

SERFF Tracking Number: SLIA-128120040 State: Arkansas
Filing Company: Security Life Insurance Company of America State Tracking Number:
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Variable STD Addendum
Project Name/Number: STDADDENDUM.2011/

Filing at a Glance

Company: Security Life Insurance Company of America

Product Name: Variable STD Addendum SERFF Tr Num: SLIA-128120040 State: Arkansas
TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved State Tr Num:
Sub-TOI: H11G.002 Short Term Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Donna Lambert
Author: Stacy Patacsil Disposition Date: 02/28/2012
Date Submitted: 02/28/2012 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date: 03/28/2012
State Filing Description:

General Information

Project Name: STDADDENDUM.2011 Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 02/28/2012 Deemer Date:
State Status Changed: 02/28/2012 Submitted By: Stacy Patacsil
Created By: Stacy Patacsil
Corresponding Filing Tracking Number:
Filing Description:

Attached for your review and approval is a Variable Short Term Disability Application, which will be used when Employer Groups apply for STD Coverage. This is a new form that does not replace any existing form. This STD Application will be used in conjunction with Group Application, GROUPAPP.2011, which was approved on 2/13/12 - SLIA-128088504.

Please note that all bracketed text is intended to be variable and will be customized based on the product being offered. A Statement of Variability has been attached to explain all variable text.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

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Filing Contact Information

Stacy Patacsil, spatacsil@securitylife.com
 1808 Colonial Village Lane 800-233-0307 [Phone] 5718 [Ext]
 Suite 102
 Lancaster, PA 17601

Filing Company Information

Security Life Insurance Company of America CoCode: 68721 State of Domicile: Minnesota
 10901 Red Circle Drive Group Code: 492 Company Type: Life, Accident &
 Health
 Minnetonka, MN 55343-9137 Group Name: State ID Number:
 (952) 544-2121 ext. 3589[Phone] FEIN Number: 41-0808596

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Security Life Insurance Company of America	\$50.00	02/28/2012	56701418

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	02/28/2012	02/28/2012

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Disposition

Disposition Date: 02/28/2012

Implementation Date: 03/28/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	STD Addendum	Approved	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	STDADDE	Application/	STD Addendum	Initial		0.000	STDADDEND
02/28/2012	NDUM.201	Enrollment					UM.2011.pdf
	1	Form					

Security Life Insurance Company of America
Short Term Disability Insurance Addendum – [Product Description, i.e. - 2-9,10+, Voluntary]

Group Information	
Name of Employer:	Requested Effective Date:
Number of Eligible Employees:	Number of Employees Enrolling:
Do you currently have Group Short Term Disability Insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes Current Carrier: <small>(If yes, attach a copy of the certificate and the latest billing statement.)</small>	
[Will this coverage applied for replace the current coverage, if any? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>If "No," provide explanation:] </small>	
W-2 preparation for Third Party Sick Pay Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Tax ID # is required:	

Coverage Information	
[Class A]	[Class B]
[Class Description:]	[Class Description:]
[Weekly Work Hours Required for Eligibility:] [_____] <small>[(min. 30 hours)]</small>	[Weekly Work Hours Required for Eligibility: _____] <small>[(min. 30 hours)]</small>
[Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Amount EMPLOYEE Contributes: [_____]% If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis]	[Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Amount EMPLOYEE Contributes: [_____]% If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis]
[Employee premiums are paid on a : <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis]	[Employee premiums are paid on a : <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis]
[Eligibility Waiting Period:] [minimum 30 days] <input type="checkbox"/> [_____] [days from date of hire] <input type="checkbox"/> [First of month following [_____] days from date of hire]	[Eligibility Waiting Period:] [minimum 30 days] <input type="checkbox"/> [_____] [days from date of hire] <input type="checkbox"/> [First of month following [_____] days from date of hire]

Short Term Disability Insurance Addendum – [Product Description, i.e. - 2-9, 10+, Voluntary]

Plan Information – [for Employer Funded] [and] [Voluntary]
 [(Select One) Plan I Plan II Plan III]

[Class A]	[Class B]
<p>Benefit Amount: <input type="checkbox"/> Percent of weekly earnings[*]: <input type="checkbox"/> [____%] to a maximum of [\$____] per week] <input type="checkbox"/> Flat Amount: [\$____] [to a maximum of \$____] [not to exceed 66²/₃% of weekly earnings]</p> <p>[*excludes commissions, bonuses, overtime and other extra compensation]</p> <p>[Frequency of Benefit Payments: <input type="checkbox"/> Weekly] <input type="checkbox"/> Bi-weekly] <input type="checkbox"/> Monthly]</p> <p>[Weekly Earnings Definition:] <input type="checkbox"/> Base Weekly Earnings] <input type="checkbox"/> Base Weekly Earnings plus averaged commissions] <input type="checkbox"/> Other _____]</p> <p>[Elimination Period: (benefits begin on)] [Injury: Day _____] [Illness: Day _____]</p> <p>[1st Day Hospital Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included]</p> <p>[Benefit Duration:] [<input type="checkbox"/> 13 weeks] [<input type="checkbox"/> 26 weeks] <input type="checkbox"/> Other _____]</p>	<p>Benefit Amount: <input type="checkbox"/> Percent of weekly earnings[*]: <input type="checkbox"/> [____%] to a maximum of [\$____] per week] <input type="checkbox"/> Flat Amount: [\$____] [to a maximum of \$____] [not to exceed 66²/₃% of weekly earnings]</p> <p>[*excludes commissions, bonuses, overtime and other extra compensation]</p> <p>[Frequency of Benefit Payments: <input type="checkbox"/> Weekly] <input type="checkbox"/> Bi-weekly] <input type="checkbox"/> Monthly]</p> <p>[Weekly Earnings Definition:] <input type="checkbox"/> Base Weekly Earnings] <input type="checkbox"/> Base Weekly Earnings plus averaged commissions] <input type="checkbox"/> Other _____]</p> <p>[Elimination Period: (benefits begin on)] [Injury: Day _____] [Illness: Day _____]</p> <p>[1st Day Hospital Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included]</p> <p>[Benefit Duration:] [<input type="checkbox"/> 13 weeks] [<input type="checkbox"/> 26 weeks] <input type="checkbox"/> Other _____]</p>

[Pre-Existing Condition Limitation:] [Not Included] [Included for all] [Late Enrollees Only]
 New Hires Only] [Late Enrollees/New Hires Only]
 Included][[(3/12 Employer Funded) (12/12 Voluntary)]

[Additional Benefit Options:]

[Recovery Expense Benefit] Included] Not Included]

[Accidental Dismemberment and Loss of Sight Benefit] [Included] Not Included]

[Survivor Benefit] Included] Not Included]

[Work Incentive Benefit] Included] Not Included]

Short Term Disability Insurance Addendum – [Product Description, i.e. - 2-9, 10+, Voluntary]

Actively at Work — Employee Information

Are there any employees who, on the date this application is signed, have been out of work for at least 5 consecutive working days? Yes No

If Yes, give details below.

Name of Employee	Last Day Worked	Describe Nature of Injury/Illness or Other Reason for Absence

If more space is needed, attach a separate sheet signed and dated by the Applicant.

[To the best of the employer's knowledge, during the past 12 months, has any employee incurred medical expenses that exceeded \$10,000? Yes No

If Yes, give details below.

Name of Employee	Approximate Amount of Medical Expenses Incurred	Describe Nature of Injury/Illness

If more space is needed, attach a separate sheet signed and dated by the Applicant.]

Declaration

To the best of my knowledge and belief, all the statements and answers given in this addendum are true and complete.

_____ **Signature of Officer or Owner**

_____ **Date**

Submit this Addendum with the Group Application and copy of corresponding Quote Summary to Security Life Insurance Company of America.

Home Office Use:

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved	02/28/2012
Bypass Reason:	Not applicable to this Application filing.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	02/28/2012
Comments:	STDADDENDUM.2011 will be used in conjunction with the attached Group Application.		
Attachment:	GROUPAPP.2011.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved	02/28/2012
Comments:			
Attachment:	STD Addendum SOV.pdf		



SECURITYLIFE

INSURANCE COMPANY OF AMERICA

[Marketing Name] GROUP APPLICATION

PLEASE PRINT CLEARLY

General Information		
Employer's Full Legal Name (exactly as it will appear in the Contract): _____		
Coverages Requested (complete and attach an addendum for each coverage selected): <input type="checkbox"/> Term Life <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Business is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other _____		
State of Incorporation: _____		
Tax ID Number:	Years in Business:	
Nature of Business:	SIC Code:	
[For groups with 2 to 9 eligible employees: Is this a home based business? <input type="checkbox"/> Yes <input type="checkbox"/> No]	[For groups with 2 to 9 eligible employees: Are 90% or more of the employees <input type="checkbox"/> Yes <input type="checkbox"/> No in the same family?]	
Complete Street Address: Street _____ City _____ State _____ Zip _____ County _____		
Complete Mailing Address (if different): Street _____ City _____ State _____ Zip _____ County _____		
Contact Person:	Title:	
Email:	Telephone Number:	Fax Number:
Who should receive the initial Certificates and Administration Materials? <input type="checkbox"/> Employer— <i>Email required:</i> _____ <input type="checkbox"/> Producing Agent		
Type of Bill Requested: <input type="checkbox"/> List Bill <input type="checkbox"/> Self-Administered (Not available to groups <100 lives or groups applying for Dental or Vision)]		
Billing Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly] (Not available for Dental or Vision)]		
Easy-Pay Method (electronic transfer of premium): <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, then Form# [EZPAY2008] must be completed.		

Subsidiaries to be Included

Subsidiaries or Other Business Locations to be covered: No Yes; if Yes, complete the following:

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

Subsidiary Name: _____

Complete Street Address: _____

Nature of Business:

Same Other _____

Number of employees _____

[FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF ARKANSAS, LOUISIANA AND WEST VIRGINIA

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.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit, if false information materially related to a claim was provided by the applicant.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF NEW MEXICO

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 civil fines and criminal penalties.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OHIO

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF OREGON AND TEXAS

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of fraud.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF TENNESSEE, VIRGINIA, AND WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

[FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VERMONT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.]

Declarations

APPLICANT'S DECLARATION

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of Security Life Insurance Company of America; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

Signature of Officer or Owner

Print Name of Officer or Owner

Date

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, its employees, the dependents of these employees, or any continued persons that is not fully stated in this application.

Signature of Agent

Print Name of Agent

Date

Address:

Telephone #:

License #:

Email:

HOME OFFICE USE:

STD Addendum – Statement of Variability

Section	Language	Variability
Title	Product Description, i.e. 2-9, 10+, Voluntary	Space available to Describe the type of Short Term Disability Insurance being offered
Group Information	Will this coverage applied for replace the current coverage, if any? <input type="checkbox"/> No <input type="checkbox"/> Yes If “No,” provide explanation:	Question included when the Addendum is being used for small groups
Coverage Information	Class A, Class B	Included if there are more than one class of employees
	Class Description	Space available to describe different classes of employees
	Weekly Work Hours Required for Eligibility	Included if there is a minimum number of work hours required for eligibility
	Blank space or 15-40	Blank space is included if the Employer has an option. Number of hours between 15-40 will be inserted if there is a required amount of hours
	(min. 30 hours)	Included if there is a required minimum
	<input type="checkbox"/> Employer Funded <input type="checkbox"/> Voluntary	Optional to be included or not included, based on product being offered
	Does Employee Contribute? <input type="checkbox"/> Yes <input type="checkbox"/> No If “Yes,” Amount EMPLOYEE Contributes: _____ % If employee contributes, premiums are paid on: <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	Question included if Employer has the option to choose if an employee contributes.
	Blank space or 0-100%	Blank space is included if the Employer has an option to choose how much an employee contributes. Percentage between 0-100 will be inserted if there is a required percentage
	Employee premiums are paid on a : <input type="checkbox"/> Pre-tax basis <input type="checkbox"/> After-tax basis	Optional to be included or not included
	Eligibility Waiting Period:	Optional to be included or not included
	minimum 30 days	Included if there is a required minimum
	<input type="checkbox"/> _____ days from date of hire	Eligibility Waiting Period Option Blank space included if the Employer has an option to choose how many days from date of hire, or a day range of 0-365 days will be automatically included.
	<input type="checkbox"/> First of month following _____ days from date of hire	Eligibility Waiting Period Option Blank space included if the Employer has

		an option to choose how many days, or a day range of 0-365 days will be automatically included.
Plan Information	for Employer Funded and Voluntary	Options included depending on whether the plan is Employer Funded, Voluntary or both
	(Select One) Plan I <input type="checkbox"/> Plan II <input type="checkbox"/> Plan III <input type="checkbox"/>	Included if there are different plan options available
	Class A/Class B	Optional to include or not include if there are separate plans offered for different Classes
	Plan # (If Selected)	Included if there are different plan options available
	Benefit Amount: <input type="checkbox"/> Percent of weekly earnings*: <input type="checkbox"/> _____% to a maximum of \$_____ per week	Benefit Option included if offered. Variable phrases included as needed to explain the Benefit Amount Option offered. Percent 1-100% Dollar Amount - \$50 - \$3000
	<input type="checkbox"/> Flat Amount: \$ _____ to a maximum of \$ _____ not to exceed $[66\frac{2}{3}]$ % of weekly earnings	Benefit Option included if offered. Variable phrases included as needed to explain the Benefit Amount Option offered. Dollar Amount - \$50 - \$1500 Percentage Amount - 50 - 75 %
	*excludes commissions, bonuses, overtime and other extra compensation	Included with Percent of weekly earnings option
	Frequency of Benefit Payments: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly	Frequency of Benefit Payment options, one or more options can be included.
	Weekly Earnings Definition: <input type="checkbox"/> Base Weekly Earnings <input type="checkbox"/> Base Weekly Earnings plus averaged commissions <input type="checkbox"/> Other _____	Weekly Earnings Definition options, one or more options can be included
	Elimination Period: (benefits begin on)	Optional to be included or not included
	Injury: Day _____	Optional to be included or not included Day range - 0 - 60
	Illness: Day ____	Optional to be included or not included Day range - 0 - 60
	1 st Day Hospital Benefit: <input type="checkbox"/> Included <input type="checkbox"/> Not Included	Optional to be included or not included
	Benefit Duration:	Optional to be included or not included
	<input type="checkbox"/> 13 weeks <input type="checkbox"/> 26 weeks	Benefit Duration options available to be included

	<input type="checkbox"/> Other	
	Pre-Existing Condition Limitation:	Included if there is a Pre-Existing Condition Limitation
	<input type="checkbox"/> Not Included <input type="checkbox"/> Included for all <input type="checkbox"/> Late Enrollees Only <input type="checkbox"/> New Hires Only <input type="checkbox"/> Late Enrollees/New Hires Only <input type="checkbox"/> Included][([3/12] Employer Funded) ([12/12] Voluntary)	Available selections that can be included for the Pre-Existing Condition Limitation Employer Funded/Voluntary optional to include Month range 6 – 24
	Additional Benefit Options:	Included if there are additional benefits offered
	Recovery Expense Benefit	Included if this benefit is offered
	<input type="checkbox"/> Included <input type="checkbox"/> Not Included	If the option is automatically included, 'Included' will be stated. If the employer has an option, both 'Included' and 'Not Included' will be stated.
	Accidental Dismemberment and Loss of Sight Benefit	Included if this benefit is offered
	<input type="checkbox"/> Included <input type="checkbox"/> Not Included	If the option is automatically included, 'Included' will be stated. If the employer has an option, both 'Included' and 'Not Included' will be stated.
	Survivor Benefit	Included if this benefit is offered
	<input type="checkbox"/> Included <input type="checkbox"/> Not Included	If the option is automatically included, 'Included' will be stated. If the employer has an option, both 'Included' and 'Not Included' will be stated.
	Work Incentive Benefit	Included if this benefit is offered
	<input type="checkbox"/> Included <input type="checkbox"/> Not Included	If the option is automatically included, 'Included' will be stated. If the employer has an option, both 'Included' and 'Not Included' will be stated.
	<p>To the best of the employer's knowledge, during the past 12 months, has any employee incurred medical expenses that exceeded \$10,000? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, give details below.</p> <p>Name of Employee/Approximate Amount of Medical Expenses Incurred/Describe Nature of Injury/Illness</p> <p>If more space is needed, attach a separate sheet signed and dated by the Applicant.</p>	Question included when the Addendum is being used for small groups