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.

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: _____ NCCI Code: _____
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: _____

If Employer Liability Policy is not being purchased in conjunction with this Policy, questions 11 through 17 are not required.

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 ($500 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 ☐ 28
  - Benefit Amount (% of weekly wage): ☐ 75%
  - Maximum Weekly Indemnity: ☐ $600 ☐ 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:	
One Time Issue / Policy Fee:	
One Time ERISA Set-Up Fee*:	
Initial Payment:	

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

☐ Please check for (electronic) Bank Draft/ACH Debit Payment Option. (If yes, ACH Debit form must be completed, Agreement for Electronic Funds Transfer and ACH Sold Case Census Form must be completed)

Note: Monthly ERISA maintenance fee of $5 is applicable when employer liability coverage is selected.

(Please make premium check payable to NABCO)

* Applicable when Employer liability coverage is selected.

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 0817) 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.

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:_____

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.

NORTH AMERICAN BENEFITS COMPANY

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

NORTH AMERICAN BENEFITS COMPANY