

NOTICE AND CONSENT TO EMPLOYERS APPLICATION FOR LIFE INSURANCE

NAME AND ADDRESS OF CARRIER:

1. EMPLOYEE (PROPOSED INSURED) INFORMATION

Full Name (First, Middle, Last. Include maiden name in parentheses.)		Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth MM/DD/CCYY	Social Security Number
Street Address	City	State	Zip Code	
Occupation				

2. EMPLOYER (OWNER) INFORMATION

Full Legal Name			
Street Address	City	State	Zip Code

3. NOTICE BY EMPLOYER (OWNER)

- Employer intends to apply for insurance on the life of the Employee (Proposed Insured).
- The maximum face amount the Employee (Proposed Insured) could be insured for at the time the contract is issued is \$_____.
- The Employer will be the Owner of any policy issued and a beneficiary of any proceeds payable upon the Employee's (Proposed Insured's) death.

4. CONSENT OF EMPLOYEE (PROPOSED INSURED)

- I consent to being an insured under the life insurance policy for which my Employer intends to apply.
- I consent to my Employer continuing coverage, after my employment ends, under any policy issued.
- I understand that my Employer will own the policy. Unless provided in a separate agreement, my Employer will receive all of the death proceeds, and my personal representative, next of kin, and heirs at law will have no beneficial interest in the policy or its death proceeds.

AGREEMENT AND AUTHORIZATION

This form is provided as a convenience to the Employer and to obtain information that may be needed for information reporting services. By providing this form, the carrier makes no representation that completing it will constitute compliance with any law or regulation, tax or otherwise. Federal tax law specifies that the death benefits of certain employer-owned life insurance contracts will not be completely excluded from federal gross income of the Employer unless notice-and-consent requirements and other requirements specified in the law are fulfilled.

The carrier and its representatives and distributors do not provide tax or legal advice. The carrier did not accept this form for use by any taxpayer to avoid any Internal Revenue Service penalty. You should ask your independent tax and legal advisors for advice based on your particular situation.

A photocopy of this form shall be as valid as the original.

Signature of Employee (Proposed Insured)

Date

Signature of Employer (Owner)

Date

Title