

Administrative Office: P.O. Box 30066, Tampa, FL 33630-3066
Street Address: 3501 Frontage Road, Tampa, FL 33607
Phone: 877-672-1648 Fax: 877-672-1651

In order to install the below named group we must receive the required paperwork. The applicable requirements are listed below.

Group Name: _____ Group Effective Date: _____
American General Sales Representative: _____
Master General Agent: _____ Producer: _____
Submitted By: _____ Phone/Email: _____
Date: _____

For all Employer-funded and Employee-Paid products the below data must be submitted.	
<input type="checkbox"/> Master Application ¹ – not applicable for Individual products. <input type="checkbox"/> Sold Quote – benefits and number of employees should match application and enrollment forms/census list. <input type="checkbox"/> Large Group Underwriting Exhibits and Assumptions, if applicable. <input type="checkbox"/> If replacing coverage, provide Current Prior Carrier Bill and Certificate/Booklet	
For Worksite products² the below data must be submitted.	
Pre-Enrollment – requirements must be submitted a minimum of 10 business days prior to the first scheduled date of enrollment.	Post-Enrollment – requirements must be submitted 10 business days prior to the requested effective date.
<input type="checkbox"/> Employers Agreement <input type="checkbox"/> Case Data Sheet <input type="checkbox"/> Census – Employer-funded only	<input type="checkbox"/> Individual Application for Insurance ¹ <input type="checkbox"/> Payroll Deduction Authorization <input type="checkbox"/> HIPPA authorization – applicable for all Individual products except Life and DI ² <input type="checkbox"/> Replacement forms – Individual products, if applicable
For Employer-funded products (excluding Worksite products²) the below data must be submitted 10 business days prior to the requested effective date.	
<input type="checkbox"/> Census <input type="checkbox"/> Employee Enrollment Form <input type="checkbox"/> Deposit check – should match quote or one month's premium <input type="checkbox"/> Excess Insurance Application ¹ – if applicable <input type="checkbox"/> Waiver forms <input type="checkbox"/> Quarterly Wage & Tax – required for employees age 70 and above, high family content or questionable eligibility	
For all Employer-funded and Employee-paid products the below data must be completed..	
W2 Election (applicable for STD & LTD only) If you need American General to provide W2's for your employee's, please complete form # 06233413-1005 in your administration kit and return it promptly to the address noted on the form. You will be receiving your administration kit shortly after the issuance of your policy.	
Please indicate the billing method: <input type="checkbox"/> Home Office <input type="checkbox"/> Self Billing (over 100 lives)	
Is an American General A&H policy being submitted in addition to this application? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For Employee-funded products (excluding Worksite) the below data must be submitted 10 days prior to the requested effective date.	
<input type="checkbox"/> Statement of Insurability for Group Programs ¹ <input type="checkbox"/> Excess Insurance Application ¹ - if applicable <input type="checkbox"/> Payroll Deduction Authorization form – to be submitted separately following completion of case set-up – if applicable <input type="checkbox"/> Quarterly Wage & Tax – required for employees age 70 and above, high family content or questionable eligibility	
Special Handling requests: _____	
Send Administration Kit to: <input type="checkbox"/> Policyholder <input type="checkbox"/> General Agent <input type="checkbox"/> Producer/Broker <input type="checkbox"/> Account Manager <input type="checkbox"/> Sales Rep Unless otherwise noted above, the Administration Kit will be sent directly to the Policyholder for groups less than 200 lives and to the Account Manager for Groups of 200 or more lives.	

1. The Master Application, Statement of Insurability forms and Group Worksite Employee Enrollment applications may be subject to state laws. For the complete listing of available forms please visit our online ordering system at www.smartworks.com

2. Universal Life, Level Term Life, Return of Premium Term Life, Critical Illness, Cancer, Accident, Hospital Indemnity and Disability Income

Send new case submissions to TSC Case Implementation Department at the address listed above.

MASTER APPLICATION FOR EMPLOYEE BENEFITS

AIG Life Insurance Company*

Wilmington, Delaware

Administrative Office: P.O. Box 30066, Tampa, FL 33630-3066

*This company does not solicit business in New York.

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust, or will be issued a group policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Applicant Data (A group proposal is required as part of this application)

1. Full Name of Applicant (Company): _____

2. Group Contact Name: _____

3. Street Address: _____

City: _____ State: _____ Zip: _____ Telephone: (____) _____

Mailing Address (if different) _____ Fax: (____) _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ SIC Code: _____

4. Applicant is a: Proprietorship Partnership Corporation Union

Other (Explain): _____

5. Nature of Business: _____

6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? Yes No
If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	Nature of Business	Full Address	# of Full-Time Employees
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7. Have you ever applied for, or been insured for, group insurance with any member company of AIG Inc., including United States Life? Yes No

If yes, give details: Group Policy Number(s) _____

Date Insurance Ended/Declined _____ Effective Date (if still insured) _____

8. Please complete the information below for those coverages being replaced:

Current Coverage Employer	Voluntary	Replacing with the Company's Plans?*	Prior Plan Name & Effective Date	Proposed Termination Date
Life** <input type="checkbox"/>	Life** <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Dental <input type="checkbox"/>	Dental <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Vision <input type="checkbox"/>	Vision <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
STD <input type="checkbox"/>	STD <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
LTD <input type="checkbox"/>	LTD <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).

** Are there other Group Life Insurance plans in force which you are not replacing or currently applying for with another carrier? Yes No If yes, please indicate the highest benefit amount of each plan.

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only

Group Number: _____

Division Number: _____

Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least * 30 hours (20 hours for Voluntary Life only) per week, or _____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

9. Do you want to exclude any classes of full-time employees from coverage? Yes No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** _____
 _____ Total # of excluded employees _____

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees _____ months OR First of the month following _____ months*
 Future Employees _____ months OR First of the month following _____ months*

*Only option available for Voluntary Coverages. Available on Group coverages with the 1st of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued) _____
 b. Number of Full-Time Employees **waiving all coverages** _____
12. Do you employ 20 or more employees? (Include part-time, union, etc.) Yes No

Contribution Data – Not applicable to Voluntary Coverages

13. Will the employees be required to contribute toward the cost of the insurance? Yes No
 If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.

Coverage	LifelAD&D	Dep Life	EE Dental*	Dep Dental*	EE Vision*	Dep Vision*	STD	LTD
Employer %								

*The employer must contribute a minimum of 35% of the total dental and vision premiums.

14. Premiums will be paid: Annually Semi-annually Quarterly Monthly EFT

Employee/Dependent Data

15. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? Yes No

If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **NOTE: This question does not need to be answered for Life and AD&D groups with more than 50 employees insured, Dental coverages, for Disability coverages with ten (10) or more employees insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.**

Name of Employee	Date Disability Began	Current Amount of Group Life Insurance In Force	Describe Nature of Injury/Sickness	Date Return To Full-Time Work

Requested Effective Date

I request that the coverage(s) chosen take effect on:

the date the application is approved in writing by the Company; or

_____ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For Voluntary Plans, the effective date must be the first of the month.

Applicant's Declaration

- I verify that all employees applying for coverage listed on the census form are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all employees meet the eligibility requirements as listed on the application.
- I verify that the Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s). Note: Changes in the Census data may affect previously quoted rates.
- To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
- The agent(s) appointed for this application is (are): _____.
- I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund.
A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.
- I understand and agree that:
 - no agent may change or waive any of the provisions of this application or of any plan of insurance;
 - any change or waiver may be made only by an officer of the Company; and
 - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
 - If the insurance contract compromises a part of an employee benefit plan, the Company is granted **sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
- It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.

DATE _____ PRINT NAME OF OFFICER, PARTNER, PROPRIETOR _____

WITNESS _____ SIGNATURE OF OFFICER, PARTNER, OR PROPRIETOR _____

* Amount of hours may vary by state law

** May not be applicable in all states, and may vary by state law.

The Policyholder/Participant Employer hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.

Producing Agent's Declaration

Please Print

PRODUCING AGENT

Producer #	Tax ID # / SS #	% Commissions split with other agents
Name As Licensed		License #
Mailing Address		
City/State/Zip		
Phone	Fax	E-Mail
Signature	Date	City and State Where Signed

Please Print

GENERAL AGENT

General Agent #	Name	Tax ID # / SS #
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	Premium Deposit \$	Underwriter
Mode	Coverages	
Group Contact	Producer	GA

AIG Life Insurance Company*

Wilmington, Delaware

Administrative Office: Client Services 3-A, 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583

Phone: 1-800-346-7692 Fax: 1-732-922-7604

*This company does not solicit business in New York.

Completing Your GROUP ENROLLMENT FORM
1. Fully complete each section
2. Sign and date Refusal/Authorization Section, as needed.
Group Policy No.(s)
NEW ENROLLMENT
CHANGE IN ENROLLMENT

1. PERSONAL DATA: (Must always be completed)

Division No. Class Social Security No. Last Name First Name Initial
Sex Male Female Date of Birth MM DD YY Street Address City State Zip Code
Name of Employer Location Salary \$ Per
Occupation Title Date of Full-Time Employment MM DD YY No. Hours Worked Per Week Union NonUnion
Marital Status Single Married Widowed Divorced Dependent Children No Yes If Yes, #

2. ENROLLMENT

If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured.
PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.
Name Relationship Self Sp. Ch. Date of Birth MM/DD/YY Sex
SELF X
Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured.
Indicate your effective and termination dates of coverage also.

3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate

Life Amount for: Employee \$ Spouse \$ Dependent \$

4. Supplemental AD&D Benefit: If this benefit is a plan option and you wish to enroll for Supplemental AD&D coverage, please indicate

AD&D Amount for: Employee \$

5. Beneficiary Designation: as is

EX: MARY A. JONES, WIFE First Name Initial Last Name Relationship
NOT MRS. JOHN JONES

6. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)

I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by AIG Life Insurance Company.
I am refusing: LTD Dental: Vision:
STD Employee & Dependents Employee & Dependents
Life/AD&D Spouse Spouse
Dependent Life Child(ren) Child(ren)
All coverages offered All Dependents All Dependents

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:
Are you or your dependents now covered by any other group plan? YES NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)

If Yes: Policyholder's Name Carrier

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.
I must furnish, at my expense, evidence of insurability satisfactory to AIG Life Insurance Company if I later wish to enroll in any other coverage that is now being refused.

DATE OF REFUSAL SIGNATURE IF REFUSING ANY COVERAGE
*IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.

7. AUTHORIZATION:

- I hereby certify that all information furnished is true to the best of my knowledge.
I request group insurance for which I am or may become eligible.
If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to AIG Life Insurance Company.
I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.
If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by AIG Life Insurance Company.
I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to AIG Life Insurance Company information about me. Such information will pertain to my employment or other insurance coverage.

DATE SIGNED APPLICANT'S SIGNATURE