NLI America
BENEFIT FROM OUR DEDICATED SERVICE

Nippon Life Insurance Company
of America
PO Box 10310
Des Moines, IA 50306-0310

Employer Application for Group Insurance

This form is for: ☐ new case ☐ amendment Account number: _____

Requested effective date: _____ Advanced premium received $ _____

Employer Information

Legal name of company (include dba)

☐ corporation ☐ partnership ☐ sole proprietorship ☐ other _____

Street address | Billing address

City | State | ZIP code

Contact | Telephone number | FAX number

E-mail address | Nature of business

SIC code | Federal tax ID number | Number of years in business

Have you been insured by Nippon Life Insurance Company of America (NLI America) previously? ☐ yes ☐ no

If yes, when and under what name? _____

Has the company been denied credit within the past two years, ever filed for bankruptcy, or is the firm now in the process of (or considering) filing for bankruptcy? ☐ yes ☐ no (attach an explanation)

Employee benefit booklets to be produced on: ☐ CD ☐ paper

Are there any additional locations or participating units that will be covered? ☐ yes ☐ no

Employers with Participating Units

If employees of any associated business organizations (e.g. parent-subsidiary, brother-sister relationships, affiliated groups, etc.) are to be covered, please list the affiliate or subsidiary below.

Participating unit is an entity that is an affiliate or subsidiary related to the employer through common control or ownership.

Unit name/address/federal tax ID	Nature of business	Relationship to company		Number of employees
1.			☐ include unit ☐ exclude unit	
2.			☐ include unit ☐ exclude unit	

Are there any excluded locations or participating units that are not covered? ☐ yes ☐ no

Excluded Locations

Address(es) of other employer location(s) which are excluded from this policy. | Number of employees

Small Employer Qualification

In order for us to issue and maintain your group health policy in accordance with state law, we need to know if you qualify as a **Small Employer.**

A **Small Employer** means an employer that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year, and who employs at least two employees on the first day of the plan year.

Does your group meet the definition of Small Employer? ☐ yes ☐ no

Small Employer Qualification (continued) 210

I understand that a **Qualification Statement** may be required prior to each renewal as a condition of renewal as a Small Employer group.

I understand that if our group qualifies as a Small Employer group under Illinois law at the time of this qualification, the provisions of the law will continue to apply to our group until the next policy anniversary, even if our group ceases to qualify as a Small Employer group prior to that date.

Employee Eligibility

Employees in the waiting period are considered eligible. Are there any employees in the waiting period?

☐ yes ☐ no If yes, submit enrollment form.

Eligible Employee

☐ an employee must work at least 30 hours per week to be eligible for insurance.

☐ other _____ (if agreed to by the home office of NLI America)

Ineligible Employee: an independent contractor (unless required by law) or an employee who works less than the required number of hours per week, or is employed as a temporary or seasonal employee, is not eligible for insurance.

Total number of employees (full and part-time): | Total number of eligible employees (full and part-time):

Are you excluding any class of employees? ☐ yes ☐ no If yes, describe: _____

_____ Number of employees: _____

Waiting Period/Effective Date Provisions

Applies to:	☐ only employees hired after the effective date ☐ all employees, including those hired before, on, or after the effective date
Waiting period:	☐ 1 month ☐ 3 months ☐ 6 months ☐ other _____
Employees will be eligible on the:	☐ day immediately following the final day of the waiting period or change ☐ first of the insurance month coinciding with or next following the final day of the waiting period or change

Employer Request for Benefits and Contribution

Term Life Insurance (Proof of good health may be required before insurance can become effective.)

	Benefit for:	Contribution %	Benefit for:	Contribution %
	employee	employer	dependent	employer
basic term life	☐ yes ☐ no	%	☐ yes ☐ no	%
basic accidental death and dismemberment	☐ yes ☐ no	%	☐ yes ☐ no	%
Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier			
	Effective date	Discontinue date		
Employees not actively at work and dependents in a period of limited activity:	List all employees who are not actively at work and dependents in a period of limited activity			

Are you requesting disability insurance? ☐ yes ☐ no **210**

Do you have any employees who are not actively at work? ☐ yes ☐ no

Disability Insurance (Proof of good health may be required before insurance can become effective.)

Request for ➢	employee short term disability	employee long term disability
Contribution:	employer %	employer %
Employees not actively at work:	List all employees who are not actively at work	
State specific information (short term disability only)	Are there employees located in any of the states listed below (policies offered in these states are supplemental)? ☐ yes ☐ no (If yes, indicate the number of employees for each state.)	
	California / Hawaii / New Jersey / New York / Rhode Island	
	Unemployment Insurance or Department of Labor number	

* If employees contribute to the cost of STD or LTD insurance, are these contributions made on a ☐ pre-tax or ☐ post-tax basis?

Medical Insurance (including Prescription Drugs and Mail Order if elected)

Request for ➢	employees	dependents
Contribution:	employer %	employer %
Will you continue to offer HMO coverage?	☐ yes ☐ no If yes, number of employees:	
State specific information	Do you have employees located in New York? ☐ yes ☐ no / Number of employees located in New York	
	Do you have employees located in Hawaii for whom medical expense coverage is intended? ☐ yes ☐ no	
	Number of employees / Department of Labor number	
	Note: Hawaii state law mandates special plan designs, eligibility, and waiting period requirements for employees located in Hawaii. Please contact the home office of NLI America regarding these special requirements.	
Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier	
	Effective date / Discontinue date	

If more than one carrier provided insurance in the past 12 months, provide carrier name, address, effective date and discontinue date(s) on a separate sheet of paper, and attach to application.

Do you offer medical insurance to your employees through another carrier? ☐ yes ☐ no

TEFRA eligibility is defined as employers who employed 20 or more full or part-time employees for 20 or more calendar weeks in the current or preceding year. If this requirement is met, the group is TEFRA eligible and NLI America will pay primary to Medicare.

Do you meet the eligibility definitions? ☐ yes ☐ no

Dental Insurance **210**

Request for ➢	employees	dependents
Contribution:	employer %	employer %
Will you continue to offer HMO coverage?	☐ yes ☐ no If yes, number of employees:	
Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier	
	Effective date	Discontinue date

Did your prior dental insurance include benefits for orthodontia treatment? ☐ yes ☐ no

If yes, number covered: _____

Vision Insurance

Request for ➢	employees	dependents
Contribution:	employer %	employer %
Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier	
	Effective date	Discontinue date

Medical/Prescription Drugs/Mail Order Prescription Drugs/Dental/Vision (check continuation that applies)

COBRA eligibility is defined as employers who employed 20 or more full or part-time employees on at least 50% of the working days in the prior calendar year. Do you meet the eligibility definition? ☐ yes ☐ no

Employee or dependent name	COBRA ☐	USERRA ☐	state cont. ☐
Employee or dependent name	COBRA ☐	USERRA ☐	state cont. ☐
Employee or dependent name	COBRA ☐	USERRA ☐	state cont. ☐
Employee or dependent name	COBRA ☐	USERRA ☐	state cont. ☐

Please attach separate sheet of paper if more space is needed.

All Coverages

ERISA plan number: _____

The Employee Retirement Income Security Act of 1974 (ERISA) requires that each employee benefit plan subject to the Act designate a "Named Fiduciary who shall have authority to control and manage the operation and administration of the plan."

If this plan is subject to ERISA and the Named Fiduciary is other than the employer, fill in the information below. NLI America may not be designated as Named Fiduciary.

The "Named Fiduciary" shall be: _____

Designation as Named Fiduciary is accepted. (Required only if the "Named Fiduciary" is an individual.)

By: _____

Title: _____

It is understood that NLI America shall not be responsible for any tax or legal aspects of the plan. The employer assumes responsibility for these matters. The employer acknowledges that they have counseled to the extent necessary with selected legal and tax advisors. The obligations of NLI America shall be governed solely by the provisions of its contracts and policies. NLI America shall not be required to look into any action taken by the named fiduciary or the employer and shall be fully protected in taking, permitting, or omitting any action on the basis of the employer's actions. NLI America shall incur no liability or responsibility for carrying out actions as directed by the named fiduciary or the employer.

It is further understood that by signing this application, the employer is purchasing insurance and not making an investment. No reserves, undeclared or unpaid experience premium refunds, or interest with respect to claim payments, nor claim proceeds themselves shall be considered plan assets under ERISA.

Agreement and Signatures 210

- The employer has been informed of the minimum participation and contribution requirements. The employer agrees that coverage applied for shall not become or remain effective unless: a) participation and contribution requirements are met, and b) the employer is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code, and c) the application and any attached page(s) are received, accepted, and approved by NLI America.
- If this application is accepted, all group policies will be combined and treated as one policy for the purpose of determining any experience premium refund.
- The preexisting condition restrictions for medical and long term disability insurance have been explained to and understood by the employer.
- The employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If a policy is issued from this application and is accepted by the proposed policyholder, we will apply the premium deposit to the first premium due for such policy. If no policy is put into force, the premium deposit will be refunded.
- Premium payment will be monthly unless otherwise indicated.
- Acceptance by the employer of any policy or policies issued with this application shall constitute approval of any corrections, additions, or changes specified in the space “For NLI America Use Only” or as otherwise indicated on this application.
- Your agent or broker cannot change or waive any provision of this application or the policy or policies without the written approval of an officer of NLI America in the home office.
- The employer acknowledges and understands that if this application is approved, the group policy will determine all rights and benefits.
- The person signing this form for the employer has legal authority to bind the employer for whom application is being made.
- The employer agrees to make timely notification of any employee termination, status change, or other material changes that may affect the eligibility of employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The employer understands that coverage may also be terminated for other reasons as provided in the group policy.
- I certify all information given on this application, and any attachments, are true and complete to the best of my knowledge and belief.

NOTE: If NLI America determines, due to requirements of law or because of our own underwriting criteria, to issue our group insurance through a multiple-employer group insurance trust, the employer hereby subscribes to and agrees to the terms of that trust.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines. Fraud or misrepresentation may be grounds for nonrenewal or termination under the terms of the group policy.

Employer (company name)

Signed by (must be an officer)	Officer’s title	Date signed

Licensed resident agent(s) (individual/firm)	Agent’s license number

Signature of soliciting agent(s) (If more than one, all must sign)

Employer Instructions

After this form is completed and signed, make one copy for your records and send the original to Nippon Life Insurance Company of America.

For NLI America Use Only

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