Health Net
Life Insurance Company

APPLICATION FOR GROUP TERM LIFE INSURANCE POLICY

❑ New Group
❑ Revision to existing HNL Group

Please prepare and sign the original of this form and return it with the membership enrollment forms.

APPLICATION					
LEGAL NAME OF POLICYHOLDER		NAMES OF ❑ AFFILIATES OR ❑ SUBSIDIARIES TO BE INCLUDED			
POLICYHOLDERMAILING ADDRES S		STREET ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP
PHONE # ( )	TYPE OF BUSINESS	SICCODE	EFFECTIVE DATE		

Application is hereby made for: **A HEALTH NET LIFE INSURANCE COMPANY GROUP POLICY**
The provisions ot which will be made available to ali eligible employees, as detined below, and their eligible dependents desiring coverage thereunder.
1, in the event this application is accepted, the Applicant , agree to make authorized payroll deductions, it any, tor such eligible employees who enroll under the Policy and to torward such amounts in advance ot the due date to Health Net Lite Insurance Company together with reports necessary to maintain accurate and complete membership records.
Furthermore, the applicant agrees to comply with the policy regulations pertaining to membership requirements , additions to, and deletions from the group.

EMPLOYEE DATA	TOTAL EMPLOYEES	TOTAL ELIGIBLE EMPLOYEES	TOTAL INELIGIBLE EMPLOYEES
ELIGIBLE CATEGORIES*	* Employees must be actively at work on the ettective date ot coverage to be considered eligible. Are all eligible employees presently actively employed? ❑ Yes ❑ No. It no, attach a list ot names and explanations.		
	❑ REGULAR ❑ FULL TIME, WORKING 30 HOURS OR MORE PER WEEK ❑ OTHER _____		
EMPLOYER CONTRIBUTION	EMPLOYEE BASIC LIFE COVER AGE _____%	DEPENDENT COVER AGE _____%	** Emplayer must pay at least 25% af ali premiums far basic life insurance.
SERVICE AGREEMENT	The enrollment date tor newly eligible employees will be the tirst day tollowing _____days ot re gular, tull-time employment. (Coverage will be ettective on the enrollment date.)		

Does this policy replace an existing policy? ❑ Yes ❑ No **It yes, list carrier _____ effective date _____**

LIFE & AD&D BENEFITS

CLASS	FLAT AMOUNT	SALARY BASED
1._____	❑ $ _____ or	❑ _____ x salary
2._____	❑ $ _____ or	❑ _____ x salary
3._____	❑ $ _____ or	❑ _____ x salary
4._____	❑ $ _____ or	❑ _____ x salary
5._____	❑ $ _____ or	❑ _____ x salary

Mínimum Benetit $ _____ Maximum Benetit $ _____

For salary-based benefits, round to:

❑ Next Higher $ _____ Nearest $_____

❑ Next Lower $ _____ Other $_____

❑ This benefit will be reduced to 65% at age 65 and 50% at age 70 and will termínate upon retirement.

❑ This benefit will be reduced to_____ % at age _____ and_____ % at age
This benefit will termínate at the earlier of age _____or retirement.

SUPPLEMENTAL LIFE

❑ YES ❑ NO

❑ Flat Amount $ _____ Mínimum Benefit $_____

❑ Multiple ot Salary _____x salary Maximum Benetit$ _____

❑ Increments ot $ _____

❑ This benefit will be reduced to_____% al age _____and _____ % al age
This benefit will termínate al the earlier ot age _____ or retirement.

SUPPLEMENTAL AD&D ***

❑ YES ❑ NO

❑ Same as Supplemental Lite

❑ Other (describe) _____

*** Supplemental AD&D is only available it supplemental lite has been selected.

DEPENDENT BENEFITS

❑ YES ❑ NO

Spouse/Domestic Partner $ _____

Child (6 months to_____, or _____if full-time student) $ _____

Child (live birth to 6 months) $ _____

RATES****

Basic Lite _____/ $1,000

Basic AD&D _____/ $1,000

Dependen! Lite _____/ Family unit

Supplemental Lite _____/ $1,000

Supplemental AD&D _____/ $1,000

**** It age-banded, please attach rate table.

GENERAL CONDITIONS:
1. This is an application only.
2. Issuance ot a Group Policy is subject to review and approval by Health Net Lite Insurance Company.
3. The insurance will be ettective on !he above ettective date it:
   • The application is accepted and approved by Health Net Lite Insurance Company.
   • At least 75% ot eligibles have enrolled (tor contributory) .
   • All eligibles have enrolled (for non-contribut ory).

DATED	POLICYHOLDER SIGNATUR E	PREMIUM DEPOSIT
This _____ day of ____, 20 _____	X	$ _____
PRINT NAME, TITLE		LICENSED AGENT

INTERNAL USE ONLY				
ENROLLMENT	COVERAGE EFFECTIVE DATE	COVERAGE CODE	SIGNATURE	DATE