



EMPLOYER ENROLLMENT FOR GROUP COVERAGE

(Please type or print in ink - May be photocopied or duplicated)

AIG AMERICAN GENERAL

POLICY ISSUED BY THE UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK
A SUBSIDIARY OF AMERICAN INTERNATIONAL GROUP, INC. (AIG) NEW YORK, NEW YORK

FIRM NAME PHONE ()
ADDRESS FAX ()
CITY STATE ZIP
E-MAIL ADDRESS

1. I hereby apply to participate in the following Allied™ Plan(s) (check all that apply):

- Dental, Takeover, Orthodontia, Enhanced Benefits, Life/AD&D, STD, LTD
Prior carrier name, Effective date
Attach a copy of proposal for each desired benefit plan to describe the purchased benefits

- 2. Minimum contribution of 25% of all employee costs. Employer contribution is % STD, % LTD, % Life, % Dental
3. Type of Business Organization: Sole Proprietorship, Partnership, Corporation, LLC, Not-For-Profit, Other
4. Exact Nature of Employer's Business
5. Date company first began operating SIC Code (often found on work comp policy)
6. Name of individual employee at business handling insurance details
7. Subsidiary or Affiliated Companies - (The employees of the following subsidiary or affiliated companies also request participation):

8. An employee must work at least 30 hours per week (less than 30 hours must comply with state law and requires approval) to be considered full time. I hereby certify that there are, as of this date, a total of () full-time (working 30 hours or more per week) eligible employees (including owner(s), partners and officers in the employment of this firm). If any class or classes are to be excluded from eligibility describe them briefly. (Such class exclusions must be non-discriminatory.)

9. I understand and agree that only those full-time employees who meet the eligibility requirements are to be included and that participation must be met before the insurance can be made effective. Participation, as outlined in the brochure under the heading "Participation Requirements" including a minimum of two insured employees, must be maintained continuously while insurance is in force to prevent cancellation of coverage. The undersigned employer understands that if participation falls below minimum requirements for three consecutive months, coverage will be automatically terminated at the end of the third month without further notice.

10. I understand and agree that the following benefit waiting period will apply to all employees of this firm
A. All full-time employees actively at work on or before the case effective date are eligible on completion of:
B. All new employees (actively at work after the case effective date) shall become eligible on the first day of the month coinciding with or next following the completion of:

11. I understand and agree that investigation(s) will be made by Allied, now and in the future, to verify the number and names of full-time employees of this firm and I will furnish with this application, and upon any future request, a current census and State Quarterly Unemployment Tax Report, and any other information requested.

12. DESIRED EFFECTIVE DATE: Month Day Year May be any day of the month. All papers must be signed and dated on or before the requested effective date and be received by the Administrator within 5 working days (including the effective date) after that date in complete and acceptable form. No insurance is effective until approved in writing by Allied.

13. I verify that all employees enrolling for coverage are actively at work, working full time and meet the eligibility requirements as listed on the employer enrollment form.

I verify that The United States Life Insurance Company in the City of New York's benefit plan(s) have been offered to all employees. Completed waivers or declination of coverage 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.

I understand any existing plans being replaced by this coverage should not be terminated until written notice of acceptance has been received. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.

I understand and agree that: no agent may change or waive any of the provisions of this application or any plan of insurance; any change or waiver may be made only by the administrator; this application will be accepted or declined partly on the basis of the statements and answers given on this enrollment form; if the insurance contract comprises a part of an employee benefit plan, The United States Life Insurance Company is granted sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The United States Life Insurance Company in the City of New York has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.

I understand that this enrollment form requests our participation in a Multiple Employer Trust. I agree to be bound by the terms of the trust agreement, a copy of which will be furnished to me upon my request.

I request membership in Allied Employers Association and appoint its president to cast votes on all matters as my proxy.

Signature Title Date

(Must be signed in ink by Firm Owner, Partner or Officer)



ADMINISTRATORS USE ONLY
CASE # _____

MAIL TO:
NEW CASE UNDERWRITING
ALLIED NATIONAL
P. O. BOX 29187
SHAWNEE MISSION, KS 66201-9187

1-800-825-7531

OVERWRITE NAME (your Allied General Agent) _____
OVERWRITE ALLIED ID # _____ AIG AMERICAN GENERAL GA # _____

PRODUCER'S INFORMATION

Please Print or Type Legibly:

Allied Agent # _____ AIG American General Producer # if known _____

Producer's Name _____

Agency or Company _____

Address _____

City _____ State _____ ZIP _____

TEL () _____ FAX () _____

E-Mail Address _____

Pay Commissions To Agent _____ Agency _____

Check here, if currently receiving commission and wish no change to be made.

SSN OR TAX ID # _____

I certify that all of the information contained in **the Employer Enrollment** is correct to the best of my knowledge. I have complied with the underwriting rules and have explained in detail the coverage to the employer and its employees (copies of all proposals for all desired benefit plans are attached).

In the event of cancellation of insurance coverage for which I am an agent, I hereby agree to reimburse Allied National for any and all unearned Commissions on such cancelled insurance.

Date Completed _____ Signature of Producer _____

GROUP SUBMISSION REQUIREMENTS

The following information must be submitted with each group enrollment:

- Employer Enrollment Form—Signed in ink by Broker and Employer
- Employee Enrollment Forms
- Initial Premium Check for First Month made payable to Allied National (preprinted business check)
- Completed Rating Worksheet **or** Final Proposal (with sold rates and benefits)
- State Quarterly Tax and Wage Statement (for groups with 10 eligible employees or fewer)*
- Copy of Prior Carrier Certificate or Booklet when requesting takeover benefits
- Copy of Current Bill and Bill from 12 months prior to requested effective date for groups requesting takeover benefits

*Allied needs to see salary documentation for life and disability benefits based on salary.