

THE LAFAYETTE LIFE INSURANCE COMPANY

HOME OFFICE: 1905 Teal Road, P.O. Box 7007

Lafayette, Indiana 47903

Telephone (800) 443-8793 Facsimile (317) 477-3369

APPLICATION FOR GROUP INSURANCE

Terms used herein, which are defined in the Contract, shall have the meanings given to them in the Contract.

1. *Name, address and telephone number of Policyholder:*

2. *Name and address of subsidiaries and/or affiliates to be covered, or, in the case of a union Policyholder, name and address of all employers participating in a collective bargaining agreement with the union Policyholder:*

3. *Name, title and telephone number of contact person:*

4. *Nature of business and SIC Code:* _____

5. *Billing Mode:* Monthly Other - please attach additional information sheet

6A. *Desired Effective Date of Contract for insurance:* _____

6B. *Effective Date of Class or Earnings Changes:* Next Contract Anniversary
 First day of the month following the effective date with Employer
 Immediately
 Other - please attach additional information sheet

7. *Eligibility:*

Current Employees - First day of the month coincident with or next following completion of eligibility period
 Other - please attach additional information sheet
Future Employees - First day of the month coincident with or next following completion of eligibility period
 Other - please attach additional information sheet
Late Enrollees - First day of the month coincident with or next following approval of Evidence of Insurability
 Other - please attach additional information sheet

8. *Eligibility period:* 90 days of Active Employment
 Other: _____

9. *Active Employment requirement:* a minimum of _____ hours per week
Other - please attach additional information sheet

10. **EMPLOYEE BENEFITS:** (please attach additional information sheets as necessary)

Employee Term Life Insurance
Classes:

Contributory

Non-contributory
Amount:

Waiver of Premium (applies to Employee Term Life Insurance only)

12 month duration

Termination at age 65

Other - please attach additional information sheet

Continuation of Employee Life Insurance

Accelerated Benefits Rider (applies to Employee Term Life Insurance only)

Accidental Death & Dismemberment Insurance
Classes:

Contributory

Non-contributory
Amount:

Weekly Disability Income Insurance
Classes:

Contributory

Non-contributory

Benefit Period:

13 week benefit period

26 week benefit period

Other - please attach additional information sheet

Weekly Benefit:

1. Amount _____ % of Basic Weekly Earnings OR
 \$ _____ per week

2. Minimum Weekly Benefit: \$ _____

3. Maximum Weekly Benefit: \$ _____

Elimination Period:

Standard - 7 days for Sickness; 0 days for Injury or Hospital Confinement

Other - please attach additional information sheet

Replacement of Benefits:

Applied for

NOT Applied for

Waiver of Premium:

Applied for

NOT Applied for

17. The Policyholder hereby applies for the group insurance coverages indicated, subject to the elections noted above. Any supplement to this Application shall be considered part of this Application. The Policyholder, by signing this Application, understands and agrees that the mere completion of this Application, and any supplements, does not bind the Company to issue a Contract and that no insurance coverages for any person are created by this Application, or any supplements. No insurance shall be effective unless and until a Contract is issued by the Company, the premium for all coverages has been paid in full and received by the Company, and all terms and conditions for such coverages, as specified in the Contract, have been met. The Policyholder is fully aware of the dangers of canceling any existing insurance coverage before a Contract has been approved and issued by the Company.

The Policyholder understands and agrees that: (1) No insurance is extended to any person except in accordance with the strict terms of any Contract issued pursuant to this Application, and any supplements; (2) No statement made in the course of the negotiations for the Contract shall form a part of any Contract issued by the Company unless actually included, in writing, in the Contract; (3) The acceptance by the Company of any premium and/or the issuance by the Company of any Certificate shall in no case be deemed to be a waiver of any condition, limitation or exclusion in effect under the Contract and shall not create or otherwise extend coverage for any person who is not otherwise eligible for such coverage under the Contract; and (4) any Employee not in Active Employment, or in a class otherwise eligible to apply for insurance coverage on the Contract Effective Date of any Contract to be issued by the Company, **WILL NOT** be eligible to apply for any insurance issued by the Company unless and until such Employee becomes a member of a class eligible to apply for insurance coverage.

The Policyholder represents that its answers on this Application, and any supplements, are true, accurate and complete, and the Policyholder understands and agrees that this Application, and any supplements, shall be made part of any Contract which may be issued by the Company. The Policyholder acknowledges that it has read and fully reviewed, before signing, this Application and all supplements hereto.

The Policyholder agrees, if any premiums for the Contract are contributory, that it will, if a Contract is issued pursuant to this Application, and any supplements, make the appropriate deductions from each Certificateholder's paycheck and remit such premiums to the Company within the period specified in the Contract. Except where otherwise specified by law, the Policyholder shall, for all purposes, be deemed to be the agent of its Employees and all Insureds under any Contract issued by the Company and shall not be deemed to be an agent for the Company. The person whose name appears below certifies that he or she is fully authorized by the Policyholder to execute this Application, and any supplements, on the Policyholder's behalf.

Date: _____

By: _____
Signature of authorized Policyholder representative

Printed name and Title

18. **Agent's Statement:** Is the insurance being applied for replacing any insurance now in force? Yes No
I have fully explained to the Policyholder that any Employee not in Active Employment or in a class otherwise eligible to apply for insurance coverage on the Contract Effective Date of any Contract to be issued by the Company **will not** be eligible to apply for any insurance issued by the Company unless and until such Employee becomes a member of a class eligible to apply for insurance coverage. I have also fully explained to the Policyholder that this Application, and any supplements, creates no insurance and does not bind the Company to issue a Contract or otherwise extend any insurance. I have informed the Policyholder that it should not cancel any current insurance coverage before a Contract has been approved and issued by the Company.

I hereby certify that either the Policyholder fully completed this Application, and any supplements, on its own, or that I have truly and accurately recorded in this Application, and any supplements, the information supplied to me by the Policyholder.

Date: _____

By: _____
Signature of licensed agent

State of license and license number of agent

Printed name of licensed agent