



APPLICATION FOR GROUP INSURANCE

Please Type or Print All Information

17800 Royalton Road
Strongsville, Ohio 44136-5149

**CONSUMERS LIFE
INSURANCE COMPANY**
A MEDICAL MUTUAL OF OHIO COMPANY

Group Number

PART 1: APPLICANT INFORMATION

1. Policyholder (legal name)		Check if applicable: <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Subchapter S Corp. <input type="checkbox"/> Sole Proprietorship	
2. Mailing Address (not P.O. Box)			
Group Contact	Phone ()		
City	State	Zip	Fax ()
3. Name of any <input type="checkbox"/> Affiliates <input type="checkbox"/> Subsidiaries to be covered			e-mail
4. Nature of Business			5. SIC Code

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, DEPENDENT LIFE AND SHORT-TERM DISABILITY

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

Proposal number _____ is incorporated by reference in and made part of this application for all purposes.

If multiple plans are indicated on the proposal, indicate plan number elected _____

If participation-free, voluntary coverages are being elected, please indicate below:

Yes, I am electing participation-free Voluntary Life and Accidental Death & Dismemberment

Yes, I am electing participation-free Voluntary Life and Accidental Death & Dismemberment, and short-term disability

If participation-free, voluntary short-term disability is elected, indicate the plan: 1/8/13 1/8/26

Waiting period:

None

First of month following completion of _____ days

Other _____

Employees working less than **20 hours** per week are not eligible for coverage. If different than 20 hours, please indicate number of hours: _____

Employer contribution percentages (%) for all products are as stated in the proposal, unless indicated below:

GROUP LONG-TERM DISABILITY

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be approval of the policy terms

Proposal number _____ is incorporated by reference in and made part of this application for all purposes.

Prior carrier: _____
(Prior carrier must be listed and a copy of the prior policy included for **continuity of coverage** to apply.)

Termination date of prior policy: _____

Waiting period – present employees: _____

Waiting period – future employees: _____

Employees working less than 30 hours per week are not eligible for coverage. If different than 30 hours, please indicate number of hours: _____.

Contribution:

Employer _____% Employee _____% Pre-tax dollars Post-tax dollars

GENERAL CONDITIONS

The above information is true and accurate to the best of my knowledge. I understand that the information on this application and any other information I provide shall serve as the basis for the Policy to be issued, and that I have a duty to notify Consumers Life of any changes.

Policyholder/Authorized Signature

Date

Title

Licensed Resident Agent (if required)

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Business of One SuperMed Life Trust Participation Agreement

This Participation Agreement relates to participation in the following group Insurance trust policy:

1. Name of Policyholder: The Trustee of the SuperMed Life Trust
Situs of Trust: Strongsville, Ohio
2. Group Policy Number: _____
3. Effective Date of Policy: _____
4. Name of Insurance Company: Consumers Life Insurance Company

Request for Participation:

The undersigned employer or other eligible membership organization ("Participating Employer") hereby applies to become a Participant in the group insurance Trust identified above. The undersigned Participating Employer acknowledges that a copy of the group insurance policy is maintained in Consumer Life Insurance Company's business office in Strongsville, Ohio and is subject to examination by participating employers and employees. The undersigned Participating Employer acknowledges that participation in the Trust will not commence unless the Participating Employer receives written notice of approval from Consumers Life Insurance Company's home office.

Agreement Concerning Participation:

The Participating Employer agrees that, upon its acceptance by the Trustee for participation in the Trust and subject to approval by Consumers Life Insurance Company for insurance purposes, it will, so long as such participation continues, fully comply with all obligations applicable to participating employers under the Trust as set forth therein. The Participating Employer understands that the insurance coverages under the group insurance policy will be only as provided for under the policy issued to the Trustee as the Policyholder. The undersigned acknowledges that the Trustee is not an insurer, and has no obligations regarding payment of premiums or handling of claims for the insurance provided under the group insurance policy issued to it as policyholder.

Acceptance by Participating Employer

Employer Name

Signature

Title

Date