BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road, NE, PO Box 105185, Atlanta, Georgia 30348-5185 (404) 266-5600

ATLANTIC AMERICAN
Employee Benefits

MASTER APPLICATION

(Home Office Use Only) Group ID #

PART A - EMPLOYER INFORMATION

A1. Company Information

Company's Legal Name (including any DBA's):		SIC#:
Type of Business:	Employer Tax ID Number (EIN):	
Owner Name:	Website (url):	
Business Contact (if different from Owner):	Phone:	Ext:
Company's Physical Street Address:	Business Contact Email:	
City:	State:	Zip:

A2. Billing Information

Company's Billing Name (if different from Legal Name):			
Company Billing Address (if different from above):		Contact Name:	
City:		State:	Zip:
Email:	Fax:	Phone:	Ext:

If more than one location is to be billed, please complete Commission Set-Up Form B 0214 CSUF.

TPA (if applicable, requires Home Office approval):			
TPA Billing Address (if different from above):		TPA Contact Name:	
City:		State:	Zip:
Email:	Fax:	Phone:	Ext:

Payroll Deduction Frequency: ❑ Weekly ❑ Bi-weekly ❑ Semi-monthly ❑ Monthly ❑ Other:_____

Billing Frequency: ❑ 28 Day ❑ Monthly ❑ Other:_____

Payment Method: ❑ Check ❑ Electronic Draft/ACH Invoice Type: ❑ Electronic ❑ Paper ❑ Self-bill

A3. Case Specifics

Effective Date:	Initial Enrollment Period: (max 30 days unless approved by Home Office) Start Date_____ End Date_____	Date Deduction Starts:
Number of eligible employees:	Employee Eligibility Requirements: Minimum Hours per Week _____ Eligibility Waiting Period: ❑ 30 Days ❑ 60 Days ❑ 90 Days ❑ Other:_____	

Is this case being enrolled through an electronic enrollment platform? ❑ Yes ❑ No If "Yes": _____
Platform name

Estimated date for receipt of electronic file _____

Census attached? ❑ Yes ❑ No (A census may be required to verify enrollment eligibility)

How are refunds to be handled? ❑ Credit to Account ❑ Issue to Account
❑ Issue to the employee (post-tax plans only) ❑ Mail to the account and make payable to the employee

List of States Enrolling _____

State of Incorporation _____ Are products to be included in ERISA plan? ❑ Yes ❑ No

PART A - EMPLOYER INFORMATION, continued

A4. Payroll Deduction Agreement - Employer/Company

The undersigned employer and/or authorized representative: 1) understands and represents to the best of their knowledge and belief that the statements made in this Application, and the Part B supplemental forms attached, are true and complete; and, 2) further agrees by payment of the required premium, if approved for coverage, to the following:

I. The employer will: a) provide direct access by our authorized agents and/or enrollers to the company's employees in a suitable location on company property during company hours to conduct the enrollment; b) make the insurance coverage available to all Eligible Employees and their eligible Dependents and to distribute information and documents to employees as needed to facilitate such coverage; c) maintain records and furnish to Bankers Fidelity any information required in connection with the administration of the insurance coverage, including applications or enrollment forms for new hires or persons with qualifying events; and, d) provide notice of applicable continuation rights, if any, to eligible employees and dependents.

2. The employer will deduct premiums as necessary from the wages of participating employees and remit them to Bankers Fidelity. The Employer understands that failure to remit premiums may result in delay of claim payments or termination of insurance for participating employees and their dependents in accordance with the terms of the Policy(ies). The employer shall maintain records of all premiums deducted from its employees' wages while this agreement remains in force and for two years thereafter. These records shall always remain open to inspection and audit by the insurer during normal business hours and for two years after the agreement has been terminated.

3. All employees applying for coverage are: a) employees of the employer; b) receive salary or wages documented on state and/or federal payroll reports; c) work full-time; and, d) meet any other eligibility requirements for coverage.

4. This Payroll Deduction Agreement may be terminated by either party upon at least 60 days written notice.

IMPORTANT NOTICE, PLEASE READ None of the products offered are comprehensive or major medical insurance and do not take the place of such insurance. They are limited benefit indemnity-only policies. These products do not meet the requirements for "Minimum Essential Coverage" under the Affordable Care Act (ACA). The Employer agrees that it will inform and educate all current and future employees about the Minimum Essential Coverage requirements under the ACA.

WARNING: 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 may be committing a fraudulent insurance act, which is a crime and could subject such person to criminal and civil penalties.

Authorized Employer Signature: _____ Date Signed: _____

Title: _____

A5. Producer Information

Broker of Record Name (First, Last):	Commission:	Split %	Advance:	Producer #(s):
	❑ Heaped ❑ Levelized		❑ Yes ❑ No	
Additional Producer (if any):			❑ Yes ❑ No	

If more than two producers, complete Commission Set-Up Form B 0214 CSUF.

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance products in detail; and (d) to the best of my knowledge and belief the proposed Employer is financially sound.

Broker of Record Signature: _____ Date Signed: _____

HOME OFFICE USE ONLY

HOME OFFICE REMARKS AND CONFIRMATION	Date Received:
Date Approval Letter sent:	Occupation Class(es):
Census Received: ❑ Yes ❑ No	Industry Class(es):
Remarks:	
Approved by:	Date: