

GROUP LONG TERM DISABILITY INSURANCE POLICY MASTER APPLICATION

POLICY NUMBER _____ EFFECTIVE DATE: 12:01 AM EST, _____

*All statements are true and correct to the best of the Applicant's knowledge and belief.
This application becomes part of the policy*

1. Employer (Policyholder/Insured): _____

2. Business Address: _____

Suite or Floor No.: _____

City/State/ZIP: _____

Telephone Number: (____) _____ - _____ Contact Person: _____

3. Mailing Address, if different: _____

Suite or Floor No.: _____

City/State/ZIP: _____

4. Nature of business (SIC Code): _____

5. Covered subsidiaries or affiliated companies, if their employees will be covered:

Name	Address	SIC Code, if different
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Full-time employees (must work at least 30 hours per week on a permanent, full-time basis at a location set by the employer/policyholder): _____

7. All employees are covered: Yes No
Eligible employees: _____ Enrolled employees: _____

Class(es) of eligible employees (describe): _____

8. Service Waiting Period
Current Employees: _____ New Employees: _____

9. Employer is currently:
 Insured for LTD (Provide a copy of prior insurer's plan for claims administration purposes.)
Name of prior carrier, if applicable _____ Termination date: _____
Reason for termination: _____

New business, not previously insured Self-insured

10. Employer has (has not) had coverage with First Rehab Life. Type of coverage: _____

11. Benefit Qualifying Period:
 30 days 90 days 150 days 365 days
 60 days 120 days 180 days

12. Benefit Percentage:
 50% 60% 66%
 70% 75% 80%

13. Total Disability for Own Occupation

- 24 Months
- 36 Months

- 60 Months
- Continuous

14. Partial Disability

- Requires total disability for duration of Benefit Qualifying Period
- Does NOT require total disability for duration of Benefit Qualifying Period

15. Optional Coverages:

Mental Illness and Substance Abuse

- 12 months
- 24 months

Unlimited

Cost of Living Adjustment

Workplace Modification Benefit

16. Social Security Integration

- Employee
- Employee and Family

17. Maximum Benefit Period:

- Reducing SSNRA Schedule
- 65/5/70

- 5 year Reducing Benefit Duration
- To 65 with Reducing Benefit Duration

18. Minimum Monthly Benefit:

- greater of \$100 or 10% of gross disability payment
- greater of \$50 or 10% of gross disability payment
- \$50
- \$100

19. Maximum Monthly Benefit: _____

20. Rates per employee per month: _____

- Contributory
- Non-Contributory

_____ % of premium employer contributes.
 (Employer must contribute at least 50% of premium.)
 (At least 75% participation must be maintained for contributory programs.)

21. Premium is paid monthly on the first day of each calendar month.

One month's deposit premium of \$ _____ must accompany this application.

No one except the President, a Vice President or the Secretary of THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA may make or modify any contract on behalf of THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA. No waiver is valid unless it is in writing and signed by one of these officers.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Dated _____ Signature of Employer _____
 Name (Print) _____
 Title _____

Dated _____ Signature of Agent _____
 Producer Number _____ Company Name (Print) _____
 Agent's Address _____
