



Nippon Life Insurance Company of  
America  
PO Box 25951  
Shawnee Mission, KS 66225-5951

**Employer Application for Large  
Group Insurance - CA**

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

This form is for:      new case      amendment      Group number: \_\_\_\_\_

Requested effective date: \_\_\_\_\_ Advanced premium received \$ \_\_\_\_\_

Instructions for completing this agreement:

- 1) The employer or employer representative and agent must sign and date this agreement.
- 2) A signed copy of the proposal/quote must accompany this submission.
- 3) The first month's premium made payable to Nippon Life Insurance Company of America must accompany this submission.

**Employer Information**

Legal name of company (include dba) \_\_\_\_\_

_____			Federal tax ID number
_____ corporation	_____ partnership	_____ sole proprietorship	_____ other
Street address		Billing address	
City	State	ZIP code	
Contact	Telephone number	FAX number	
E-mail address	Nature of business/SIC code	Number of years in business	

Have you been insured by Nippon Life Insurance Company of America (Nippon Life Benefits) previously?      yes      no

If yes, when and under what name? \_\_\_\_\_

Has the company been denied credit within the past two years, ever filed for bankruptcy, or is the firm now in the process of (or considering) filing for bankruptcy?      yes      no (attach an explanation)

**Employers with Participating Units**

If employees of any associated business organizations (e.g. parent-subsidary, brother-sister relationships, affiliated groups, etc.) are to be covered, please list the affiliate or subsidiary below.

Participating unit is an entity that is an affiliate or subsidiary related to the employer through common control or ownership.

Unit name/address/federal tax ID	Nature of business	Relationship to company	include unit exclude unit	Number of employees
1.				
2.				

**Excluded Locations**

Address(es) of other employer location(s) which are excluded from this policy. \_\_\_\_\_

Number of employees \_\_\_\_\_

**Employee Eligibility**

**Eligible Employee**

an employee working at least 30 hours per week.

other \_\_\_\_\_ (if agreed to by the home office of Nippon Life Benefits)

**Ineligible Employee**

an independent contractor (unless required by law)

an employee who works less than \_\_\_\_\_ hours per week

a temporary or seasonal employee

other \_\_\_\_\_ (if agreed to by the home office of Nippon Life Benefits)

**Employee Eligibility (continued)**

Total number of employees (full and part-time):

Total number of eligible employees (full and part-time):

Describe any class of employees excluded from coverage.

Number of employees

**TEFRA**

**TEFRA** eligibility is defined as employers who employed 20 or more full or part-time employees for 20 or more calendar weeks in the current or preceding year. If this requirement is met, the group is TEFRA eligible and Nippon Life Benefits will pay primary to Medicare.

Do you meet the eligibility definitions?                      yes                      no

**Employer Group Size for Medical (this information is in reference to Medicare status)**

Companies that are affiliated or file a combined tax return must be considered one employer. Count the employees of all affiliated companies and units (including those located abroad) when answering the following questions.

#1. Did you have 20 or more (full-time, part-time, seasonal, or partners) total employees for each working day in each of 20 or more calendar weeks in the current or preceding year?

yes                      no                      If yes, you must also answer question #2. If no, skip question #2.

#2. Did you have 100 or more (full-time, part-time, seasonal, or partners) total employees on 50 percent or more of your business days during the previous calendar year?                      yes                      no

If 20 or 100 employees is reached mid-year, as of what date did you have 20 or 100 employees for the number of weeks required in the definition above? \_\_\_\_\_

**Important Note:** In the absence of employer-provided information, we may be required to administer your group health plan to pay Medicare claims as primary payer rather than as secondary payer. This may impact the amount of claims paid under the plan, increasing the amount of claim benefits, and have a related effect on future premium increases for your health insurance coverage.

**Waiting Period/Effective Date Provisions**

Applies to:	only employees hired after the effective date		
	all employees, including those hired before, on, or after the effective date		
Waiting period:	30 days	60 days	90 days (only available with option 1)
	1 month	2 months	Other _____
Employees will be eligible on the:	Option 1: day immediately following the final day of the waiting period or change date		
	Option 2: first of the insurance month coinciding with or next following the final day of the waiting period or change date		
	In no event will the waiting period exceed 90 days		

**Employer Request for Benefits and Contribution****Term Life Insurance** (Proof of good health may be required before insurance can become effective.)

	Benefit for:		Contribution %		Benefit for:		Contribution %	
	employee		employer	employee	dependent		employer	employee
basic term life	yes	no	%	%	yes	no	%	%
supplemental term life	yes	no	%	%	yes	no	%	%
basic accidental death and dismemberment	yes	no	%	%	yes	no	%	%
supplemental accidental death and dismemberment	yes	no	%	%	yes	no	%	%

**Term Life Insurance** (Proof of good health may be required before insurance can become effective.)

Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier	
	Effective date	Discontinue date
Employees not actively at work and dependents in a period of limited activity:	List all employees who are not actively at work and dependents in a period of limited activity	

**Employer Request for Benefits and Contribution****Disability Insurance** (Proof of good health may be required before insurance can become effective.)

Request for ➤	employee short term disability		employee long term disability	
Contribution:	employer %	employee %	employer %	employee %
Employees not actively at work:	List all employees who are not actively at work			
State specific information (short term disability only)	Are there employees located in any of the states listed below (policies offered in these states are supplemental)?      yes                  no (If yes, indicate the number of employees for each state.)			
	California	Hawaii	New Jersey	New York      Rhode Island
	Unemployment Insurance or Department of Labor number			

\* If employees contribute to the cost of STD or LTD insurance, are these contributions made on a  
pre-tax    or    post-tax basis?

**Medical Insurance** (including Prescription Drugs and Mail Order if elected)

Coverage includes:	prescription drugs		prescription drugs with mail order	
Request for ➤	employees		dependents	
Contribution:	employer %	employee %	employer %	employee %
Do you offer HMO coverage?	yes	no	If yes, number of employees	
State specific information	Do you have employees or their dependents residing or working in New York?		If yes, how many?	
	yes      no			
	Do you have employees located in Hawaii for whom medical expense coverage is intended?			
	yes      no			
	Number of employees		Department of Labor number	
	Note: Hawaii state law mandates special plan designs, eligibility, and waiting period requirements for employees located in Hawaii. Please contact the home office of Nippon Life Benefits regarding these special requirements.			
Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier			
	Effective date		Discontinue date	

If more than one carrier provided insurance in the past 12 months, provide carrier name, address, effective date and discontinue date(s) on a separate sheet of paper, and attach to application.

Do you offer medical insurance to your employees through another carrier?                  yes      no

**Dental Insurance**

Request for ➤	employees		dependents	
Contribution:	employer %	employee %	employer %	employee %
Do you offer HMO coverage?	yes	no	If yes, number of employees	
Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier			
	Effective date		Discontinue date	

Did your prior dental insurance include benefits for orthodontia treatment?                  yes      no

**Employer Request for Benefits and Contribution****Vision Insurance**

Request for ➤	employees		dependents	
Contribution:	employer %	employee %	employer %	employee %
Complete if policy replaces other group insurance (if yes, provide a copy of most recent billing):	Name and address of prior carrier			
	Effective date		Discontinue date	

**Medical/Prescription Drugs/Mail Order Prescription Drugs/Dental/Vision (check continuation that applies)**

COBRA eligibility is defined as employers who employed 20 or more full or part-time employees on at least 50% of the working days in the prior calendar year. Do you meet the eligibility definition?

	yes	no	
Employee or dependent name	COBRA	USERRA	state cont.
Employee or dependent name	COBRA	USERRA	state cont.
Employee or dependent name	COBRA	USERRA	state cont.
Employee or dependent name	COBRA	USERRA	state cont.

Please attach separate sheet of paper if more space is needed.

**All Coverages**

ERISA plan number \_\_\_\_\_

The Employee Retirement Income Security Act of 1974 (ERISA) requires that each employee benefit plan subject to the Act designate a "Named Fiduciary who shall have authority to control and manage the operation and administration of the plan."

**If this plan is subject to ERISA and the Named Fiduciary is other than the employer, fill in the information below. Nippon Life Benefits may not be designated as Named Fiduciary.**

The "Named Fiduciary" shall be: \_\_\_\_\_

Designation as Named Fiduciary is accepted. (Required only if the "Named Fiduciary" is an individual.)

By \_\_\_\_\_

Title \_\_\_\_\_

It is understood that Nippon Life Benefits shall not be responsible for any tax or legal aspects of the plan. The employer assumes responsibility for these matters. The employer acknowledges that they have counseled to the extent necessary with selected legal and tax advisors. The obligations of Nippon Life Benefits shall be governed solely by the provisions of its contracts and policies. Nippon Life Benefits shall not be required to look into any action taken by the named fiduciary or the employer and shall be fully protected in taking, permitting, or omitting any action on the basis of the employer's actions. Nippon Life Benefits shall incur no liability or responsibility for carrying out actions as directed by the named fiduciary or the employer.

It is further understood that by signing this application, the employer is purchasing insurance and not making an investment. No reserves, undeclared or unpaid experience premium refunds, or interest with respect to claim payments, nor claim proceeds themselves shall be considered plan assets under ERISA.

**Agreement and Signatures**

- The employer has been informed of the minimum participation and contribution requirements. The employer agrees that coverage applied for shall not become or remain effective unless: a) participation and contribution requirements are met, and b) the employer is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code, and c) the application and any attached page(s) are received, accepted, and approved by Nippon Life Benefits.
- If this application is accepted, all group policies will be combined and treated as one policy for the purpose of determining any experience premium refund.
- The preexisting condition restrictions for long term disability insurance have been explained to and understood by the employer.

## Agreement and Signatures (continued)

- The employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If a policy is issued from this application and is accepted by the proposed policyholder, we will apply the premium deposit to the first premium due for such policy. If no policy is put into force, the premium deposit will be refunded.
- Premium payment will be monthly unless otherwise indicated.
- Acceptance by the employer of any policy or policies issued with this application shall constitute approval of any corrections, additions, or changes specified in the space "For Nippon Life Benefits Use Only" or as otherwise indicated on this application.
- Your agent or broker cannot change or waive any provision of this application or the policy or policies without the written approval of an officer of Nippon Life Benefits in the home office.
- The employer acknowledges and understands that if this application is approved, the group policy will determine all rights and benefits.
- The person signing this form for the employer has legal authority to bind the employer for whom application is being made.
- The employer agrees to make timely notification of any employee termination, status change, or other material changes that may affect the eligibility of employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The employer understands that coverage may also be terminated for other reasons as provided in the group policy.
- All information given on this application, and any attachments, are true and complete to the best of my knowledge and belief.

**NOTE:** If Nippon Life Benefits determines, due to requirements of law or because of our own underwriting criteria, to issue our group insurance through a multiple-employer group insurance trust, the employer hereby subscribes to and agrees to the terms of that trust.

**Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines. Fraud or misrepresentation may be grounds for nonrenewal or termination under the terms of the group policy.**

Employer (company name)

Signed by (must be an officer)

Officer's title

Date signed

## Agent Attestation

The information on this application, and any attachments, is complete and accurate to the best of my knowledge.

I have explained to the employer, in easy-to-understand language, the risk of providing inaccurate information and the employer has indicated an understanding of the explanation.

## Agent Notice

If, in the attestation above, you willfully state as true any material fact you know to be false, you shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars (\$10,000).

Licensed resident agent(s) (individual/firm)

Agent's license number

Date signed

Signature of soliciting agent(s) (If more than one, all must sign)

## Employer Instructions

After this form is completed and signed, make one copy for your records and send the original to Nippon Life Insurance Company of America.

## For Nippon Life Benefits Use Only