

**FRAUD NOTICE:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.**  
 5011 GATE PARKWAY, BLDG. 200 • JACKSONVILLE, FLORIDA 32256  
**APPLICATION FOR GROUP INSURANCE**

1. LEGAL NAME OF POLICYHOLDER: \_\_\_\_\_

2. ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

3. GROUP ADMINISTRATOR: \_\_\_\_\_ 4. TELEPHONE NUMBER: \_\_\_\_\_ 5. NATURE OF BUSINESS: \_\_\_\_\_ 6. SIC CODE: \_\_\_\_\_  
 ( )

7. NAME OF SUBSIDIARIES, DIVISIONS, OR AFFILIATES TO BE COVERED: \_\_\_\_\_ 8. NATURE OF THEIR BUSINESS: \_\_\_\_\_

9. EFFECTIVE DATE 12:01 A.M. (MO/DAY/YR): \_\_\_\_\_ 10. GROUP NUMBER: \_\_\_\_\_ 11. NUMBER OF EMPLOYEES CURRENTLY: \_\_\_\_\_  
 Eligible: \_\_\_\_\_ Enrolled: \_\_\_\_\_

12. PREMIUMS ARE TO BE PAID:  Monthly  Other  
 Due date:  1st of the month  15th of the month  \_\_\_\_\_ of the month

13. EMPLOYER CONTRIBUTION FOR:  
 Employee Life and AD&D \_\_\_\_\_%  
 Basic \_\_\_\_\_%  
 Supplemental \_\_\_\_\_%  
 Short Term Disability \_\_\_\_\_%  
 Dependent Life \_\_\_\_\_%  
 Other \_\_\_\_\_%

14. FULL-TIME EMPLOYEE: The normal work week for your full-time employees is \_\_\_\_\_ hours.  
 Usually, the normal work week is at least 30 hours.

15. WAITING PERIOD: Each employee must complete the following waiting period of continuous active work:  
 \_\_\_\_\_ days for present employees; and \_\_\_\_\_ days for future employees.

16. INELIGIBLE CLASSES AND/OR DIVISIONS (IF NONE, PLEASE STATE): \_\_\_\_\_

17. SCHEDULE OF BENEFITS (ATTACH ADDITIONAL SHEET OF PAPER, IF NEEDED. SIGN AND DATE IT.)

Eligible Classes	Term Life Amount	Accidental Death, Dismemberment, and Loss of Sight Amount	Short Term Disability Benefits	Dependent Life Insurance Amount	Long Term Disability
				Spouse _____ Children _____ (less than 6 mos.) Children _____ (6 mos. and older)	<input type="checkbox"/> Yes <input type="checkbox"/> No  (If yes, see attached LTD master application.)
RATES					

18. Amounts of life insurance in excess of \$ \_\_\_\_\_ are subject to evidence of insurability. Amount cannot exceed plan maximum.

19. REDUCTION OF BENEFITS: Please check the appropriate box below, or use the "Special Remarks" section for other options.  
 Life and AD&D reduce 35% at age 65, reduce to 50% at age 70, and to 25% at age 75.  
 Life and AD&D reduce 33% at age 70, and 33% of the previously reduced amount every five years thereafter (rounded to nearest \$250).  
 No reduction of benefits.

20. Short term disability benefits start on the earliest of the: (1) \_\_\_\_\_ day of accidental disability; (2) \_\_\_\_\_ day of sickness disability; or (3) \_\_\_\_\_ day of hospital confinement. These benefits continue for a maximum period of \_\_\_\_\_ weeks.

21. REPLACEMENT: Will this insurance replace any insurance now in force with another insurer covering employees eligible for this insurance? (If yes, attach copy of current policy.)  
 No  Yes Name of insurance company: \_\_\_\_\_ Date to which premiums paid: \_\_\_\_\_

22. SPECIAL REMARKS: \_\_\_\_\_

The applicant hereby certifies that the information contained in this application, including any attachment to it, is true and complete. The applicant understands that Florida Combined Life Insurance Company, Inc. (FCL), relies upon such information in considering or accepting this application, which will become part of the contract. If the policy is issued, it will be binding on you and us. It is also agreed that no insurance will become effective until approved by FCL. **(Please print, except where signature is requested.)**

FOR (NAME OF APPLICANT): \_\_\_\_\_ GROUP REPRESENTATIVE: \_\_\_\_\_ LICENSED AGENT (FLA.) (IF NONE, PUT N/A.): \_\_\_\_\_

BY AND TITLE: \_\_\_\_\_ GROUP REPRESENTATIVE CODE: \_\_\_\_\_ LICENSE # (SOCIAL SECURITY #/FEDERAL TAX ID): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ GROUP REPRESENTATIVE SIGNATURE: \_\_\_\_\_ LICENSED AGENT SIGNATURE: \_\_\_\_\_

SIGNATURE OF WITNESS: \_\_\_\_\_ DATED AT: \_\_\_\_\_ DATE: \_\_\_\_\_

**AGENT'S (OR GROUP REPRESENTATIVE'S) USE ONLY:**  
 To the best of my knowledge, replacement  is  is not involved at this time.  
 AGENT (IF NONE, GROUP REPRESENTATIVE) NAME **(Please print.):** \_\_\_\_\_  
 SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_