

Application for Authority to Purchase Discretionary Group Life Insurance

Please print or copy this form onto two separate sheets. Please do not duplex (two side) print. Complete each item. If an item is not applicable, enter N/A. Extra space is provided on page 2 to continue answers beyond the space provided. Applicants may also attach additional sheets if necessary.

Name of group applying for authority

Address of group

Contact person name

Contact person phone

Group's Tax ID number (FEIN)

Contact person EMail address

Name of insurance company underwriting the policy

NAIC Company Number

List the requirements for admission to the group

Describe the active purposes of the group (as defined by constitution, by-laws, trust agreement)

Describe any group life insurance in force on the whole or any part of this group presently, or within the past 3 years

Please list below or attach a complete schedule showing different levels of benefits to be paid and the classifications of members who will receive each level of benefits:

What is the date of organization of the group?

MM / DD / YY

Current number of members in the group:

Number of members not eligible for group life insurance _____

Explain why these members would not be eligible:

Eligible members expected to participate in group life insurance (as a percentage) _____ %

Explain rationale used to estimate participation:

What type of group policy will be written?

- Term Life Whole Life
 Universal Life Annuity
 Other: *explain*

What is the maximum amount of insurance per member pursuant to MCLA 500.4424(6)?

Who will be designated as the policyholder?

- Group Trust Other: *explain*

Who will pay the premiums?

- Individual Group Both

Who will name the beneficiaries under the policy?

- Insured members Other: *explain*

Applicant may use this area as a continuation for page 1 answers if needed, or include any additional information you would like to present to help us with our review of this application.

If applicant group has a constitution and by-laws, attach one certified copy of each. Application should be executed by the President or Secretary.

If applicant group is applying through a Trustee, attach a certification of authority of Trustee, and a copy of the trust agreement. Application should be executed by the Trustee.

Certification

I certify that to the best of my knowledge and belief, this application is true, complete and correct.

Signature of Authorized Representative	Date signed	Authorized Representative email address
Authorized Representative name and title (<i>typed or printed</i>)		Authorized Representative phone number



Michigan Department of Labor & Economic Growth

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Send completed filing with payment stub below and \$100.00 payment to:

OFIR - Health Plans
 PO Box 30220
 Lansing MI 48909-7720

Please cut on dashed line. Paperclip payment to this card. Return application, payment card and payment.

Thank you! This helps us process your application faster.

Payment Card for form FIS 0810

Name of Group (*enter name shown on page 1, even if payment is being made by another party*)

Group's Tax ID number (FEIN)

100.00 72 91 19 10

Please make check or money order payable in US dollars to:
State of Michigan-OFIR
 Amount due is \$100.00
 Please return this card with your payment.

Please do not write below or on back of this stub.