



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)



**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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Details: _____ |
| Pharmaceuticals | <input type="checkbox"/> Yes <input type="checkbox"/> No | Details: _____ |
| Fuel Oils | <input type="checkbox"/> Yes <input type="checkbox"/> No | Details: _____ |
| Hazardous Materials | <input type="checkbox"/> Yes <input type="checkbox"/> No | Details: _____ |
| Nuclear Materials | <input type="checkbox"/> Yes <input type="checkbox"/> No | Details: _____ |
| Asbestos Materials | <input type="checkbox"/> Yes <input type="checkbox"/> 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 (\$500 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):
 - \$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): \$ _____
- 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	Class Description	Payroll, including tips	Payroll Rate	Total for Class
Total Payroll				
Please check for Credit Card Payment Option. (If yes, Credit Card Authorization Form must be completed.)		Composite Rate		
Please check for (electronic) Bank Draft/ACH Debit Payment Option. (If yes, ACH Debit Form/Application must be completed)			Premium Subtotal:	
			Monthly Admin / Billing Fee:	
			One Time Issue / Policy Fee:	
			Initial Payment:	

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 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 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
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. TAPP. GROUP ACCIDENT PROTECTION PLAN

Employee Census Supplemental Page.

Census

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
Job Titles/Duties		Termination Date					

Employee Name	Social Security #	DOB	Date of Hire	Monthly Wages \$	NCCI Class	W2 <input type="checkbox"/>	1099 <input type="checkbox"/>
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)

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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: _____

Table with 2 columns: Bank Name, Account Name (as it appears on the account), Bank Account Number, Type of Account (Checking/Savings), Bank ABA Routing Number, Bank Address. Includes a VOIDED CHECK notice.

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