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)

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 • Phone: 1-800-356-9601
Administrative Office: (NABCO) 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

GROUP ACCIDENT PROTECTION PLAN APPLICATION FOR COVERAGE – GAPP II

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. Business is: ☐ Corporation ☐ LLC ☐ Sole Proprietorship ☐ Other (explain): _____
7. How long has Applicant been in business? _____ What are hours of operation? _____
8. Describe nature of business: _____
9. What date was the Workers' Compensation Act rejected? _____
10. Does Applicant or its affiliate(s) 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: _____
11. Has Occupational Accident and/or Employer Liability Insurance ever been canceled, refused or non-renewed by any company during the past three (3) years? ☐ Yes ☐ No If Yes, please provide details: _____
    _____
12. Does Applicant or its affiliate(s) perform any work at heights taller than 10 feet? If Yes, please provide details: _____
13. What percentage of loads are <u>manually</u> loaded or unloaded (enter 0% if none): _____% Loaded _____% Unloaded
14. Does Applicant or its affiliate(s) currently have any open Employer Liability or Occupational Accident claims?
    ☐ Yes ☐ No If Yes, please provide details: _____
15. With regard to occupational injury and illness, has the Applicant or its affiliate(s) ever:
    Received a citation, warning or judgement? ☐ Yes ☐ No
    Been fined, sued or settled an occupational injury or employer liability claim? ☐ Yes ☐ No
    Paid an award or judgement? ☐ Yes ☐ No
    If Yes, please provide details: _____

16. Please submit three years loss history with this Application.

17. 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.

18. Are any affiliated entities to be covered? ☐ Yes ☐ No If Yes, please provide Legal Names and Addresses:

_____

_____

Please specify number of employees at each location: _____

19. Are multiple locations or job sites to be covered? ☐ Yes ☐ No If Yes, please provide Addresses:

_____

Please specify number of employees at each location: _____

20. 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: _____

_____

21. Policy Elections:

- Deductible Type:
  - ☐ Aggregate Deductible ($2,500 min/ $50,000 max): $ _____
  - ☐ Individual Deductible - per covered person per occurrence ($1,000 min/ $50,000 max): $ _____
- Combined Single Limit - per covered person per occurrence ($100,000 min/ $3 mill max): $ _____
- Aggregate Limit of Liability - per occurrence :
  - ☑ $5 mill
- Accumulation Period (weeks):
  - ☐ 52 ☐ 110 ☐ 156
- Weekly Indemnity:
  - Elimination Period (days): ☐ 7 ☐ 14
  - Benefit Amount (% of weekly wage): ☐ 75% ☐ Other, please list (50% min/ 75% max):_____%
  - Maximum Weekly Indemnity: ☐ $750 ☐ Other, please list ($200 min/ $800 max): $_____
  - Maximum Weeks Duration (weeks): ☑ same as Accident Medical
- Accidental Death, Dismemberment and Loss of Use:
  - ☐ $150,000 ☐ Other, please list ($100,000 min/ $500,000 max): $_____
  - ☐ 10 times employee salary (max $500,000)
- Occupational Disease, Cumulative Trauma and Occupational Hernia (subject to policy limits):
  - ☑ Included
- Include Waiver of Subrogation: ☐ Yes ☐ No
- Include Alternate Employer Endorsement: ☐ Yes ☐ No

22. Premium Calculation and Payment Mode: ☑ Monthly Bill

NCCI Code	Class Description	Payroll, including tips	Payroll Rate	Total for Class
	Total Payroll			
		Composite Rate		
			Premium Subtotal:	
			Monthly Admin / Billing Fee:	$60
			One-Time Issue / Policy Fee:	$100
			One-Time ERISA Set-Up Fee*:	
			Monthly ERISA Maintenance Fee*:	
			Initial Payment:	

* Applicable when Employer liability coverage is selected.

(Please make premium check payable to Administrator, NABCO)

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

Employer Authorized Signature

Signature Date

Broker or Agent Name (please print)

Broker or Agent Signature

Signature Date

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

INDEPENDENCE AMERICAN INSURANCE COMPANY

a Delaware Insurance Company

Home Office: 485 Madison Avenue, 14th Floor, New York, NY 10022

Administrative Office: (NABCO) 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

Employers Liability Coverage Election Form

Election is hereby made for the coverage specified to become effective on: _____ at 12:01 A.M. Central Standard Time at the address described below and provided that the initial premium is paid in full and the Company approves the coverage.

1. Legal Name of Employer: _____

   DBA: _____ Federal Tax ID Number: _____

2. Contact Person: _____ Title: _____

   Email Address: _____ Business Phone: _____

3. Physical Address: _____

   City: _____ State: _____ Zip: _____

4. Mailing Address: _____

   City: _____ State: _____ Zip: _____

5. Policy Elections:

   - Deductible per Occurrence: ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000
   - Maximum Amount of Indemnity per Occurrence: ☐ $10,000 ☐ $25,000 ☐ $50,000

6. Premium Calculation and Payment Mode: ☐ Monthly Bill

NCCI Code	Class Description	Payroll	Payroll Rate, including Tips	Total for Class
		Total Payroll		

Composite Rate $

Initial Payment $

Please make premium check payable to "North American Benefits Company."

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

As per the policy provisions, we have the right to audit your payroll records at any time. If it is determined that premiums have been unpaid, we shall be entitled to recover such underpayments.

1. The Employer requests coverage for a policy of insurance as described above. The Employer also agrees to be bound by all of the terms, conditions and exclusions of the policy. The Employer further understands and agrees that:

    a. Neither the Request for Coverage, nor the payment of any monies to be applied, shall guarantee insurance to become effective. In order for insurance to take effect on the date specified, the "Company" must accept and issue a policy.

    b. The Insured/Employer will agree to pay the required premiums to the Company when due.

2. Acceptance of this request is subject to all of the following: (a) Company's requirements; (b) Terms of the Policy; (c) Company verification of the quoted premium.

3. The Company will notify the Insured/Employer of any approval or disapproval of this request. Any notice/binder of approval will specify the policy effective date and schedule of coverage.

4. The undersigned Insured/Employer understands that he/she may be subject to on-site loss control/safety inspections. Periodic loss control/safety inspections may be required as a contingency for continuation of coverage. The Insured/Employer also understands and agrees that he/she will be required to comply with any/all loss control/safety recommendations as a contingency for continuation of coverage.

5. The undersigned Insured/Employer has reviewed with his agent (who signs below) and understands the coverage, limits, terms, conditions and exclusion of this application and the Policy.

6. The Employer shall make modified duty available for employees approved for rehabilitation and able to return to some form of work as agreed to by the employee's treating physician.

7. The undersigned Insured/Employer understands coverage is written on a Combined Single Limit basis. All coverage afforded under this policy shall not exceed the coverage amount specified for any one person or occurrence per the policy terms and conditions.

8. This is not Workers' Compensation Insurance, nor is it a replacement for Workers' Compensation Insurance. Independence American Insurance Company does not sell, nor is it authorized to sell, Workers' Compensation Insurance.

Employer Signature (Officer): _____

Title: _____ Date: _____

The undersigned agent warrants he/she has not represented the above coverage as anything other than an Occupational Accident policy for on-the-job employee-related injuries.

Agent of Record: _____ Date: _____

Agency/Recording Agent Printed Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

License I.D. Number: _____

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

Disclosure and Acknowledgement Concerning Workers' Compensation

This will acknowledge that in solicitation of the Independence American Insurance Company Employers Liability Insurance Policy, the Agent named below (herein referred to as "Agent"), explained to me the following facts about the Texas Workers' Compensation Act (the "Act"). The following facts were discussed, and as an employer I am aware of their importance. To my knowledge, no statements contrary to the following statements were made by the Agent to anyone employed by or representing me.

1. Workers' compensation insurance is a "No-Fault" system that affords coverage for my employees and protections for me which no alternative insurance plan can duplicate.
2. It is my responsibility, should I elect not to purchase workers' compensation insurance, to notify the Texas Department of Insurance, Division of Workers' Compensation ("DWC") at the time of such election by filing the appropriate form (currently the DWC Form 5). I must also annually file the appropriate form (currently DWC Form 5) with the DWC on the anniversary date of the original filing or if I have canceled my workers' compensation policy, on the anniversary of the cancellation date of the workers' compensation policy. I am aware of the penalty for failure to properly file can be as much as $25,000 per day. I also must notify my workers' compensation carrier, in the manner provided by the law, at the time of my election. All notices and elections must be made by certified mail, return receipt requested.
3. Agent has advised me that if I become a non-subscriber under the Act, I should seek the advice of competent legal counsel in meeting the provisions of the Act. Agent has advised me to seek legal advice for the current law as it applies to my situation.
4. I am aware that as a non-subscriber, should I purchase an alternative insurance product that provides occupational injury benefits for my employees, I may come under the Employee Retirement Income Security Act of 1974 (ERISA). I understand that it may be in my best interest to have a written occupational injury benefit plan, and to file this plan under ERISA with the U.S. Department of Labor. Such insurance and plan do not preempt a personal injury negligence lawsuit.
5. I understand that a safety program could help reduce the frequency and severity of on-the-job injuries and could also help me meet my responsibility to provide a "reasonably safe place to work" for our employees.

I acknowledge the option I have selected is solely my choice and the alternative plan I have chosen was not represented by Agent to any person as being a substitute for statutory workers' compensation insurance. Agent did not induce me or any representative of my company to reject Workers' Compensation. I have sought, or been given the opportunity to seek, competent legal counsel to advise me on this decision.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

I read the above and acknowledge Agent has discussed each of these items with me.

Signed this _____ day of_____, 20_____.

_____	_____
Agent Signature	Employer Name (please print)
_____	_____
Agent Name (please print)	Signature – Officer/Owner
_____	_____
Witness	Name and Title (please print)

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

GAPP I. GAPP II.

ERISA plan Worksheet

This form must be completed for GAPP I and GAPP II with Employer Liability

Employer Legal Name: _____

Address: _____

City:_____State:_____ Zip:_____

Mailing Address: _____

City:_____State:_____ Zip:_____

Phone: ( ) _____ Fax #: _____

Email: _____

Federal Tax I.D. No.:_____

Employer's fiscal year ends: _____

Employer is: ■ Corporation ☐ Sole Proprietorship ☐ Partnership

Affiliated or subsidiary companies covered? ■ Yes ☐ No %_____Common Ownership
(Attach additional sheets showing above information for each entity and indicate % of ownership)

Name and Title of ERISA Plan Administrator:

Contact Name: _____ Title: _____

Number of Employees:_____

Effective Date of ERISA Plan:_____

Do you currently have any existing Employee Welfare Benefit Plans, which are governed by ERISA?

(I.E. Group Health Insurance)? ■ Yes ☐ No

If yes, please specify Plan I.D. Number(s): _____

Describe each Plan: _____

Producer Agent:

Name: _____ Agency: _____

Phone #: _____ Fax #: _____

City: _____ State: _____ Zip:_____

Employee Census Supplemental Page.

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

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

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.