

Home Office Use Only Policy Number:	
<b>Proposed Policyholder Information (Type or Print):</b>	
Full legal name of proposed Policyholder:	Telephone: (     )
Principal Office (Street, City, State, ZIP):	Taxpayer Identification Number (TIN):
Mailing Address (if different than Principal Office):	Situs State:
Contact Name:	Contact Title:
Contact Telephone: (     )	Contact Email:
Nature of Business (including SIC Code):	
If employees of subsidiary or affiliated companies (companies under common control through stock ownership, contract or otherwise) are to be included, list legal names and addresses of such companies and the nature of their businesses. (Attach additional sheet if necessary.)	
Advance Premium (This will be refunded if the Policy is not approved):	Requested Effective Date (subject to Company approval and receipt of the required accompanying documents):
Type of Billing: <input type="checkbox"/> Self-Billed <input type="checkbox"/> List-Billed    Premium Mode: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	
As of the date of this Application, list any [employees] currently disabled and not actively at work: _____ _____	

W-2 Services Option

- Option 1: Withhold state and federal income taxes, and the employee's portion of FICA. Prepare and file W-2 Forms.
- Option 2: Withhold federal income taxes, and the employee's portion of FICA. Applicant waives W-2 Forms services.

A detailed description of the W-2 services elected by applicant pursuant to this Application will be sent to the applicant via mail. Such services will be performed in accordance with the above election and established as standard procedures.



[ ]

Pre-existing Take-Over	<input type="checkbox"/> No Loss No Gain <input type="checkbox"/> No Loss Your Gain <input type="checkbox"/> Not Applicable	
Does this Policy replace existing Group Long Term Disability Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of current carrier: _____
Special Remarks		

### Short Term Disability

<b>Short Term Disability Coverage Requested:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Employee Contribution Percentage</b> _____%
Number of Eligible Active Employees:	Number of Enrolled Active Employees:
<b>Eligibility:</b>	
Definition Eligible Employee (by Class): Class I _____ Class II _____ Class III _____	Actively at Work Definition: Class I: _____ hours per week Class II: _____ hours per week Class III: _____ hours per week
Waiting Period, Current Employees: Class I Employees: Eligible on date of employment Class II Employees: Eligible after active employment for _____ days Class III Employees: Eligible after active employment for _____ days	
Waiting Period, Rehired Employees: Class I Employees: Eligible on date of employment Class II Employees: Eligible after active employment for _____ days Class III Employees: Eligible after active employment for _____ days	
Effective Dates for Changes in Amounts of Coverage: Increases/decreases due to change in Class will be effective on the first day of the month following the date of change Increases/decreases requested by Employee will be effective on the first day of the month following date requested Increases (with Evidence of Insurability) requested by Employee will be effective on the first day of the month following approval date	

<b>Short Term Disability Plan Provisions</b>	Provision Option
Benefit Percentage	_____ %
Weekly Maximum	\$ _____
Minimum Benefit	<input type="checkbox"/> None <input type="checkbox"/> Other
Accident Benefits Begin Day	
Sickness Benefits Begin Day	
Benefit Duration in Weeks	
First Day Hospital	<input type="checkbox"/> Not Included <input type="checkbox"/> Included
Earnings Definition	<input type="checkbox"/> Base Salary <input type="checkbox"/> Average _____ Months Bonus <input type="checkbox"/> Average _____ Months Commission <input type="checkbox"/> Other
Pre-existing Condition Limitation	<input type="checkbox"/> None <input type="checkbox"/> 3/3/12
Pre-existing Take-Over	<input type="checkbox"/> No Loss No Gain <input type="checkbox"/> No Loss Your Gain <input type="checkbox"/> Not Applicable
Does this Policy replace existing Group Short Term Disability Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, name of current carrier: _____
Special Remarks	



**Important Information, Representations and Understandings:**

Application is hereby made to Kanawha Insurance Company on the basis of the information contained in this Application, the group risk specifications, the enrollment data, and available experience data. The Application in its entirety, and any required additional information, is subject to Home Office approval before insurance can become effective.

If this Application is approved by the Company, it will be attached to and made part of the Group Policy(ies). Insurance will become effective on the requested effective date, unless the Company sends a written notice of a different effective date.

If this Application is not approved by the Company, no insurance is in effect at any time, and any deposit premium the Company has received will be returned.

If any insurance requires employee contributions, any underwriting requirements for enrollment must be met before insurance can become effective.

For the purpose of the Employee Retirement Income Security Act of 1974 (ERISA), the Policyholder, and not Kanawha Insurance Company or any of its affiliates, is the Plan Sponsor, Plan Administrator and Named Fiduciary. Kanawha Insurance Company does not have nor does it assume, either expressly or impliedly, any responsibility for the Policyholder's obligations or compliance under ERISA, COBRA or any other applicable federal or state law, regulation or rule.

**Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.**

**I REPRESENT**, on behalf of the Applicant, that the statements in this Application, and the attached Disclosure Statement, and other information provided to the Company for the purpose of underwriting the Policy, are complete and true to the best of my knowledge and belief. All statements will be deemed representations and not warranties, and no such statement shall be used to contest the validity of the Policy or of a claim unless it is contained in this Application.

**I UNDERSTAND THAT** the Policy will not become effective on the Date of Policy, but only when: 1) approved and issued by the Company; and 2) the first premium is paid.

Dated at \_\_\_\_\_ State of \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_  
Authorized Representative of Applicant Please Print

\_\_\_\_\_  
Printed Name of Authorized Representative of Applicant

Signature, Licensed Insurance Producer:  
  
\_\_\_\_\_  
Date \_\_\_\_\_  
Producer must be appropriately licensed and appointed by Kanawha Insurance Company.

Producer Lic. No. & State \_\_\_\_\_  
  
Telephone (\_\_\_\_) \_\_\_\_\_  
  
E-Mail \_\_\_\_\_