

NEW CASE TRANSMITTAL FORM

Attention: Incomplete Case Submissions Experience Delays

Have you checked this case? Are all questions answered completely and appropriately? Have you checked rates and completed the benefits portion of the Master Application? Do we need waiver cards?

Failure to present a properly completed case will result in underwriting delays. Properly completed cases will be given first priority, regardless of the sequence they arrive in our office. Incomplete cases cost you and Allied valuable time and put commissions on hold until the case is written. Your thoroughness is well worth the time taken. **This completed sheet MUST accompany the submitted case.**

Overwrite Information

Overwrite Name & Allied or American General Number:
(Use overwrite stamp)

American General GA Number 96054
Telephone No. 206-521-9451
Fax No. 206-521-9554
E-mail cindyk@matrixinsurance.com
Person to Contact Cindy Kamimae
Date _____
Special Instructions _____

Agent Information

Agent Name _____
Allied or American General Agent Number _____
Producing Agent _____
Agent's **Street** Address _____
Agent's City, ST Zip _____
Agent's Phone No. _____
Agent's Fax Number _____
Agent E-mail _____
Agent's SSN/Tax ID. No. _____
Special Commission Arrangements _____

Case Information

Case Name _____
Case Contact Name _____
Case Address _____
Case City, ST Zip _____
Case Phone No. _____
Case Fax No. _____
Contact Person's Extention _____
Contact Person's E-mail _____
Requested Effective Date _____
Other _____

Enclosed

All of these **MUST** be included:

- Employer Master Application—Fully completed and signed by an owner, officer or partner.
- Individual Applications—Fully completed and signed in ink.
- For CoreValue Health Plan - Employee Voluntary enrollment forms if required.
- Waiver Cards—Employee OR Dependent—Must show spouse's name and spouse's place of employment (if applicable).
- Complete copy of most recent State Quarterly Unemployment Tax Report.*
- Imprinted company check for first month's premium.
- Copy of final quote used for sale.
- Appointment information.
- Continuity of Coverage Requirements: Health and dental products with takeover benefits require proof of prior coverage. Certificates of Creditable Coverage and/or current and prior carrier bills are **required**. See proposal or brochure for what is required for this particular case submission.**

*Refer to Agent Guide for product specific requirements.

**For dental submissions, the actual copy of the prior carrier's Certificate of Coverage is required.



Please submit completed forms to:

Matrix Insurance Marketing, Inc.
1225 S Weller St, Ste 320
Seattle, WA 98144-1906
Ph: 206-521-9451 or 800-929-6123
Fax: 206-521-9554
Email: info@matrixinsurance.com

MASTER APPLICATION FOR EMPLOYEE BENEFITS

American General Life Insurance Company of Delaware*
Wilmington, Delaware

American International Life Assurance Company of New York
New York, New York

Administrative Office: Allied National P.O. Box 29189, Shawnee Mission, KS 66201-9189

* This company does not solicit business in New York

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust, or will be issued a group policy.

(A group proposal is required as part of this application. If any of the data on this application conflicts with the data in the group proposal, the data in the group proposal will supercede.)

Applicant Data

1. Full Name of Applicant (Company): _____

2. Group Contact Name: _____

3. Street Address: _____ City: _____ State: ____ Zip: _____

4. Telephone: _____ Fax: _____

Mailing Address (if different) _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ SIC Code: _____

5. Applicant is a: Proprietorship Partnership Corporation Union

Other (Explain): _____

6. Nature of Business: _____ Number of years in business: _____

7. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? Yes No

If yes, give details below. If more space is needed, attach a separate sheet.

<i>Name of Company</i>	<i>Nature of Business</i>	<i>Full Address</i>	<i># of Full-Time Employees</i>
_____	_____	_____	_____
_____	_____	_____	_____

8. Have you ever applied for, or been insured for, group insurance with any member company of American General, including United States Life? Yes No

If yes, give details: Group Policy Number(s) _____

Date Insurance Ended/Declined _____ Effective Date (if still insured) _____

9. Please complete the information below for those coverages being replaced:

Current Coverage		Replacing with the Company's Plans?*	Prior Plan Name & Effective Date	Proposed Termination Date
Employer				
Life**	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
STD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
LTD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No		

* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).

** Are there other Employer Sponsored plans in force which you are not replacing or currently applying for with another carrier? Yes No
If yes, please indicate the highest benefit amount of each plan.

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number:	Division Number:
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General Form # G-APPComb-40040 (8/06)

California Form # G-APPComb-40040-CA (8/06)

Maryland Form # G-APPComb-40040-MD (8/06)

Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least *30 hours (20 hours for Employee Pay All Life only) per week, or ____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

10. Do you want to exclude any classes of full-time employees from coverage? Yes No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** _____

_____ Total # of excluded employees _____

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

11. Waiting Period: Present Employees _____ months OR First of the month following _____ months*
 Future Employees _____ months OR First of the month following _____ months*

*Only option available for Employee Pay All Coverages. Available on Group coverages with the 1st of the month effective date only.

12. a. Number of Full-Time Employees (Include employees not to be covered and those being continued) _____
 b. Number of Full-Time Employees **waiving all coverages** _____

13. Do you employ 20 or more employees? (Include part-time, union, etc.) Yes No

Contribution Data – *Not applicable to Employee Pay All Coverages*

14. Will the employees be required to contribute toward the cost of the insurance? Yes No

If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.

Coverage	Life	AD&D	Dep Life	EE Dental*	Dep Dental*	EE Vision*	Dep Vision*	STD	LTD	Critical Illness	Cancer	Hospital Indemnity	Accident
Employer %													

* The employer must contribute a minimum of 35% of the total dental and vision premiums.

15. Premiums will be paid: Annually Semi-annually Quarterly Monthly EFT

Requested Effective Date

I request that the coverage(s) chosen take effect on:

the date the application is approved in writing by the Company; or

_____ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For Employee Pay All Plans, the effective date must be the first of the month.

Applicant's Declaration

1. I verify that all employees applying for coverage listed on the census form are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all employees meet the eligibility requirements as listed on the application.
2. I verify that the Company's benefit plan(s) have been offered to all employees. Completed waivers 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.
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are): _____.
5. I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund. A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.
6. I understand and agree that:
 - no agent may change or waive any of the provisions of this application or of any plan of insurance;
 - any change or waiver may be made only by an officer of the Company; and
 - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
 - If the insurance contract compromises a part of an employee benefit plan, the Company is granted ** sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
7. It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.
8. It is understood and agreed that the group employer will pay, in advance, the required premium for these coverages.

DATE	PRINT NAME OF OFFICER, PARTNER, PROPRIETOR
WITNESS	SIGNATURE OF OFFICER, PARTNER, PROPRIETOR

* Amount of hours may vary by state law

** May not be applicable in all states, and may vary by state law

The Policyholder [Participant Employer hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.]

Note: *If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

Producing Agent's Declaration

Please Print Producer #	PRODUCING AGENT Tax ID # / SS#	% Commissions split with other agents
Name as Licensed		License #
Mailing Address		
City / State / Zip		
Phone	Fax	E-Mail
Signature	Date	City and State Where Signed

Please Print General Agent # 96054	GENERAL AGENT Name Matrix Insurance Marketing, Inc.	Tax ID # / SS# 91-1757698
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	Premium Deposit \$	Underwriter
Mode	Coverages	
Group Contact	Producer	GA

Important Notice

[For residents of Arkansas, Louisiana, Maryland, Massachusetts and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of New York: 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.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: 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 subjects such person to criminal and civil penalties.]



**ALLIED NON-MEDICAL
EMPLOYEE ENROLLMENT FORM**
(Please type or print in ink - May be copied or duplicated)

1. Employee Information

FULL NAME OF EMPLOYEE				MARITAL STATUS	# OF ELIGIBLE CHILDREN	GENDER (M/F)	ADM. USE ONLY CASE NO. EMPLOYEE NO. CLASS BENEFITS TDLS XS EFFECTIVE DATE UWF 48 YES NO DATE _____
RESIDENCE ADDRESS		CITY	STATE	ZIP			
AGE (LAST BIRTHDAY)	BIRTHDATE (MM/DD/YY)	DATE OF HIRE (FULL TIME)	SOCIAL SECURITY NUMBER				
EMPLOYER NAME			AVG. # HOURS WORKED WEEKLY	GROSS MONTHLY EARNINGS \$			
EMPLOYER'S LOCATION - STREET ADDRESS		CITY	STATE	ZIP			
EMPLOYER'S PHONE NUMBER (include Area Code)		OCCUPATION, TITLE, DUTIES					
<input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER OF THE ABOVE EMPLOYER							

2. Benefit Information

I am applying for (check one) <input type="checkbox"/> Self Only; <input type="checkbox"/> Self & Spouse; <input type="checkbox"/> Self & Child(ren); <input type="checkbox"/> Self, Spouse & Child(ren)
I elect (check all that apply): <input type="checkbox"/> Dental <input type="checkbox"/> Life Insurance <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability

3. Dependent Information

If enrolling for dependent Dental coverage – please list all dependents below

Names of all Dependents to be Insured	Relationship (spouse, son, daughter)	Sex M/F	Date of Birth	Age	Full time student	ADMIN USE ONLY			
						LAT	D&R T/O	Ortho D&R	PXT
	EMPLOYEE								
1.					Y or N				
2.					Y or N				
3.					Y or N				
4.					Y or N				
5.					Y or N				

4. Life Insurance Beneficiary Information

Life Insurance Beneficiary _____ Relationship _____

I am working the average number of hours shown above on a regular basis for the above-named employer. I hereby authorize my employer to make the necessary payroll deduction.

Signature _____ Date _____
PLEASE SIGN IN INK

Please mail completed enrollment form to: Matrix Insurance Marketing, 1225 S Weller St, Ste 320, Seattle, WA 98144

FOR WAIVER OF ELIGIBILITY, COMPLETE REVERSE SIDE

(may be photocopied or duplicated)
WAIVER OF GROUP DENTAL COVERAGE

AFTER due consideration, I have chosen:

- Not to enroll myself and/or my dependents in the Group Dental Plan being offered by my employer.
- Not to enroll my spouse in the Group Dental Plan being offered by my employer.
- Not to enroll my children in the Group Dental Plan being offered by my employer.

Please answer the following:

1. I and/or my dependents are covered under another employer-sponsored dental benefit (if you or your spouse are covered under an employer-sponsored plan, please provide the following information)..... YES NO

Employer Name: _____

Name of current insurance carrier above: _____

Insurance carrier phone number: _____ Case or Plan Number: _____

2. I and/or my dependents are covered under an individual dental plan..... YES NO

3. I opt not to apply for coverage for myself and/or my dependents in the Group Dental Plan due to reasons other than having any existing coverage as listed above. I understand that I have the right to apply for coverage at this time and am voluntarily declining coverage. YES NO

I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents. Further, I understand that if I and/or my dependents enroll under this plan in the future, first year benefits may be limited.

Name of Your Employer: _____ Case Number: _____

Date: _____ Name of Employee: _____

(Please Print or Type)

Signature of Employee: _____

Social Security Number: _____