NAMIC® WELFARE BENEFIT PLAN

NAMIC Welfare Benefits Plan
Request for Employee Benefits Proposal / Company Election Form

General Information

Requested Effective Date for Coverage to Begin _____ FEIN # _____

(Coverage would not be provided retroactively)

Employer's Legal Name _____

Billing Address _____

City State Zip

Mailing Address _____

City State Zip

Telephone Number _____ FAX Number _____

Name/Title of Contact Person _____

Email Address of Contact Person _____

Is your company a member of NAMIC ? (X) Yes ( ) No

Eligibility Information

Total Number of Employees on Payroll: _____

Total Number of Permanent *Full Time* * Employees: _____ *Full-Time employess must work a minimum 20 hours per week

Number of Directors who are not Active Employees _____

Number of Employees Currently Enrolled	**Employer Contributions**
_____ Group Life/AD&D	_____ % Group Life/AD&D
_____ Dependent Life	_____ % Dependent Life
_____ Supplementary Life Insurance	_____ % Supplemental Life Insurance
_____ Supplementary Accidental Death & Dismemberment	_____ % Supplemental Accidental Death & Dismemberment
_____ Long Term Disability	_____ % Long Term Disability
_____ Short Term Disability	_____ % Short Term Disability
_____ Critical Illness	_____ % Critical Illness
_____ Accident	_____ % Accident
Dental Insurance: _____ High Plan _____ Low Plan	_____ % Dental Insurance
_____ Vision Insurance	_____ % Vision Insurance

Benefits waiting period for new employees is the completion of:
( ) 0 Days ( ) 30 Days ( ) 60 Days ( ) 90 Days ( ) 180 Days ( ) 365 Days

Continuation

Are any former employees and/or dependents eligible for coverage through COBRA for dental or vision? ( ) Yes ( ) No
If yes, please identify by name. Attach separate sheet if necessary.

_____

To the best of your knowledge, are any employees or dependents proposed for coverage disabled or unable to work because of a current or approaching hospital confinement, leave of absence or or otherwise incapacitated? ( ) Yes ( ) No
If yes, please provide the person's name and current status.

_____

Please indicate all options below for which you would like a quote(s):

Group life/AD&D Insurance *

Fixed Amounts	( ) $10,000	( ) $15,000	( ) $20,000	( ) $25,000	( ) $50,000				
Salary Option ($300K Maximum)	( ) 1 X Salary	( ) 1.5 X Salary	( ) 2 X Salary	( ) 2.5 X Salary	( ) 3 X Salary				
Salary Option ($500K Maximum)	( ) 1 X Salary	( ) 1.5 X Salary	( ) 2 X Salary	( ) 2.5 X Salary	( ) 3 X Salary				

*Employers must pay 100% of the premium to be eligible for pricing quoted.

Supplementary Life Options

These products may be either employer paid or employer/employee shared payment:

Supplemental Life	( )	Dependent Life Age Limit Spouse 70, Children 26	( )	Supplemental AD&D	( )

Long Term Disability Insurance (LTD)

Elimination Period	( )	90 Days	( )	180 Days
Benefit Schedule	( )	50% (180 day EP, $8,000 max only)	( )	66.67%
Benefit Payment	( )	$8,000 Monthly Maximum (50% ben, 180 day EP only)	( )	$10,000 Monthly Maximum (n/a to 50% benefit option)
Funding	( )	Employer-Paid	( )	Employee/Shared Payment

Short Term Disability Insurance (STD)

Elimination Period (Sickness/Injury)	( )	7 Days	( )	30 Days (applies to 13 wk benefit only)
Benefit Period	( )	13 Weeks	( )	26 Weeks (applies to 7 day EP only)
Benefit Schedule	( )	66.67%		
Benefit Payment	( )	$300 Weekly Maximum	( )	$2,000 Weekly Maximum
Funding	( )	Employer-Paid	( )	Employee/Shared Payment

Critical Illness / Accident

Critical Illness	( )	Accident	( )

Dental Insurance

High Option	( )	Low Option	( )	No Dental	( )

Groups can offer both a high and a low dental plan to all employees

Vision Insurance

Vision	( )	No Vision	( )

Company Election Form

*NAMIC reserves the right to perform employer audits to ensure employers are paying the entire cost of any coverage elected as "100% employer paid".

As confirmation of acceptance of quote, please initial by each plan election being made and sign below.

Company Officer Approval: _____ **Date:** _____

Return this form by mail or fax to the attention of Robin Sobolewski at:

NAMIC Welfare Benefits Program
PO Box 68700, Indianapolis, IN 46268-0070
Fax: 317-415-0158 Phone: 800-336-2642

Thank you for considering NAMIC for your Group Trust benefit needs! Would you take a moment to tell us why you chose NAMIC?