Nippon Life Benefits®

Nippon Life Insurance Company of America
PO Box 25951
Shawnee Mission, KS 66225-5951

Nonmedical Employer Application for Group Term Life Insurance

This form is for: ☐ **New Case** ☐ **Amendment** Group number: _____

Requested effective date: _____ Advanced premium received $ _____

The first month's premium made payable to Nippon Life Insurance Company of America must accompany this submission.

Employer Information

Legal name of company (also include any doing-business-as or trade name):

☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ Other Federal tax ID number:

Street address:	Billing address:	Policy Situs State
City:	State:	ZIP code:
Contact:	Telephone number:	FAX number:
E-mail address:	Nature of business/SIC code:	Number of years in business:

Have you been insured by Nippon Life Insurance Company of America (Nippon Life Benefits) 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)

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, or you are excluding, please list the affiliate or subsidiary below.

A 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	

Employee Eligibility

Eligible Employee: An employee must work at least 30 hours per-week on a regular basis (or less, if required by state law) to be eligible for insurance.

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):

Describe any class of employees excluded from coverage:	Number of employees electing coverage:

Waiting Periods/Effective Date Provisions

Applies to:	☐ All employees including those hired before, on, or after the effective date				
(choose 1)	☐ Only those employees hired after the effective date				
Waiting period:	☐ 0* days	☐ 30 days	☐ 60 days	☐ 90 days	☐ Other (if greater than 90 days)
(choose 1)		☐ 1 month	☐ 2 months	☐ 3 months	

Effective Date/Termination Date Option for Non-Disability Coverage(s): (choose 1)

☐ On the first of the month coinciding with or next following Waiting Period/Termination at end of month

☐ On the day immediately following Waiting Period/Termination at midnight on last day worked

Effective Date/Termination Date Option for Disability Coverage: (choose 1)

☐ On the day immediately following Waiting Period/Termination at midnight on last day of your coverage

☐ On the first of the month coinciding with or next following Waiting Period/Termination at midnight on last day of your coverage

* 0 Day waiting period is not an option for groups with less than 50 enrolled employees

Employer Request for Benefits and Contribution

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

	Benefit for: Employee	Contribution % Employer	Contribution % Employee	Benefit for: Dependent	Contribution % Employer	Contribution % Employee
Basic term life	☐ Yes ☐ No	%	%	☐ Yes ☐ No	%	%
Supplemental term life	☐ Yes ☐ No	%	%	☐ Yes ☐ No	%	%
Voluntary term life	☐ Yes ☐ No	%	%	☐ Yes ☐ No	%	%
Basic accidental death and dismemberment	☐ Yes ☐ No	%	%	☐ Yes ☐ No	%	%
Supplemental accidental death and dismemberment	☐ Yes ☐ No	%	%	☐ Yes ☐ No	%	%
Voluntary 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:	

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 %	Employee %	Employer %	Employee %

Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing and for LTD provide a copy of the booklet-certificate):	Name and address of prior carrier:	
	Effective date:	Discontinue date:
Employees not actively at work:	List all employees who are not actively at work:	

Employer Request for Benefits and Contribution (continued)

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

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?

Dental Insurance

Request for ➢	Employees	Dependents
Contribution:	Employer % of premium contributed:	Employer % of premium contributed:
Do you offer other dental coverage?	☐ Yes ☐ No If yes, number of employees covered:	
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

PPO network(s) selected _____

Vision Insurance

Request for ➢	Employees		Dependents	
Contribution:	Employer %	Employee %	Employer %	Employee %
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:	

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. Nippon Life Benefits 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 Nippon Life Benefits 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 Nippon Life Benefits shall be governed solely by the provisions of its contracts and policies. Nippon Life Benefits 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. Nippon Life Benefits 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

- 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 Nippon Life Benefits.
- 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 long term disability insurance have been explained to and understood by the employer. Actively at work and period of limited activity has 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 Nippon Life Benefits 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 Nippon Life Benefits 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.

Agreement and Signatures (continued)

NOTE: If Nippon Life Benefits 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 presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Employer (company name):	Signed at (city, state)

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

Licensed resident agent(s) (individual/firm):	Agent's license number:	Date signed:

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, P.O. Box 25951, Shawnee Mission, KS 66225-5951, and keep a copy for your records.

For Nippon Life Benefits Use Only

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