# TEXASWORKS
# GAPPWORKS

# GAPP I

## Group Acceptance
## Protection Plan

*FULLY INSURED BY:*

**BCS Insurance Company, Oakbrook Terrace, IL**

THE GAPPWORKS PROGRAM IS NOT A WORKERS' COMPENSATION INSURANCE PROGRAM. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THE PROGRAM AND, IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

**Administered by:**

North American Benefits Company (NABCO)

GAPP I (4Q03)

# GAPP I. A plan that works for you and your employees.

*In these budget challenging times, smart Texas employers are signing up for GAPP I – a Group Accident Protection Plan that can be tailored to fit your needs.*

*BCS Insurance Company is rated in the "A" (Excellent) category by the A. M. Best Company. Licensed in all states, BCS is a company known for excellence in product development and special risk underwriting with more than 50 years of experience in the group market.*

***With GAPP I, the employer can choose the coverage levels that will provide the desired protection. The employer can choose from the following 3 plan designs:***

| | PLAN 1 | PLAN 2 | PLAN 3 |
|---|---|---|---|
| Accident Medical Expense Coverage | $300,000 | $500,000 | $500,000 |
| Accidental Death & Dismemberment Benefit | $100,000 | $100,000 | $200,000 |
| Weekly Accident Disability Income | 70% of Base Salary<br>$600 per week max. | 70% of Base Salary<br>$600 per week max. | 70% of Base Salary<br>$700 per week max. |
| Benefit Period | 110 Weeks | 110 Weeks | 104 Weeks |
| Hernia Benefit | not available | not available | up to $25,000 med.<br>up to 6 weeks W.I. |
| Occupational Disease Benefit | not available | not available | up to $50,000 med.<br>up to 12 weeks W.I. |

***And,*** *the employer chooses from the following options to apply to the plan selected:*

1. *Elect either a $500, $1,000 or $2,500 per accident All Benefits Deductible*
2. *Elect either a 7-day or 14-day waiting period under the weekly accident disability income*

The per accident All Benefits Deductible means that the deductible must be satisfied prior to any payments for any line of coverage.

## ELIGIBLE EMPLOYEES

All your permanent employees (full-time and part-time) over the age of 14 must be covered. Permanent employees are those employees for which employment is expected to be continued with no foreseeable expectation of termination.

Full-Time: Employees that work 30 hours or more per week, or for the number of hours the employer requires for an employee to be full-time, but in no event less than 17.5 hours per week.

Part-Time: Employees that work less than the number of hours the employer requires for an employee to be full-time.

## EFFECTIVE DATE OF COVERAGE

Applications must be received and approved by the Company prior to the policy effective date. Employees must be eligible and actively at work on the policy effective date to be covered. New employees can be insured as soon as they are eligible.

## PREMIUMS

Initial premiums are due on the policy effective date. There is a 12-month initial rate guarantee. Insurance will lapse as of any subsequent premium due date if the premium is not paid by the end of the 31-day grace period. GAPP I premium is to be paid entirely by the employer.

## RATES

GAPP I rates are on a per-person, per-month basis. Rates are based on the policyholder's industry. Agent note: SIC Code determines whether or not the industry is acceptable. Refer to your GAPP I SIC Code Guide to determine your client's eligibility.

## LIMIT OF LIABILITY FOR ANY ONE ACCIDENT

The Company's limit of liability for any one accident is $3,000,000 for all employees injured in the same accident.

## ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT LIMITS

Full-time Employees: 10X Base Salary up to the selected Plan max.
Part-time Employees: 10X Base Salary up to $100,000 regardless of Plan max.

## OCCUPATIONAL HERNIA & OCCUPATIONAL DISEASE/CUMULATIVE TRAUMA:

There is a 180 day waiting period before coverage begins during which time coverage must remain in continuous force.

# GAPP I. Coverage Information

## ACCIDENT MEDICAL EXPENSE COVERAGE *

When an injury results in covered medical expenses, the Company will pay benefits as described below to reimburse the cost of those charges, up to the amount of coverage purchased, and after satisfaction of the All Benefits Deductible.

The covered charges must be the direct result of a covered injury and the employee must be covered at the time of the accident. The first charges for care must be incurred within 30 days of the accident. Services must be medically necessary for the treatment of the covered injury. All medical treatment must be received during the applicable Benefit Period.

The Company will pay benefits:

1) equal to 100% of the usual, reasonable and customary covered charges incurred when the employee uses Preferred Providers under the GAPP Managed Care Program;

2) equal to 80% of the usual, reasonable and customary covered charges incurred when the employee does not use Preferred Providers under the GAPP Managed Care Program.

The first $500 of covered hospital inpatient charges will not be paid unless all Pre-Admission Notification requirements have been met. For a scheduled inpatient admission, the requirement is that the employee contact the GAPP Managed Care Program no less than 3 days prior to the admission. For emergency admissions, the contact must be made the next day.

Accident Medical Expense benefits are payable for up to 110 weeks (104 weeks for Plan 3).

## WEEKLY ACCIDENT DISABILITY INCOME *

When an injury results in the employee's total disability, the Company will pay benefits equal to 70% of Base Salary after satisfaction of the All Benefits Deductible. The benefit cannot exceed $600 per week ($700 per week for Plan 3) and is payable after from either a 7-day or 14-day elimination period. Base Salary means a combination of regular annual pay at the time of loss and, if applicable, an average annual amount of additional compensation (this includes compensation commissions, bonuses, overtime, and any other reported for tax purposes). Average annual amounts of additional compensation will be calculated based on length of employment.

The disability must commence within 30 days of the date of the accident and the employee must be covered at the time of the accident. For benefits to be paid, the employee must be totally disabled and under the regular care and treatment of a physician. Proof of total disability will be required.

Weekly Accident Disability benefits are payable for up to 110 weeks (104 weeks for Plan 3).

## ACCIDENTAL DEATH & DISMEMBERMENT *

When a covered employee suffers any one of the losses listed in the chart below, the Company will pay the applicable benefit shown after satisfaction of the All Benefits Deductible. The loss must occur within 365 days of the covered accident.

| LOSS | BENEFIT |
|---|---|
| Life | The Principal Sum |
| Both Hands | The Principal Sum |
| Both Feet | The Principal Sum |
| Sight of Both Eyes | The Principal Sum |
| One Hand and One Foot | The Principal Sum |
| One Hand and Sight of One Eye | The Principal Sum |
| One Foot and Sight of One Eye | The Principal Sum |
| One Hand | One-Half The Principal Sum |
| One Foot | One-Half The Principal Sum |
| Sight of One Eye | One-Half The Principal Sum |
| **Loss of Use Provisions:** | |
| Speech and Hearing in Both Ears | The Principal Sum |
| Use of Both Arms or Both Legs | The Principal Sum |
| Use of One Arm and One Leg | Three-Fourths The Principal Sum |
| Speech | One-Half The Principal Sum |
| Hearing in Both Ears | One-Half The Principal Sum |
| Use of One Arm or One Leg | One-Half The Principal Sum |

If an employee suffers more than one loss due to any one accident, the greater benefit will be paid.

### Occupational Hernia Benefit (For Plan 3 only)

This pays covered medical expenses/weekly income benefits when the hernia arises solely out of and in the course of active employment and meets ALL of the following five estblished criteria: 1) sudden onset with 2) sudden pain and 3) sudden swelling and 4) results from a direct injury and 5) does not result from a condition that previously existed.

### Occupational Disease/Cumulative Trauma Benefit (For Plan 3 only)

This pays for covered medical expenses/weekly income benefits when damage or harm to the physical structure of the body arises solely out of active employment and meets either of the following criteria: 1) is caused by a disease of life to which the general public is exposed; or 2) occurs as a result of repetitious, physically traumatic activities that happen over time.

### Rehabilitation Benefit*

This special benefit encourages the employee to begin working again by continuing to provide Weekly Accident Disability benefits even while the disabled employee returns to work on a part-time basis (up to 17.5 hours per week) during a recovery period. The plan will make up the difference between the part-time pay received by the recovering employee and 100% of pre-disability pay (up to the amount of coverage purchased).

** This is only a brief description of the GAPP I plan. It is not an insurance contract. Additional conditions and limitations may apply. If a conflict arises between this brochure and the issued policy, the policy will govern.*

# GAPP I. Coverage Information, continued

**PLAN EXCLUSIONS*:** 1. Suicide or self-inflicted injury; 2. Commission of an assault or felony, or engagement in an illegal occupation; 3. War or act of war, whether declared or undeclared; 4. Participation in armed forces, or in a riot or rebellion; 5. Any illness not the result of an injury; 6. Hernia, except as provided under the Occupational Hernia Benefit; 7. Ptomaine or bacterial infection unless due to an accidental wound; 8. Any loss caused on certain aircrafts or aircrafts used for certain purposes; 9. Any loss caused while: intoxicated, under the influence of any alcohol, or taking any narcotic, barbiturate, or hallucinatory drug, unless on doctor's orders; 10. Organized competitive athletic events; 11. Driving or testing a race vehicle; 12. Losses due to an injury caused prior to this coverage; 13. Travel to/from work; 14. Any loss covered by any Workers' Compensation Act or similar law; 15. Charges for care rendered by a family member; 16. Care deemed to be not medically necessary.

** This is only a brief description of the GAPP I plan. It is not an insurance contract. Additional conditions and limitations may apply. If a conflict arises between this brochure and the issued policy, the policy will govern.*

# GAPP I. Rates – Per Insured, Per Month

| | | PLAN 1 | | | | | | PLAN 2 | | | | | | PLAN 3 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | $500 Deductible | | $1,000 Deductible | | $2,500 Deductible | | $500 Deductible | | $1,000 Deductible | | $2,500 Deductible | | $500 Deductible | | $1,000 Deductible | | $2,500 Deductible | |
| **INDUSTRY** | **SIC Code** | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim | 7 Day Elim | 14 Day Elim |
| **AGRICULTURE** | 011 thru 085 except 090-097 | $95 | $91 | $76 | $73 | $66 | $63 | $101 | $96 | $81 | $77 | $70 | $67 | $113 | $109 | $92 | $88 | $79 | $77 |
| **MINING** | 131-149 except 101-130 | $64 | $60 | $54 | $51 | $47 | $45 | $68 | $64 | $58 | $54 | $50 | $48 | $73 | $70 | $61 | $57 | $52 | $50 |
| **CONSTRUCTION** Category 1 | 152-173 | $100 | $96 | $79 | $77 | $69 | $67 | $104 | $99 | $82 | $78 | $72 | $69 | $112 | $108 | $91 | $89 | $80 | $76 |
| Category 2 | 174-178 & 521 | $100 | $96 | $79 | $77 | $69 | $67 | $104 | $99 | $82 | $78 | $72 | $69 | $117 | $111 | $95 | $90 | $82 | $78 |
| Category 3 | 179 | $100 | $96 | $79 | $77 | $69 | $67 | $104 | $99 | $82 | $78 | $72 | $69 | $109 | $107 | $96 | $92 | $84 | $80 |
| **MANUFACTURING** | 201-399 except 241-242 281-282,331-334 | $110 | $106 | $88 | $85 | $77 | $75 | $114 | $108 | $91 | $86 | $79 | $76 | $129 | $123 | $106 | $102 | $92 | $88 |
| **TRANSPORTATION** Category 1 | 472-478 | $75 | $73 | $60 | $58 | $52 | $49 | $78 | $74 | $62 | $59 | $54 | $52 | $125 | $118 | $100 | $94 | $87 | $82 |
| Category 2 | 411-471, 479-497 | $75 | $73 | $60 | $58 | $52 | $49 | $78 | $74 | $62 | $59 | $54 | $52 | $84 | $80 | $68 | $63 | $60 | $55 |
| Category 3 | 753-754 | $69 | $65 | $58 | $54 | $53 | $49 | $72 | $68 | $60 | $57 | $56 | $54 | $80 | $77 | $65 | $60 | $57 | $53 |
| **TRADE** | 501-599 | $65 | $63 | $52 | $50 | $45 | $42 | $66 | $64 | $53 | $51 | $46 | $44 | $78 | $75 | $63 | $60 | $56 | $53 |
| **SERVICES** Category 1 | 601-679 | $50 | $46 | $40 | $37 | $35 | $33 | $55 | $53 | $44 | $42 | $38 | $36 | $65 | $60 | $50 | $46 | $45 | $41 |
| Category 2 | 701-874 | $60 | $56 | $46 | $44 | $40 | $38 | $63 | $60 | $46 | $45 | $41 | $40 | $70 | $67 | $56 | $54 | $51 | $48 |

**Subtract this credit from base rates to calculate part-time employee rate. *PART-TIME EMPLOYEES MUST BE COVERED.***

| PART-TIMER CREDIT | $15 | $14 | $11 | $10 | $9 | $8 | $16 | $15 | $12 | $11 | $10 | $9 | $19 | $18 | $15 | $13 | $12 | $10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

# GAPP I. Proposal Information – For Your Records

Proposal for:______________________ Date:______________ Agent:______________________

**Coverage Selections:** **Benefit Amounts** **Deductible** **Waiting Period**

Benefit Amounts:
- ❑ Plan 1
- ❑ Plan 2
- ❑ Plan 3

Deductible — *Choose One:*
- [ ] $500 All Benefits Deductible
- [ ] $1,000 All Benefits Deductible
- [ ] $2,500 All Benefits Deductible

Waiting Period — *Choose One:*
- ❑ 7-Day Waiting Period
- ❑ 14-Day Waiting Period

Industry Classification:______________________ SIC Code Assigned: ________ ________ ________

Rate Per FULL-TIME Person Per Month: $____________ Rate Per PART-TIME Person Per Month: $____________

# TEXASWORKS
# GAPPWORKS

## Group Accident Protection Plan

Company Name: ____________________

Company Address: ____________________

City: ____________________ TX: Zip: ____________________

Contact Person: ____________________ Phone: (______)____________________

Email: ____________________

Broker/Agent's Name: ____________________ Commission %: ______

Address: ____________________ Tax ID# ____________

Email: ____________________

Broker/Agent's Name: ____________________ Commission %: ______

Address: ____________________ Tax ID# ____________

Email: ____________________

General Agent's Name: ____________________ Commission %: ______

Address: ____________________ Tax ID# ____________

Email: ____________________

Effective Date: ____________________ Date Submitted: ____________________

Special Instructions:____________________

____________________

*Included Are:*

_____ Employer Application
_____ Quote
_____ Broker/Agent Licensing
_____ Premium Check in the amout of $___________
_____ Owner Waiver
_____ Contract Labor Census
_____ ERISA Plan Worksheet
_____ (Electronic Bank Draft) ACH Debit Application

GAPP I _____
GAPP II _____
GAPP ULTRA _____

Distributed By: **George W. Evans & Associates, Inc.** **www.gwevans.com**

Mail All Completed Enrollment Material to: 5904 Dolores • Houston, TX 77057-5604
Call with questions: (800) 580-3826 • (713) 780-1116 • Fax: (713) 782-1113 or email
michelle@gwevans.com or lucy@gwevans.com

Administered by: NORTH AMERICAN BENEFITS COMPANY (NABCO)
P.O. Box 3056, Southeastern, PA 19398-3056 or 530 East Swedesford Road, Wayne, PA 19087
(800) 994-GAPP (4277)

# GAPP I GROUP ACCIDENT PROTECTION PLAN
# APPLICATION FOR COVERAGE

**BCS Insurance Company,**
**Oakbrook Terrace, IL**

Requested Plan Effective Date:___________________________________

Name of Employer (full/corporate name under which business operates):

_____________________________________________________________________________________

*Circle One:* *Corporation* *Partnership* *Other*

❑ Please check only if contract laborers are to be insured. (if yes, Contract Labor Census must be completed.

Street Address: ______________________________________________________________________

City/Town: _____________________________________________ County: ___________________________

State: _________________________________________________ Zip:______________________________

Email:________________________________________________________________________________

Exact Nature of Business ____________________________________ SIC Code: ________________________

| Coverage Selections: | Benefit Amounts | Deductible | Waiting Period |
|---|---|---|---|
| | | *Choose One:* | *Choose One:* |
| | ❑ Plan 1 | [ ] $500 All Benefits Deductible | ❑ 7-Day Waiting Period |
| | ❑ Plan 2 | [ ] $1,000 All Benefits Deductible | ❑ 14-Day Waiting Period |
| | ❑ Plan 3 | [ ] $2,500 All Benefits Deductible | |

Line 1: # Full-Time Employees: ______________________

Line 2: Full-Time Per Person Rate: $ ______________________

Line 3: Multiply Lines 1 & 2: $

Line 4: # Part-Time Employees: ______________________

Line 5: Part-Time Per Person Rate: $ ______________________

Line 6: Multiply Lines 4 & 5: $

Line 7: Add Lines 3 & 6: $

Total Premium: $

Billing Fee: $

One Time Issue Fee: $50.00

Total to be Submitted: $

*(Make check payable to the plan administrator, NABCO)*

❑ Please check only for the (Electronic) Bank Draft/ACH Debit Payment Option. (if yes, ACH Debit Form/Application must be completed).

Choose One: ❑ $30 Monthly*
❑ $55 Quarterly*
❑ $80 Semi-Annually*

* ERISA included

THE INFORMATION ABOVE ACCURATELY REPRESENTS: 1) THE GAPP I PROGRAM DESIGN FOR WHICH WE ARE APPLYING, AND 2) THE REQUIRED EMPLOYEE INFORMATION.

_______________________________________ _______________________
Employer Authorized Signature Date

_______________________________________
Broker or Agent Name (please print)

_______________________________________ _______________________
Broker or Agent Signature Date

**PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM. THE COMPANY CANNOT ISSUE A POLICY UNLESS THE REVERSE SIDE OF THIS FORM HAS BEEN COMPLETED.**

## EMPLOYER CERTIFICATION - THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.

We, the undersigned Employer, hereby certify the following:

1. We are applying to BCS Insurance Company (the Company) for Accident Insurance. We fully acknowledge and understand that acceptance of this request is subject to all of the Company's requirements and verification of quoted premium. The insurance applied for shall not be effective until the application has been approved and accepted by the Company in writing and the Coverage Effective Date has been assigned. A Policy and Schedule of Benefits will be issued.

2. We understand that 100% of all eligible employees must be covered and that this will be verified using quarterly employment tax statements.

3. In order for employee insurance to take effect, each employee must satisfy the eligibility requirements of the Policy.

4. We agree to pay the required premiums to the Company when due.

5. We have reviewed the sales material and the application. These materials, taken together, describe the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying, all of which have been explained to us by the broker/agent whose signature appears below.

6. We understand the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying.

7. WE ACKNOWLEDGE AND FULLY UNDERSTAND EACH OF THE FOLLOWING ITEMS:

   a. The coverage for which application being made is an employee benefit and does not insure any casualty or general liability risk of the Employer. This coverage is not intended to nor will it provide the Employer with any protection or defense against any suit which may be brought by an employee or anyone else.

   b. Neither the Company nor the undersigned broker/agent has represented the coverage as anything other than an employee benefit which offers no indemnity for the Employers' liability.

   c. THIS IS NOT A PROGRAM OF WORKERS' COMPENSATION INSURANCE. WE DO NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS COVERAGE. AND IF WE ARE A NON-SUBSCRIBER, WE LOSE CERTAIN COMMON LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATIONS ON LIABILITY THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. WE MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

8. I am authorized by the Employer to review and to sign this Certification.

9. BCS Insurance Company and its representative are authorized to contact me by mail or telephone to discuss this certification. THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.

| Employer Authorized Signature | Title | Date |
|---|---|---|
| Broker or Agent Signature | | Date |

**Mail Application to**

George W. Evans & Associates, Inc.
5904 Dolores, Houston, TX 77057-5604

## BCS Insurance Company, Oakbrook Terrace, IL

# TEXASWORKS
# GAPPWORKS

# O W N E R   W A I V E R

I (WE) THE SOLE PROPRIETOR OR PARTNERS HAVE ELECTED NOT TO CARRY ANY COVERAGE UNDER THIS TEXAS GROUP ACCIDENT POLICY. PLEASE PROVIDE THE NAME OF YOUR CURRENT CARRIER AND POLICY NUMBER BELOW.

| Name/Title | Social Security # | Signature (s) | Your Current Carrier/Policy # |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |

# Group Accident Protection Plan (GAPP)

Company Name: ______________________________ Policy #: ____________

Prepared by: ______________________________ Date: ____________

## Contract Labor Census

| Insured's Name | Social Security Number | Job Duties | Date of Hire | Termination Date | Monthly Wages (not to exceed $5000.00) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

I, ____________________ agree that all the above insured's wages are subject to 1099 reporting.
(Signature of Owner)

**Please complete this form when any new additions or terminations occur with your statement.**

**Return to: NABCO**
**Attn: GAPP**
**P.O. Box 3056**
**Southeastern, PA 19398-305**

**GAPP I / GAPP II / GAPP ULTRA**

# ERISA PLAN WORKSHEET

Company's Legal Name: ______________________________

Physical Address: ______________________________

______________________________

Mailing Address: ______________________________

______________________________

Telephone #: ____________________ Fax #: ____________________

Federal Tax I.D. No.: ____________________

Company's fiscal year ends: ____________________

Company is: ❒ Corporation ❒ Sole Proprietorship ❒ Partnership

Affiliated or subsidiary companies covered? ❒ Yes ❒ No %_____Common Ownership
(Attach additional sheets showing all above information for each, with % of ownership)

Name and Title of Contact Person / the ERISA Plan Administrator:

Contact Name:______________________________Title:____________________

Insurance Agent:

Name:____________________ Agency:____________________

Phone #:____________________ Fax #:____________________

City:____________________ State:______ Zip:____________________

Number of Employees: ______________

Effective Date of ERISA Plan: ____________________

Do you currently have any employee welfare benefit plan in place, which is governed by ERISA?
(I.E. Group Health Insurance)? ❒ Yes ❒ No

If yes, Plan I.D. Number(s): ____________________

Describe Plan: ______________________________

**North American Benefits Company**
**Agreement for Electronic Funds Transfer**

I authorize North American Benefits Company, hereinafter called THE COMPANY, to automatically deduct monthly premium payments through an Automated Clearing House (ACH) Debit transaction from the bank account listed below on the 5th of every month. Should the 5th of the month fall on a weekend or bank holiday, the ACH Debit will be processed on the next following bank business day. This agreement will remain in effect until I give written notice to change financial institutions, terminate service, or until THE COMPANY notifies me that this service has been terminated.

---

**Please Print**

Policy Name (no abbreviations): ______________________________

Mailing Address: ______________________________

City, State, Zip: ______________________________

Phone: ______________ Email: ______________

## INSTRUCTIONS FOR ELECTRONIC FUNDS TRANSFER (EFT)

Fill in complete banking information where indicated. If routing number is unknown, please contact your bank. Without the Routing Number, **the automatic debit cannot be processed.**

Check One: New EFT Debit: ☐ Change Existing EFT Debit: ☐ (Policy Number: ______________)

| Bank Name | Account Name (as it appears on the account) |
|---|---|
| Bank Account Number | Type of Account<br>Checking: ☐ Savings: ☐ |
| Bank ABA Routing Number | Bank Address |
| **VOIDED CHECK** *(Forms submitted without a voided check will not be accepted and will be returned.)* | |

I hereby authorize THE COMPANY and the financial institution to electronically debit premium payments from my designated account. If THE COMPANY is notified of any failed transactions, THE COMPANY will automatically process a second ACH Debit for my premium payment. **If a failed transaction occurs more than once THE COMPANY will automatically terminate agreement.**

| Authorized Name (Print) | Date |
|---|---|
| Authorized Signature | |

**THE REVERSE SIDE OF THIS FORM MUST BE COMPLETED WITH INITIAL EMPLOYEE INFORMATION**

# GROUP ACCIDENT PROTECTION PLAN( GAPP)

## Sold Case Census

Please Print

| INSURED'S NAME (FIRST NAME/ LAST NAME) | SOCIAL SECURITY # | GENDER | DATE OF HIRE | DATE OF BIRTH | FULL TIME/ PART TIME |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PREPARED BY:** ______________________ **DATE:** ______________________