APPLICATION FOR GROUP SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

Gulf Guaranty Life Insurance Company, Inc.
4785 I 55 North, Suite 200, Jackson, MS 39206

HOME OFFICE USE ONLY

Group Number: _____

MedPlus (check one): **MMA** ◉ **Non MMA** ○

Legal Name of Employer (include d/b/a):	Employer Identification Number:
Principal Business or Activity	SIC Code

Physical Address: (Street Number and Name)	Billing Address:
City	City
State Zip	State Zip

Management Contact:	Billing Contact:
Title:	Title:
Telephone:	Telephone:
Email Address:	Email Address:
Fax Number:	Fax Number:

Employer's Major Medical Primary Plan Data

Major Medical Plan Carrier _____ Renewal Date _____

Deductible $_____ Out of Pocket Max $_____ Coinsurance %_____ Rx Deductible $_____

No. of Eligible Employees _____ No. of Covered Employees _____

Employer Contribution Percentage: Employee _____% Dependent Tiers _____%

Eligibility

"Eligible Person," as used in the Policy, means a person who is insured under the Group Major Medical Plan issued to the Employer (CHAMPUS/ TRICARE, Medicaid or limited medical plans are not comprehensive medical plans) and who is:
[An active full time employee working [30 hours or more per week]. Employees who are not covered under the Employer's Other Medical Plan are not eligible under this Plan].

Each insured will be eligible to elect Dependent coverage on the later of the following dates:
1. The day the insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first Dependent.

The first premium must be paid before any coverage is effective. Coverage will terminate with regard to any insured who is no longer an Eligible Person in accordance with the "Termination of Coverage" provision of the Policy.

{Important Note: All persons (100 % participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be covered if the Employer Contributes to the premium.}

MedPlus Plan Selection

Deductible (circle requested option): **$100** **$250** **$500** **$750** **$1000** **$1,500** **$2,000** **$2,500** $100

Coinsurance: **Primary Plan Matching** _____**%** **or** ☐ **100%**

Physician Office Benefit Rider: **Yes** ○ **No** ○

Inpatient / Outpatient Benefit: **$**_____ **Requested Effective Date:** _____

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