Data Gathering Sheet

for

Group Submission Form

This “data gathering sheet” for worksite groups is a form that should **NOT** be submitted to LifeSecure. This form is to ensure that all products and riders LifeSecure offers is reviewed with the Employer. Information gathered on this form is submitted online at YourLifeSecure.com.

Please note some of the information gathered on this sheet does not reflect on the Group Submission Form in the agent portal and can be referenced in the notes section.

For Agent Use Only.

Group Submission Form

AGENT AND EMPLOYER INFORMATION

Writing Agent ID: _____

Worksite ◯

Association ◯

Enrollment Start Date: _____

Enrollment End Date: _____

States where applications will be taken: _____

_____

Employer/Association Full Legal Name: _____

Address: _____

Suite/Bldg./Floor: _____

State: _____ Zip Code: _____

Tax ID: _____

Type of Industry: _____

Total Number W-2 Employees/Members: _____

Total Number of Eligible Employees – *those offered LifeSecure product(s):* _____

Total Number of Eligible Spouses – *ONLY if Employer Contribution to Spousal premium:* _____

NOTE: If subsidiaries will be participating, the above fields are also required for each subsidiary.

Primary Employer Contact Name: _____

Phone Number: _____

Email Address: _____

lifesecure™

Group Submission Form

Product Selections

PERSONAL ACCIDENT INSURANCE 3.0 WITH ACCIDENTAL DEATH BENEFIT
PLEASE REFER TO THE PRODUCT AVAILABILITY CHART

Voluntary ◯

Employer Contribution ◯

If Employer Contribution:

Defined Plan Design: _____

- *Minimum=$2,500*
- *Maximum=$15,000 for Individuals or $25,000 for couples/families (**In MI:** $25,000 for individuals, $50,000 for couples/families)*
- *Must be in $100 increments.*
- *This product is Guaranteed Issue*

Defined Dollar Amount of Premium per month: $_____

Annual Deductible Amount: $0 ◯ $500* ◯

* ***In ID & PA,*** *the $500 deductible amount is not available*

Group Submission Form

HOSPITAL RECOVERY 3.0 WITH OBSERVATION COVERAGE
PLEASE REFER TO THE PRODUCT AVAILABILITY CHART

Voluntary ◯

Employer Contribution ◯

If Employer Contribution:

Defined Plan Design: _____

- *Minimum=$200 (no medical questions or build chart - Guaranteed Issue Underwriting)*
- *Or, choose an amount between $210 and $900, in $10 increments, with Simplified Underwriting*

Defined Dollar Amount of Premium per month $_____

Optional Riders for Hospital Recovery 3.0 *(not available in CO and KS)*

◯ Emergency Room & Ambulance Rider:

- Emergency Room visit (one per calendar year): $300 Benefit Payout*
- Ambulance Services (one per calendar year): $150 Benefit Payout*
  - Ground transportation: $150 Benefit Payout*
  - Air transportation: $500 Benefit Payout*

◯ Major Diagnostic Exam Rider**:

- $500 Benefit Payout* for a major diagnostic exam (one per calendar year)
  - Computerize Tomography (CT); or
  - Magnetic Resonance Imaging (MRI); or
  - Electroencephalogram (EEG)

◯ Rehabilitation Facility Rider:

- $100 Benefit Payout* for each day in a rehabilitation facility, immediately following a qualified hospital stay (up to 15 days per calendar year)

** Available per covered family member*
*** Not available in Connecticut*

Group Submission Form

HOSPITAL INDEMNITY 4.0

PLEASE REFER TO THE PRODUCT AVAILABILITY CHART

Voluntary ◯

Employer Contribution ◯

If Employer Contribution:

Defined Plan Design: _____

- *$200 or $300 (no medical questions or build chart – Guaranteed Issue Underwriting)*
- *Or choose an amount between $310 and $900, in $10 increments, with Simplified Underwriting*
- *Hospital Confinement choose 3, 6, 10, or 21 days. (Please circle one).*

Defined Dollar Amount of Premium per month $_____

Optional Riders for Hospital Indemnity 4.0

◯ Outpatient Major Diagnostic Exam Benefit Rider
- $500 per Covered Person / payable 1 time per calendar year (outpatient only)

◯ SNF / Rehabilitation Facility Benefit Rider (Days 1-20)
- $100 or $200 per day for Days 1-20 with Benefit Refresh

◯ SNF / Rehabilitation Facility Benefit Rider (Days 21-100)
- $100 or $200 per day for Days 21-100 with Benefit Refresh

◯ Emergency Room and Ambulance Benefit Rider:
- Emergency Room Benefit: $150 / two days per calendar year
- Ground Ambulance: $150 / one day per calendar year
- Air Ambulance: $500 / one day per calendar year

◯ Lump Sum Admission Rider
- $500 or $1,000 upon admission once per calendar year

◯ Outpatient Surgery Rider
- $500 or $1,000 one day per calendar year

Group Submission Form

CRITICAL ILLNESS

PLEASE REFER TO THE PRODUCT AVAILABILITY CHART

Voluntary ◯

Employer Contribution ◯

If Employer Contribution:

Defined Plan Design: _____

- *$10,000 (no medical questions or build chart – Guaranteed Issue Underwriting)*
- *$15,000 and $20,000 Benefit Amounts may be available with Simplified Underwriting.*

Defined Dollar Amount of Premium per month $_____

Group Submission Form

LONG TERM CARE INSURANCE - WORKSITE

PLEASE REFER TO THE PRODUCT AVAILABILITY CHART

Voluntary ◯

Employer Contribution ◯

If Employer Contribution:

Defined Plan Design: _____

- *$50,000 Benefit Bank*: $1,000 Monthly Benefit or $300 Cash Alternative*
- *$100,000 Benefit Bank: $2,000 Monthly Benefit or $600 Cash Alternative*
- *$200,000 Benefit Bank: $4,000 Monthly Benefit or $1,200 Cash Alternative*
- *$300,000 Benefit Bank: $6,000 Monthly Benefit or $1,800 Cash Alternative*

** In WI: The $50,000 Benefit Bank is not available*

Defined Dollar Amount of Premium per month $_____

(Minimum $25/month Per Employee or a Defined Plan Design is required for Groups 10-99)

Optional Riders for Long Term Care

Compound Inflation Benefit Riders:

◯ 1% Compound Inflation Benefit Rider

◯ 3% Compound Inflation Benefit Rider

◯ 5% Compound Inflation Benefit Rider

Nonforfeiture Benefit Rider:

◯ Yes

◯ No

Group Submission Form

BILLING

List Bill ◯

Individual Direct Billing (EFT or Credit Card) ◯

If List Bill, additional information is required.

Billing Options

Billing Option Type:

☑ List Bill/Payroll Deduction

During Enrollment Period:

◯ Common Effective Date for all initial enrollees

◯ Rolling Effective Dates as Applications issued*

*Issued by the 15th = effective the 1st of the upcoming month. Issued after the 15th = effective the 1st of the month that follows the upcoming month. For example, issued on June 16th = August 1st effective date.

Common Effective Date:

List Bill Administrator

First Name:

Last Name:

Phone:

Email Address:

Verify Email Address:

☐ List Bill Administrator company and address is the same as Employer.

Company Name:

Street Address:

Suite/Bldg/Floor:

City:

State:

Zip Code:

Group Submission Form

Writing Agent(s) Information:

LifeSecure ID #_____ Name of Main Agent_____

If Multiple Agents:

LifeSecure ID #_____ Name:_____ % Split_____

LifeSecure ID #_____ Name:_____ % Split_____

LifeSecure ID #_____ Name:_____ % Split_____

LifeSecure ID #_____ Name:_____ % Split_____

LifeSecure ID #_____ Name:_____ % Split_____