLDERS

RECURRING CREDIT CARD INSTRUCTIONS

- *Enclosed please find your modal billing statement for your current Occupational Accident Policy.*
- *Please return the completed billing statement along with a completed Report of Change or Contract Labor Census (if it pertains to your policy) to ensure that we have the most accurate data.*
- *Email completed billing statement to NABCO at gappptd@nabenefits.com by the 5th of each month.*

On the 10th of each month, NABCO will charge the Credit Card that is currently maintained on file the total amount based on the billing statement submitted to us by the 5th of each month.

If no changes are received, NABCO will process the current monthly premium based on the prior months reported lives, payroll, and paid premium.

Please feel free to contact your NABCO account manager if you have any questions or concerns.