NIPPON LIFE INSURANCE COMPANY OF AMERICA

521 Fifth Avenue
New York, New York 10175

Preliminary Application for Group Insurance

Application is made to the Insurance Company above for a Group Contract of insurance.

Group Name (Name as should appear on the Certificate)

Mailing Address

Street Address (Do not use a P.O. Box)

City State Zip Code

(_____)_____(_____)_____
Phone Number Fax Number

_____
Nature of Business Tax Identification Number SIC Code

1. Based on current payroll, how many employees are there in each of the following category?

	Employed*	Enrolled For Insurance
a. Full-time (30 hours or more per week)	_____	_____
b. Part-time (less than 30 hours per week)	_____	_____
c. Seasonal (less than 11 months per year)	_____	_____
d. Totally Disabled (unable to work)	_____	_____
e. Total Employees (a+b+c+d)	_____	_____

* COMPANY DIRECTORS TO BE COVERED, MUST BE ACTIVE, FULL-TIME EMPLOYEES. CONSULTANTS ARE NOT CONSIDERED TO BE FULL-TIME EMPLOYEES.

2. Indicate the number of dependent unit(s) for each of the following category.

	Number of Units
a. Eligible	_____
b. Covered by Other Insurance	_____
c. Total Waiving Coverage	_____
d. Total Covered Dependents	_____

3. Are there any full-time employees not covered by the Employer's current group insurance plan?
[ ]Yes [ ]No. If yes, please explain?
_____

4. Indicate the coverage requested and employer's contribution toward the monthly premiums or premium equivalent for such coverage:

Coverage	Employee	Dependents
[ ] Medical	_____%	_____%
[ ] Dental	_____%	_____%
[ ] Vision	_____%	_____%
[ ] 24hr. Coverage	_____%	_____%
[ ] Employee Life and AD&D	_____%	
[ ] Long Term Disability	_____%	
[ ] Dependent Life		_____%

5. Eligibility Period / Waiting Period (1 Month Minimum):

   Large Groups - (1 Month Minimum):
   [ ] One Month [ ] Two Months [ ] Three Months [ ] Six Months [ ] One Year
   [ ] Other:_____

   Small Groups – 3 Month or 90 Day Maximum)

   Effective date of coverage will be the 1st Day of the Month coinciding with or next following the fulfillment of the Eligibility Period/Waiting Period, Change of Status or Reinstatement. Termination of Coverage will occur on the last day of the month in which termination of eligibility occurs.

6. Are any of the Employer's present or former employees or their dependents currently being insured under COBRA, a State Mandate Continuation or a State Uninsurability Pool? [ ]Yes [ ]No. If yes, please supply the following information and a copy of their election form:

Name	Qualifying Event	Qualifying Date	Type of Continuation

7. Are any retired employees or their dependents now covered by the Employer's medical plan? [ ]Yes [ ]No. If yes, please list their names:
   _____

8. Does the Employer's insurer offer HMO coverage in addition to the medical coverage listed in this request? [ ]Yes [ ]No. If yes, list each HMO, the number covered in each, and the open enrollment period.
   _____

9. During the last 12 months, have any covered employees, retirees, COBRA participants and/or any covered dependents been treated for medical conditions or incurred medical charges that have or eventually could exceed $5,000? [ ]Yes [ ]No. If "YES" please complete the following:

Full Name	Age	Date Diagnosed	Diagnosis or Condition	Amount of Charges	Anticipated Charges	Current Prognosis

10. Please provide list of all persons who are not actively at work and all dependents who are disabled or hospitalized and who are currently covered under the Employer's existing group insurance plan and are eligible to apply for coverage under any proposed group insurance plan.

11. Are 30% or more of the eligible employees members of one family either by blood or marriage?
[ ]Yes [ ]No

12. During the last 12 months, has there been an increase or decrease in the number of employees?
[ ]Yes [ ]No. If yes, please explain.
_____
_____

13. During the last 12 months, has the company's turnover rate for employees exceeded 30%? [ ]Yes [ ]No. If yes, please explain.
_____

_____

14. Does the Employer require pre-employment drug screening for illegal drug use prior to hiring an employee? [ ] Yes [ ] No. If yes, please explain your program.

15. With regard to employees and dependents covered under any existing coverage of the Employer, is the Employer aware of any medical condition or diagnosis that might lead to surgery and/or hospitalization within the next 12 months? [ ] Yes [ ] No. If yes, please explain.

_____

_____

This form will be considered part of the application process only and will be superseded by a final application. A copy of this form will be returned to the Employer if a group insurance policy is issued by the Insurance Company.

It is understood that this is a request to provide a quote for group insurance coverage only. The Employer will be required to make application for such group insurance coverage once the Insurance Company has accepted such group and the application is requested by the Administrator for the Insurance Company. It is further understood that group insurance coverage under the Employer's prior carrier will not be terminated until written approval is received from the Administrator for the Insurance Company and an application has been accepted by the Administrator for the Insurance Company.

The undersigned person is an officer of the Employer and, as such, has knowledge of the Employer's day to day operations and its employees, and states that the above representations are based on a thorough investigation and a complete and current review of all employees' records and pertinent documents. Further, all statements made by the applicant are true and complete to the best of his/her knowledge.

The Administrator for the Insurance Company reserves the right to recalculate rates based on final review of the information provided in this preliminary application.

Signature of Employer's Representative	Title	Date

Name of Licensed Resident Agent	Dated at	Date

Name of the Administrator for the Insurance Company	Date