

Underwritten by: Security Life Insurance Company of America
 10901 Red Circle Drive | Minnetonka, Minnesota | 55343
 800.233.0307



Brought to you by: Minnesota Benefit Association
 6701 Upper Afton Road | Woodbury, Minnesota | 55125
 800.360.6117

Township Group Insurance Application				
Township Name			Contact	
Address			Nature of Business: <i>Township</i>	
City		State	Zip	Type of Business: <i>Other</i>
Telephone Number		Fax Number		Email Address
Effective Date Requested _____, 1, 20____		Initial Probationary Period: NONE for current officers / Future officers 1 st of the month following initial eligibility		
DENTAL <input type="checkbox"/> Voluntary <input type="checkbox"/> Township Funded		VISION <input type="checkbox"/> Voluntary <input type="checkbox"/> Township Funded		
Township agrees to contribute: <ul style="list-style-type: none"> • Officer \$_____ or _____ % • Officer + One \$_____ or _____ % • Officer + Child(ren) \$_____ or _____ % • Officer + Family \$_____ or _____ % 		Township agrees to contribute: <ul style="list-style-type: none"> • Officer \$_____ or _____ % • Officer + One \$_____ or _____ % • Officer + Child(ren) \$_____ or _____ % • Officer + Family \$_____ or _____ % 		
There are initially ____ officers of which ____ will be enrolled in this plan.		There are initially ____ officers of which ____ will be enrolled in this plan.		
<p>The undersigned Township officer hereby requests to insure eligible persons under Group Dental Policy GH-1112 and Group Vision Policy GH-1154 (policyholder may be a trustee group policyholder in some states) insured by Security Life Insurance Company of America, Minnetonka, MN and hereby accepts and agrees to be bound by the terms and conditions as now in effect or hereafter may be modified.</p> <p>It is agreed that the policy will become effective at rates to be determined by us, provided the application is accepted by us. The applicant declares that to the best of its knowledge and belief that statements and answers are complete and true.</p> <p>If accepted, the Township agrees: to make such benefits available to all present officers and all officers becoming eligible in the future. The Township further agrees that participation requirements must be met before the benefit plan can be made effective. The Township agrees that not less than two (2) non-related officers of the Township's eligible officers must be enrolled in the Dental and/or Vision Plan to prevent cancellation of coverage. This plan does not require any contribution from the Township. The Township requests that benefits be made available to all officers subject to the following condition: no coverage for any officer shall take effect until this Application and the officer's individual enrollment forms are accepted by the Company and the initial premium is paid.</p>				
Important Fraud Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.				
_____		_____		
Authorized Signature		Date		
Submit Application to: (be sure to include the officer applications and Payment Authorization Form along with this Township Application)				
MAIL Minnesota Benefit Association 6701 Upper Afton Road Woodbury, Minnesota 55125		FAX 651-739-3265	EMAIL info@MinnesotaBenefitAssociation.org	
For Agent use only				
Agent Statement: I hereby certify that all the information contained in this Group Insurance Application is correct to the best of my knowledge and I know nothing unfavorable about this entity or any individual proposed for participation. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the entity.				
Agent/Agency Name			Phone #	
Street Address		City	State	Zip
Email		SS#/TIN#		
Security Life Agent Authorization #		Signature		