GAPP I. GAPP II. TAPP.

Enrollment Checklist

Group Accident Protection Plan

Employer Name:____
Employer Physical Address:____
City:____________________State:____________________ Zip:____________________

Employer Mailing Address:____
City:____________________State:____________________ Zip:____________________

Contact Person:______________________________ Phone: (   )______________________________
Email:____

Primary Producer / Agent Name:______________________________ Commission %:____________________
Address:______________________________ FEIN/SS#____________________
City:____________________State:____________________ Zip:____________________
Email:____

Co-Producer / Agent Name:______________________________ Commission %:____________________
Address:______________________________ FEIN/SS#____________________
City:____________________State:____________________ Zip:____________________
Email:____

General Agent's Name:______________________________ Commission %:____________________
Address:______________________________ FEIN/SS#____________________
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 or Credit Card Authorization Form

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
(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.

1241 John Q. Hammons Dr.
Madison, WI 53717

TAPP -

TRUCKERS' ACCIDENT PROTECTION PLAN

APPLICATION FOR COVERAGE

Requested Plan Effective Date:_______________

Name of Employer (full corporate name under which business operates):

____

Mailing Address: _______________

Street Address: _______________

City/Town: _______________County:_______State:_________Zip:_______________

Phone Number: _______________

Email: _______________

NCCI Code Assigned:_______________

The applicant must be engaged in the business of trucking. Coverage for other industries is available through the Company's Group Accident Protection Plan (GAPP) program.

Describe Nature of Business ***IN DETAIL***:_______________

Goods Hauled: _______________

Number of Years in Business: _________

Are any of the truckers to be insured independent contractors? ☐ Yes ☐ No How many?_________

Are the independent contractors directly contracted to the employer applicant? ☐ Yes ☐ No

TAPP Plan Selections			
Medical Plan Limit:	☐ $300,000	☐ $500,000	☐ $1,000,000
Medical Expense Deductible:	☐ $1,000	☐ $2,500	

Waiver of Subrogation (additional cost)

Class	# of Employees		Rate Per Employee		Class Total
I	_______	X	_______	=	_______
II	_______	X	_______	=	_______
III	_______	X	_______	=	_______

Please check for Credit Card Payment Option. (If yes, Credit Card Authorization Form must be completed)

Please check only for the (electronic) Bank Draft/ACH Debit Payment Option. (If yes, ACH Debit Form/ Application must be completed)

*Choose One:
- ☐ $20 Monthly
- ☐ $35 Quarterly
- ☐ $50 Semi-Annually

Total Premium: $ _______________

Billing Fee*: $ _______________

One Time Issue / Policy Fee: $ 50.00

Initial Payment: $ _______________

(Please make premium check payable to NABCO)

Permit No.: _______________

Subject TXDOT regulations? ☐ Yes ☐ No

(**Complete Census** including each employee's name, SS#, DOB, DOH, occupation and full-time or Part-time status must be attached.)

THE INFORMATION ABOVE ACCURATELY REPRESENTS THE TAPP PROGRAM DESIGN FOR WHICH WE ARE APPLYING. THE REQUIRED EMPLOYEE INFORMATION IS ACCURATELY SHOWN ON THE ATTACHED TAPP CENSUS FORM WHICH REQUIRES INFORMATION ON ALL EMPLOYEES.

_______________ _______________

Employer Authorized Signature Date

____

Broker or Agent Name (Please Print)

_______________ _______________

Broker or Agent Signature Date

THE EMPLOYER CERTIFICATION (FORM # OCC ACC APP CERT 0817) 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

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

GAPP I. GAPP II. TAPP.

Credit Card Authorization

NORTH AMERICAN BENEFITS COMPANY

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 at gappptd@nabenefits.com by the 5th of each month. The premium will be the result of any employee changes. This notification will authorize NABCO to charge the calculated premium amount 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.

Return to: NABCO
Attn: GAPP
20 Valley Stream Parkway, Suite 310
Malvern, PA 19355
800-994-4277

GAPP I. | GAPP II. | TAPP.

Electronic (EFT) / ACH Form

North American Benefits Company

Employer Name (no abbreviations): ____________________

Mailing Address: ____________________

City: ____________ State: ____________ Zip: ____________

Phone: ____________ Email: ____________

Instructions for Electronic Funds Transfer (EFT)

Fill in complete banking information where indicated.

Check One: ☐ New EFT Debit ☐ Change Existing EFT Debit Policy Number: ____________

Bank Name	Account Name (as it appears on the account)
Bank Account Number	Type of Account ☐ Checking ☐ Savings
Bank ABA Routing Number	Bank Address
VOIDED CHECK (Forms submitted without a voided check will not be accepted and will be returned.)	

I hereby authorize North American Benefits Company (NABCO) to debit my bank account listed below on the 10th of every month or the next following bank business day (if the 10th occurs on a weekend or bank holiday) for insurance premiums due.

If notified of a failed transaction, then a second attempt by NABCO will be made to debit my account. This agreement shall automatically terminate if a failed transaction occurs more than once or until I revoke this authorization by sending written notice to NABCO.

Authorized Name (Print) ____________________ Date ____________

Authorized Signature ____________________

Return to: NABCO
Attn: GAPP
20 Valley Stream Parkway,
Suite 310 Malvern, PA 19355
800-994-4277