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# E-Z CHOICE – REQUEST FOR PARTICIPATION AND ENROLLMENT

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**To be used in states other than IN, LA, MN, SD, VT, WA**

Submission Requirements...

- Completed E-Z Choice Request for Participation & Enrollment form
- Initial deposit check equal to monthly premium amount (check must be written on a business account and may not be a starter check)
- Copy of current carrier's most recent billing statement
- Copy of current carrier's booklet for all LTD cases and all Dental cases requesting waivers
- Copy of sold proposal (including rate calculation sheet(s) if applicable) as presented to the employer

(If any of the above items are incomplete, case cannot be processed.)

If applicable...

- Notification of Waiver Form
- Evidence of Insurability Applications for benefits exceeding Non-Medical Issue Limits
- Quarterly State Wage Reports may be requested at the discretion of the Home Office.

Submission instructions...

- Submit all required materials to General Agent or Master General Agent, if applicable, or mail to:  
Genworth Financial Employee Benefits Group  
Attn: E-Z Choice Unit WIN 301  
175 Addison Road.  
Windsor, CT 06095
- New business submission material must be postmarked no later than five business days after the requested effective date. If later, the case effective date will be deferred to the following month.

## EMPLOYER INFORMATION

Please complete in full where appropriate. Incomplete applications delay processing.

Employer's Legal Name \_\_\_\_\_ Employer's Tax ID# \_\_\_\_\_

Employer's Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Firm Contact \_\_\_\_\_ Title \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
(person to contact concerning coverages)

Fax (\_\_\_\_) \_\_\_\_\_ email address \_\_\_\_\_ Effective Date Requested \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of Full Time Employees \_\_\_\_\_ Years in Business \_\_\_\_\_ SIC Code & Nature of Business \_\_\_\_\_

Please check appropriate box:  Corporation  Proprietorship  Partnership  Other \_\_\_\_\_

**Subsidiaries/Alternate Locations** Indicate subsidiaries or other locations, affiliates, to be covered:

Name \_\_\_\_\_ Address \_\_\_\_\_  
(No., Street, City, State ZIP Code)

Tax I.D. \_\_\_\_\_ SIC Code \_\_\_\_\_ Nature of Business \_\_\_\_\_

Is this employer presently insured with GLHIC or has this employer previously applied for or had coverage with GLHIC?  Yes  No

If yes, please indicate coverage(s) \_\_\_\_\_ Account # \_\_\_\_\_

Are you in the process of filing bankruptcy (Chapter 7), reorganization (Chapter 11) or similar insolvency proceedings?  Yes  No

If yes, please explain \_\_\_\_\_

Are there any applicants who are totally disabled?  Yes  No

If yes, please provide names here \_\_\_\_\_

**Certificate** – Please indicate certificate preference (check one):  Electronic (Certificate will be e-mailed as an attachment)  Paper Copies

**Definition of Eligibility** – Eligible employees must be working at the employer's usual place of business. Employees not regularly working at least 30 hours per week are considered part-time. (Foreign National employees are eligible for coverage while residing in the United States).

**Eligibility includes:**  All full-time employees\*  Other (specify) \_\_\_\_\_

\*Partnerships only – Eligibility includes Partners/Owners who are working full time for this employer.  Yes  No

**The above definition of eligibility applies to:**  All Coverages or

Applies only to:  Life/AD&D  Dental  STD  LTD

**Definition of Earnings** (complete only for Life/AD&D, Short and/or Long Term Disability)

### Option 1: (Standard)

Basic earnings **exclude overtime, bonuses, or other compensation.**

Earnings are based on:  Current level of earnings or  Prior calendar year earnings

### Option 2:

Basic earnings **exclude other compensation or overtime but include:**  Commissions  Bonuses

Earnings are based on the average of the most recent:

24 Months  36 Months  Prior calendar year  Prior 2 calendar years  Prior 3 calendar years

### Option 3: (Partners only)

Average earnings calculated from the Partnership Federal Income Tax return for the immediately prior:

Tax Year  Calendar Year

**This definition of earnings option selected above applies to:**

All Coverages or  Applies only to:  Life  STD  LTD

All Classes or  Applies only to class \_\_\_\_\_

Important: "Basic earnings" means an employee's gross rate of earnings from the employer. It includes employee pre-tax contributions to a qualified deferred compensation plan, 401 (K) plan, or Section 125 plan.

This definition defines the base against which the premium and benefits will be paid. If any employee's compensation is not reported on a W-2 or if any employee is paid on a basis other than salaried or hourly, please provide specifics. The term "Basic Earnings" refers to: an annualized amount for Life/AD&D, a weekly amount for Short Term Disability, and a monthly amount for Long Term Disability.

**LIFE/ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) 2 to 24 Lives**

**Benefit Schedules:**

**Option 1** Coverage based on \_\_\_\_\_ times each employee's annual earnings to a maximum of \$\_\_\_\_\_.

**Option 2** Coverage based on job or payroll classification (A minimum of two employees per class is required.)

Classification	Basic Life/AD&D Amount	Maximum \$ Benefit
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

**Option 3** \$\_\_\_\_\_ Coverage for each employee

**Dependent Life Option:**  Yes  No Requires 10 or more employees enrolled and at least 75% of employees with dependents enrolled

**Minimum Waiting Period**  30 days (Standard)  If longer, specify length \_\_\_\_\_

**From Date of Hire** (Eligibility for coverage begins the first day of the month following the minimum waiting period.)

**Participation** Total # of Eligible Employees \_\_\_\_\_  
 Total # of Employees Applying \_\_\_\_\_  
 Total # of Employees with Dependents \_\_\_\_\_

Number of Employees	Non-Medical Maximum Limit*	Maximum With Evidence	Minimum Participation Required
Insure 2 to 5	\$25,000	\$200,000	All Eligible
Insure 6 to 9	\$50,000	\$200,000	All or All but One
Insure 10 to 24	\$75,000 or 3 times the average benefit, whichever is less	\$300,000	75% of those eligible

\* Amounts elected in excess of the non-medical maximum limit will require medical underwriting which may include, but is not limited to, physical exams and blood testing.

**Employer Will Pay:** \_\_\_\_\_ % of Employee costs  
 \_\_\_\_\_ % of Dependent costs

(Employees may contribute up to 100% of the premium.)

Will this policy replace any existing policy of life insurance? Employer:  Yes  No Producer:  Yes  No

**DENTAL (3 to 24 Lives)**

**Plan Selected** (annual plan maximum)  Brass (\$1000)  Silver (\$1200)  Gold (\$1200)  Platinum (\$1500)

**With PPO**  Yes  No **With Vision**  Yes  No

**Is this plan replacing another group plan?**  Yes  No

If yes, attach a copy of the prior carrier's last bill and copy of certificate(s) of insurance and complete the following:

Prior Carrier effective date \_\_\_\_\_

Name of Carrier(s) being replaced \_\_\_\_\_

Coverage(s) provided \_\_\_\_\_ Termination Date(s) \_\_\_\_\_

Reason(s) for change \_\_\_\_\_

**Waiting Period**

- There is a 24 month waiting period for orthodontic coverage. (Only available with Platinum Plan.)
- There is a 12 month major services waiting period for all insured employees, unless they meet the requirements for a waiting period waiver. This benefit waiting period may be waived if the employer has existing group dental insurance, including comparable coverage for major services. The waiver will be granted to any employees who, on the day before their effective date for this coverage, would have been reimbursed for major services under the prior dental coverage. All employees that have satisfied the above requirements will be granted a waiver; there will not be any waivers for any future employees. (Only available with Silver, Gold and Platinum Plans.)

**Is the employer eligible for a waiver?**  Yes  No

(If yes, a copy of the existing dental plan, the last bill and proof of individual effective dates must be submitted.)

**Is your firm subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)?**  Yes  No

**Note:** Your maximum coverage period will be measured from loss of coverage.

**Is any person eligible to receive future benefits under your terminated plan, i.e., COBRA continuant?**  Yes  No

If yes, list below the name(s) of the employees and/or dependents under COBRA for Dental coverage only, date of qualifying event and type of qualifying event (termination of employment, death, divorce, child reaching the limiting age):

Name	Date	Event
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Minimum Waiting Period From Date of Hire**  30 days (Standard)  If longer, specify length \_\_\_\_\_  
(Eligibility for coverage begins the first day of the month following the minimum waiting period.)

**Participation:** Total # of Eligible Employees \_\_\_\_\_ (Excluding employees who waive dental coverage because they have such coverage through their spouses.)  
 Total # of Employees Applying \_\_\_\_\_  
 Total # of Eligible Employees with Dependents Applying \_\_\_\_\_

**Employer Will Pay:** \_\_\_\_\_ % of Employee costs (The employee may contribute up to 100% of the premium.)  
 \_\_\_\_\_ % of Dependent costs

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**SHORT TERM DISABILITY (2 to 24 Lives)**

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**Plan Duration**  13 weeks  26 weeks

**Plan of Benefits**

**Option 1** Percentage of Earnings Plan  50%  60%  66.7%  70%  
Maximum per week \$\_\_\_\_\_ (Plan maximum \$750 if 2–5 lives; \$1,000 if 6–24 lives)

**Option 2** Flat Benefit by Class (A minimum of two employees per class is required.)  
Description of Class Benefit Amount (Plan maximum \$750 if 2–5 lives; \$1,000 if 6–24 lives; benefit limited to 70% of the employee's earnings)  
1. \_\_\_\_\_ \$\_\_\_\_\_ per week  
2. \_\_\_\_\_ \$\_\_\_\_\_ per week  
3. \_\_\_\_\_ \$\_\_\_\_\_ per week

**Option 3** \$\_\_\_\_\_ benefit for each employee (Benefit limited to 70% of the employee's earnings)

**Minimum Waiting Period**  30 days (Standard)  If longer, specify length \_\_\_\_\_  
**From Date of Hire** (Eligibility for coverage begins the first day of the month following the minimum waiting period.)

**Participation** Total # of Eligible Employees \_\_\_\_\_  
Total # of Employees Applying \_\_\_\_\_

**Employer Will Pay:** \_\_\_\_\_% of Employee costs (Employees may contribute up to 100% of the premium.)

**Group has been in business for six (6) months or longer**  Yes  No  
**Group is currently participating in Federal Social Security Program**  Yes  No  
**Employees work where they reside (work out their homes)**  Yes  No

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**LONG TERM DISABILITY (2 to 24 Lives)**

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**Plan Selected\***  Base Plan: • Standard Risk Employees-up to age 65 for accident / the lesser of 5 years or up to age 65 for illness  
• Preferred Risk Employee<sup>1</sup>-up to age 65 for accident / illness  
 Transitional Plan: • All Employees-up to 24 months for accident / illness  
\* Plan eligibility is based on SIC/nature of business.

**Elimination Period**  60 days  90 days  180 days

**Benefit Formula** 60% of Basic Monthly Earnings to a monthly maximum benefit of:  
 \$2,000  \$3,000  \$4,000  \$5,000  \$6,000

**Is this plan replacing another group plan?**  
 Yes (If yes, attach a copy of the prior carrier's last bill and copy of certificate(s) of insurance for prior service credit)  
 No

**Minimum Waiting Period**  90 days (Standard)  If longer, specify length \_\_\_\_\_  
**From Date of Hire** (Eligibility for coverage begins the first day of the month following the minimum waiting period.)

**Participation** Total # of Eligible Employees \_\_\_\_\_  
Total # of Employees Applying \_\_\_\_\_

**Employer Will Pay:** \_\_\_\_\_% of Employee costs (Employees may contribute up to 50% of the premium.)

**Group has been in business for twelve (12) months or longer**  Yes  No  
**Group is currently participating in Federal Social Security Program**  Yes  No  
**Employees work where they reside (work out their homes)**  Yes  No

1 Preferred Risk employees are classified as executive, administrative, sales, supervisory and clerical employees who have no manual labor duties and spend at least 80% of their time inside the office.

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**NOTIFICATION OF WAIVER FORM** (This form may be photocopied)

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Please read, complete and sign this form if you have benefits under a spouse's coverage and/or contribute toward the cost of coverage and are waiving coverage for any of the following insurance products: Life, Dental, Short Term Disability and/or Long Term Disability.

**Note:** Under contributory plans (where employees contribute towards the cost of coverage), eligible employees may elect to waive coverage.

However, election to waive may not exclude that employee from the employer's participation requirements. Under non-contributory plans, all eligible employees must enroll. Eligible employees are defined in the plan brochure.

Employee's Name: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Account #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Please check the box for type(s) of insurance coverage you are waiving:**

Life     Dental     Short-Term Disability     Long-Term Disability

**If you are waiving dental coverage for yourself or your dependents, check all boxes that apply and provide information as applicable.**

I have similar dental coverage under my spouse's plan; and/or

My dependents have similar dental coverage under my spouse's plan.

If either or both above boxes are checked, please provide the following information:

Name of spouse's insurance company: \_\_\_\_\_

Spouse's plan effective date: \_\_\_\_\_

I do not have similar dental coverage under my spouse's plan, but I am waiving the employee dental coverage.

My dependents do not have similar dental coverage under my spouse's plan, but I am waiving the dependent dental coverage.

Please read and sign:

I, the undersigned, hereby affirm that I have reviewed the insurance plan(s) from Genworth Life and Health Insurance Company being offered by my employer. With my signature, I certify that I have decided to waive coverage as indicated above.

I understand that if I should later decide to enroll, I will be considered a late entrant and may be subject to Evidence of Insurability and/or reduced benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CENSUS INFORMATION & APPLICATION SIGNATURES**

Important Note: Make a copy of this page if enrolling more than 12 employees. Complete and attach it to this form. Please print or type census information.

Employee's Social Security Number	Name	Date of Birth M/D/Y	Gender M/F	Date of Hire M/D/Y	Occupation	Class	Current Monthly Salary	Hours worked per week	Coverage Selected					
									LTD	STD	Dental Status <sup>3</sup>	Life/AD&D		
													Other	Life <sup>4</sup>
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														
10.														
11.														
12.														

2. Any employee marked as "Preferred Risk" meets the definition of a "Preferred Risk Employee" i.e., they are classified as in-office executive, administrative, sales, supervisory and clerical employees who have no manual duties and spend at least 80% of their time inside the office.  
 3. Indicate: "S" for single, "+1" for employee plus one dependent or "F" for family coverage.  
 4. Must have 10 to 24 insureds to be eligible for Dependent Life coverage.

(continued on next page)

I (We) verify that all employees applying for coverage listed above are actively at work and working at least 30 hours per week, all employees listed above do not work where they reside, all employees, including myself, who are applying for disability coverage do not have other disability insurance currently in force or applied for, that when added to this insurance would exceed 75% of his/her individual current monthly earnings, and all employees meet the eligibility requirements listed in the brochure.

I (We) verify that Genworth Life and Health Insurance Company's benefit plan(s) have been offered to all eligible employees. Completed waivers are attached for those employees and their dependents electing not to participate in the plan(s).

Please Note: Changes from the Census data, as previously submitted, may affect rates.

The undersigned policyholder requests that insurance be provided in accordance with the policyholder's specifications for group insurance to which this request is attached and shall be subject to the terms of the Group Insurance Policies issued by GLHIC. The undersigned policyholder agrees that it will remit to the insurer regularly in advance, the required premiums as they become due. Further, the undersigned policyholder hereby irrevocably designates GLHIC as the claim administrator and claim appeals fiduciary for the purposes of ERISA, if applicable.

We have read this form and understand that:

1. This request for coverage is not effective until approved by GLHIC in writing. Coverage may be declined or the effective date may be deferred for incomplete submission of information as outlined in GLHIC's underwriting rules/standards. Existing coverage should not be terminated until written approval has been received.
2. All information given in connection with this request for participation is true and complete.
3. GLHIC reserves the right to re-rate any coverage retroactively to the effective date or take other appropriate actions if any information provided to us is not true or is incomplete.
4. No producer can make or modify a contract for GLHIC and all coverage will be as stated in GLHIC policies.
5. Attached is an initial deposit check payable to GLHIC equal to the estimated first month's premium. The amount will be returned if insurance does not become effective. Cashing of the check by GLHIC does not constitute acceptance of the risk or an approval of request.
6. Final premium rates are subject to final enrollment and any prior claim history that we may require.
7. When you purchase insurance from us, we pay compensation to the producer and/or to any intermediaries through which the producer works. If the producer works through an agency, the agency may pay compensation directly to the producer. This compensation may include commissions when a policy is purchased or renewed, and fees for other services. The compensation may vary by the type of insurance purchased. Additionally, bonuses and incentive trips or awards associated with sales may be paid based on the overall sales volume or persistency of business. The compensation we pay to the producer may differ from that paid by other insurance companies. If you have questions, please contact your producer directly.

Please add the figure(s) calculated using the Rate Calculation Sheet(s) or proposal. Genworth Life and Health Insurance Company reserves the right to decline a case.

Dental	\$ _____
w/Vision	\$ _____
Short Term Disability	\$ _____
Life/AD&D	\$ _____
Dependent Life	\$ _____
Long Term Disability	\$ _____
Billing Fee <sup>5</sup>	\$ 16.00
<b>TOTAL MONTHLY PREMIUM:</b>	\$ _____

#### WARNING

#### STATE LAW IN SOME STATES REQUIRES THE FOLLOWING STATEMENT:

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 (in Oregon, "may be guilty of insurance fraud,") commits a fraudulent insurance act, which (in Oregon, may be subject to prosecution.") is a crime and subjects such person to criminal and civil penalties.

#### THIS NOTICE DOES NOT APPLY IN VIRGINIA.

**IN 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."

**IN LOUISIANA:** "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."

**IN 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."

**IN 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 containing any fact material thereto, commits a fraudulent insurance act which is a crime and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation."

**IN PUERTO RICO:** "Any person who, knowingly and with the intent to defraud, presents false information in an insurance request for, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or present more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than \$5,000 nor more than \$10,000, or imprisonment for a fixed term of 3 years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of 5 years; if attenuating circumstances prevail, it may be reduced to a minimum of 2 years. "

\_\_\_\_\_  
Employer's Signature (Owner, Partner, CFO)

\_\_\_\_\_  
Date

I have complied with the underwriting rules and have explained the coverage in detail to the participating employer. I represent that all information on this application is correct to the best of my knowledge.

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Date

5. If this is the employer's first application for E-Z Choice coverage, please add the \$16.00 Billing Fee. This fee has already been included in your billing if you currently have other E-Z Choice coverages. This fee will be charged for each billing cycle.

# PRODUCER'S STATEMENT

Name of Employer to be Insured \_\_\_\_\_

**Attention Producers:** This Enrollment Form must be completed in full. Missing information will delay the new business process and your COMMISSIONS! Make sure ALL items on the list on the front of this form are included.

If not currently appointed, complete all applicable sections of this form and contact our Licensing area at 800 451.2513 (press zero at prompt, then x2534) for contracting material. We will also require a copy of your license and your firm's license if applicable.

Any product related questions should be directed to the E-Z Choice Unit at 1-877-EZChoice.

## Writing Producer 1 \_\_\_\_\_ % of payable commissions

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Firm Name \_\_\_\_\_

Firm Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Firm Tax ID # or Individual SS # \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_

GLHIC Producer Code \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Commissions Payable in  Your Name  Firm's Name

If in Firm's name are you an officer of your firm?  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Writing Producer 2 (if applicable) \_\_\_\_\_ % of payable commissions

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Firm Name \_\_\_\_\_

Firm Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Firm Tax ID # or Individual SS # \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_

GLHIC Producer Code \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Commissions Payable in  Your Name  Firm's Name

If in Firm's name are you an officer of your firm?  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

Only complete the section below if you have been appointed as a GLHIC General Agent or Master General Agent.

## General Agent (if applicable)

GA Name \_\_\_\_\_  
Last Name First Name Middle Initial

Firm Name \_\_\_\_\_

Firm Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Firm Tax ID # or Individual SS # \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_

GLHIC Producer Code \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Commissions Payable in  Your Name  Firm's Name

If in Firm's name are you an officer of your firm?  Yes  No

Questions about this case, contact  Producer  General Agent

GA Contact Name \_\_\_\_\_

## Master General Agent

MGA Name \_\_\_\_\_  
Last Name First Name Middle Initial

Firm Name \_\_\_\_\_

Firm Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Firm Tax ID # or Individual SS # \_\_\_\_\_

State License # \_\_\_\_\_ State \_\_\_\_\_

GLHIC Producer Code \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Fax ( ) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Commissions Payable in  Your Name  Firm's Name

If in Firm's name are you an officer of your firm?  Yes  No

Questions about this case, contact  Producer  General Agent

Master General Agent

MGA Contact Name \_\_\_\_\_