



Group Life Insurance Disclosure Form

Group Name _____

Address (street address only) _____

City _____ State _____ Zip Code _____

1.) Will this group have any of the following coverages through Perico Life Insurance Company?

Life _____ Yes ___ No _____ AD&D _____ Yes ___ No

Dep. Life _____ Yes ___ No _____ Other Life _____ Yes ___ No

2.) Rate per \$1000 per Unit per Month is:
 _____ Life _____ AD&D _____ Dependent _____ Other

3.) What is the Employer's (not employee's) percent of contribution for these coverages?
 _____ Life _____ AD&D _____ Dependent _____ Other

4.) Number of hours per week employee must work to be eligible for this life coverage:
 _____ Hours

5.) Classes of Employees to be covered (please give a brief description):

Description	Amount
1. _____	_____
2. _____	_____
3. _____	_____

6.) Classes of Full time Employees to be excluded (please indicate if none)

7.) What is the waiting period for coverage _____ Days/Months (circle one):

8.) Future Full Time Employees shall become eligible (check one):
 _____ on the first of the month following completion of the Waiting Period.
 _____ on the day following completion of the Waiting Period.
 _____ Other _____

9.) Present Full Time employee shall become eligible when: _____

10.) What will be the reduction schedule?
 _____ as shown in the quote
 _____ Other _____

11.) Is anyone currently disabled or not actively at work? ___ Yes ___ No
If so, please tell us who, when and why they are _____

12.) Is anyone currently receiving waiver of premium benefits? ___ Yes ___ No
If so, please tell us who, when and why they are _____

Authorized Person Signature _____
Authorized Person (Please Print) _____