APPLICATION FOR GROUP COVERAGE
Corporate Employer Plan

Proposed Effective Date: _____
(dd/mmm/yyyy)

Section 1: EMPLOYER INFORMATION

Employer Name: _____

Physical Address: _____

Street Address: _____ Country: _____ State/Province: _____

County/Region: _____ City: _____ Postal Code: _____

Mailing Address: ☐ Same As above ☐ Different from above (please provide in section 8).

Insurance Contact: _____

Name: _____ Email: _____ Fax: _____ Tel: _____

Position: _____ Preferred Method of Communication: ☐ email ☐ Phone

Section 2: BUSINESS INFORMATION

Nature of Business: _____

No. of Years in Operation: _____

Type of Business: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Non-Profit Organization

Membership: **Eligibility Criteria -** Definition of employees to be covered:

_____

Number of employees in this class: _____

Number of Employees:	**ELIGIBLE**	**ENROLLING**
Expatriates:	_____	_____
Local Nationals:	_____	_____

Employer contribution toward cost of coverage:

Employee:	☐ 100%	☐ Other: _____ %
Dependent:	☐ 100%	☐ Other: _____ %

Are all eligible **employees** required to enroll in the plan? ☐ Yes ☐ No – Please explain below

Are all eligible **dependents** required to enroll in the plan? ☐ Yes ☐ No – Please explain below

If No, Please explain:

To assure coordination between this plan and any other coverage currently offered, please provide the following for the expiring plan of benefits:

Carrier Name: _____ Anticipated Termination Date: _____ (dd/mmm/yyyy)

Type of Coverage:

Section 3: RISK EVALUATION

In order to evaluate an application properly, GBG requires the Employer to answer the questions below. This form should be filled out by the person responsible for operation of the current benefit plan. Please answer each question to the best of your knowledge with respect to all eligible employees and dependents that you intend to have covered under this plan.

1. All employees must be Actively-At-Work performing the duties of their occupation on the effective date of this plan.
   a) Are you aware of any employee that will not be Actively-At-Work on the effective of this plan? ☐ Yes ☐ No
   b) Are you aware of any employee that will be taking a Leave of Absence (medical or for other reasons) during the next 12 months? ☐ Yes ☐ No
2. Are you aware of any employee or dependent who is currently hospitalized or has hospitalization or surgery pending or that has been advised that hospitalization or surgery is needed? ☐ Yes ☐ No
3. Are you aware of any employee or dependent that has incurred claims in excess of $5,000 during the past 12 months, or will incur expenses of $5,000 or more in the next 12 months? ☐ Yes ☐ No

If you answered "Yes" to any of the questions above, please provide additional information below.

Please attach additional sheets if necessary:

Section 4: ELIGIBILITY / ENROLLMENT OPTIONS

Eligibility date for new employees: (Choose One):

☐ Date Actively at Work

☐ Waiting Period of: _____ days

Premium Proration Options (Choose One):

☐ **Option 1: Rule of 15/30**
An employee who becomes effective on or before the 15th of the month will be billed an entire month's premium. Nothing is billed for the first partial month for an employee who becomes effective on or after the 16th of the month. When an employee's coverage terminates on or before the 15th of the month, no premium is due; if coverage terminates on or after the 16th of the month, an entire month's premium is due.

☐ **Option 2: Daily Proration**
Billed only for actual days insured during the month.

Section 5: COVERAGE SELECTED

Medical	☐ Yes ☐ No	Life insurance	☐ Yes ☐ No	Long Term Disability	☐ Yes ☐ No
Travel	☐ Yes ☐ No	Personal Accident (AD&D)	☐ Yes ☐ No	Short Term Disability	☐ Yes ☐ No

Note: Please see attached proposal for benefit and rate details. Proposal Dated: _____ (dd/mmm/yyyy)

Good Neighbor Insurance
690 East Warner Road, Suite 117
Gilbert, Arizona 85296, USA
Phone: 480-813-9100 | Fax: 480-813-9930
Email: info@gninsurance.com
Website: https://www.gninsurance.com

Section 6: ADMINISTRATIVE INSTRUCTIONS

Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Note: An Administrative fee will be charged for all payment modes other than Annual

Premium Payment Currency: ☐ US$ ☐ Euro € ☐ GB£ ☐ CAD$ ☐ CNY ¥ ☐ Other: _____

Note: Premium payment and benefit payment will be in the same currency

Courier Instructions: Delivery of Policy Documents:
☐ To Physical Address ☐ To Mailing Address ☐ e-mail only: _____

Section 7: EMPLOYER STATEMENT

1. The employer herby applies for the coverage indicated and agree to all the following:
   (a) The employer warrants that all information on this application is true and complete and that GBG may rely on this application in deciding whether to provide coverage. If the application is not complete or if the information provided is inconsistent with any request or proposal submitted to GBG, GBG reserves the right to re-rate the premium associated with such coverage, or reject the application.
   (b) Any material misstatement or omission of information on this application or additional forms will be considered as misrepresentation and may be the basis of later termination of coverage.
   (c) Employer understands and agrees that no coverage will be effective until notified by GBG.
   (d) Premium rates quoted and benefits proposed may be adjusted based on actual enrollment.
   (e) Employer agrees that GBG may, for limited purpose of underwriting this application, contact its employees.
2. It is understood and agreed that no agent or broker of GBG has the authority to modify this application, waive the answer to any question, or bind GBG in any way by seeking any promise or representation.
3. **ACTIVELY AT WORK CERTIFICATION**: The Employer certifies that all employees listed as being eligible for membership under the group plan are fully capable of performing each and every duty of their occupation or on normal annual leave (excluding medical leave of absence) on the proposed effective date. In order to be eligible, all employees are required to be at work for a minimum of 20 hours per week.
   Unless Medically underwritten and accepted, no benefit shall be payable if a claim is directly or indirectly related to the medical condition or complications thereof for which the person to be insured was absent for work on the proposed commencement date of insurance or date of increase in benefit.
   For employees who are working on a part-time basis due to health reasons, any medical underwriting procedure deemed necessary by the underwriter will apply, and cover for each of these employees will need prior written approval from the underwriter.
   The continued accuracy of the data is the responsibility of the policyholder and the undersigned, as the authorized signature for the policyholder, is aware of this obligation, and hereby agrees to ensure that the accuracy of the At Work Declaration and the supplied personal data records is maintained.

Employer Signature: _____ **Date:** _____ (dd/mmm/yyyy)

Title: _____

Section 8: SPECIAL ARRANGEMENTS / IMPORTANT NOTES: