

**APPLICATION TO  
PRESIDENTIAL LIFE INSURANCE COMPANY  
Nyack, New York  
FOR  
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE**

Application is hereby made to the Presidential Life Insurance Company ("Company") for Excess Loss Insurance. This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1. Full Legal Name of Applicant: \_\_\_\_\_
2. Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
3. If employee benefit plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies.  
\_\_\_\_\_
4. Enter the full name of your Employee Benefit Plan(s) - (A copy of such Employee Benefit Plan(s) must be attached.)  
\_\_\_\_\_
5. Name and address of Designated Third Party Administrator:  
\_\_\_\_\_
6. Effective Date: \_\_\_\_\_
7. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month):  
\_\_\_\_\_ Singles and \_\_\_\_\_ Families (or) \_\_\_\_\_ Composite
8. **GENERAL SCHEDULE OPTIONS:**
  - (a) Contract Period: \_\_\_\_\_ to \_\_\_\_\_
  - (b) Disabled Persons [ ] are [ ] are not covered.  
Retired Employees [ ] are [ ] are not covered.
  - (c) Aggregate Benefit [ ] Yes [ ] No

Aggregate Contract Basis: Employee Benefit Plan Expenses must be:

Incurred from \_\_\_\_\_ through \_\_\_\_\_, and  
Paid from \_\_\_\_\_ through \_\_\_\_\_,  
Claims Incurred prior to the Contract Effective Date are limited to \$ \_\_\_\_\_



**11. IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT:**

- (a) All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within thirty (30) days of the requested Effective Date.
- (b) If the Schedule shows disabled persons are not covered, no benefits will be paid under the Contract for expenses Incurred or Paid under the Employee Benefit Plan for a disabled person until:
  - (1) if an employee, he or she returns to active, full-time employment for at least one (1) full working day; or
  - (2) if a dependent or Continuation Beneficiary, he or she is able to perform the normal functions of a person of like sex and age.
- (c) Issuance of the Contract is in reliance upon the information provided by the Applicant or its Agent. Should subsequent information become known which, if known prior to issuance of the Contract, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Applicant.
- (d) The Contract, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.
- (e) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Presidential Life Insurance Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.
- (f) If a Contract is issued and later rescinded, the sum of all benefits paid will be deducted from the sum of all premiums paid. If the result is positive, such amount will be paid by the Company to the Applicant. If the result is negative, such amount will be paid by the Applicant to the Company.
- (g) The initial premium will be paid on or before the Effective Date, and subsequent premiums are due no later than the first day of each calendar month during the Contract Period.
- (h) Applicant acknowledges that the Contract which is the subject of this Application is a reimbursement Contract. Applicant must first pay claims before submitting them for reimbursement.
- (i) Oral Statements not expressly incorporated herein are not part of this Contract. Only the President or Executive Officer of the Company may make changes to the Contract Form or Addenda on behalf of the Company. All changes to this Contract must be in writing and attached to this Contract.
- (j) **NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.**

**12. IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT: (Continued)**

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

**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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_.

Witness: \_\_\_\_\_ Applicant:  
Signature of Licensed Resident Agent Tax ID #:

By: \_\_\_\_\_

Title: \_\_\_\_\_

Licensed Resident Agent: \_\_\_\_\_  
(Type or Print)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security or Tax ID #

**ACCEPTANCE**

Accepted on behalf of the Company, this \_\_\_\_\_ day of \_\_\_\_\_.

By: \_\_\_\_\_

Title: \_\_\_\_\_

Contract No.: \_\_\_\_\_ Effective Date: \_\_\_\_\_