Gerber Life Insurance Company
[1311 Mamaroneck Avenue
White Plains, New York 10605]

Please send completed forms to:
P.O. Box 25209; Santa Ana, CA 92799

APPLICATION FOR LARGE GROUP COVERAGE

This Application, the Certificate, the Policy, and any applicable state rider or endorsement constitute(s) the entire contract between the Policyholder and Gerber Life Insurance Company.

Group Applicant

Full Legal Name of Employer/Group:	SIC:	
Group Contact:	E-mail Address:	
Address (Street):	Telephone:	
City:	State:	Zip Code:
County:	Other State Location(s):	

Legal Entity:
☐Corporation ☐S-Corporation ☐Partnership ☐Sole Proprietorship ☐Trust ☐Association ☐Other: _________

Nature of Business:

Subsidiaries or Affiliates to be insured: ☐ No ☐ Yes, Full Legal Name(s):
1.

2.

Coverage Requested

1. Plan: ☐Vision Only ☐Vision + Hearing *Benefit Frequency and Allowances:*	2. Requested Effective Date:
3. Number of Eligible Employees:	4. Number of Employees Enrolling:

5. Number of Eligible Dependents:	6. Number of Dependents Enrolling:	6a. Dependent Age Limit:

7. Waiting Period: Initial Employees: ☐ None Future Employees: ☐ One Month ☐ Other: _________

8. Employer Contribution: _______% Employee _______% Dependents	9. ☐ Employer Paid ☐Voluntary

10. Domestic Partner Coverage: ☐ Same Sex ☐ Opposite Sex ☐ Both

11 All or part of this insurance will replace similar coverage:
☐ No ☐ Yes, please submit copies of the policy(ies) and/or certificate(s)

Prior Carrier:	Coverage:	Termination Date:

12. Initial Premium Deposit: Minimum First Month Premium $ _________, Plus $ _________ Billing Fee.

TOTAL REMITTED: $ _________

Disclosure and Acknowledgement

THIS IS VISION-ONLY INSURANCE, UNLESS A HEARING BENEFIT RIDER TO THE VISION POLICY IS SELECTED. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Do you offer group comprehensive hospital, surgical and medical health insurance (minimum essential coverage) to your employees? ☐ Yes ☐ No

The group policyholder understands that this is vision-only insurance, unless a Hearing Benefit Rider to the Vision Policy is selected. This is a supplement to health insurance and is not a substitute for major medical coverage or other minimum essential coverage. ☐ Yes ☐ No

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Agreement

It is agreed that the policy will not become effective unless the application is approved by the Company at its Home Office at rates to be determined by the Company. The Premium Deposit will be refunded if the application is not approved by the Company. If approved, the effective date of the policy will be: (a) the effective date requested; or (b) the date the required number of Employees who are to contribute to the Cost of the Group Insurance have enrolled, whichever is later. The Applicant declares that to the best of his knowledge and belief, the statements and answers to the above questions are complete and true.

Authorization

Dated at: (City, State)	This: (Month, Day, Year)
Witness: (Licensed Broker/Agent Signature)	By: (Authorized Policyholder Signature)
Print Broker/Agent Name:	Print Name:
Broker/Agent License Number:	Title:

Group Effective Date:

Group Information

Name of Group:		
Billing Address:		City:
State:	Zip:	County:
Billing Contact:		Title:
Telephone:	Fax:	E-mail:

Eligibility

Indicate the Number of Eligible Employees and the Number of Employees Initially Insured:

Plan: (Benefit Frequency, Frame Allowance, Contact Lens Allowance)	**Copayment/ Deductible**	**Number of Eligible Employees**	**Number of Enrollment Forms**

Deliver Administration Package to: ☐ Group ☐ Broker/Agent ☐ MES Representative

If this insurance applied for is a replacement of existing insurance, are you the same broker/agent who previously wrote the case? ☐ Yes ☐ No

Rates (Please attach a copy of the proposal and rates.)

EE Only: $	EE + 1 (Spouse or Child): $	EE + Family (Spouse & Children): $	EE + Children: $

Rate Guarantee: ☐ 12 months ☐ 24 months ☐ Other __________

Commission: _______% (Commission included in rate.)

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Broker/Agent Statement & Information

I hereby certify that all the information contained in this Application for Group Insurance is correct and I know nothing unfavorable about this entity or any individual proposed for the insurance. I have complied with underwriting rules and regulations and have explained in detail the coverages to the entity and its employees.

Broker/Endorsed Agent Name:		Telephone:	Email:
Agency Name:		Tax ID No (of Appointed Entity):	Insurance License No & State:
Broker/Agent Street Address: (PO Box not acceptable)		Broker/Agent E-mail Address:	☐ Agency ☐ Individual
City:		State:	Zip:
General Broker/Agent: (If Applicable)		Telephone:	Email:
MES Regional Sales Manager:	Telephone:	Email:	Office:

This form, the initial enrollment, and the first month's premium should be submitted to the local representative.

BROKER/AGENT SIGNATURE: ____ DATE: ________________

PRINT NAME: ____

Notice: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FRAUD WARNING

NOTICE TO CALIFORNIA APPLICANTS: THE FALSITY OF ANY STATEMENT IN THE APPLICATION FOR THIS POLICY SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THIS POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY US.