



### 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)** \_\_\_\_\_