

***SOUTHWEST SERVICE LIFE INSURANCE COMPANY*** does not issue group health and accident policies nor does it offer health insurance plans as a Small Employer Health Benefit Plan under the provisions of Chapter 26 of the Insurance Code. For that reason it is necessary to complete the following form:

## **EMPLOYER INSURANCE DISCLAIMER**

You have applied for an insurance policy with the Southwest Service Life Insurance Company ("Company"). Please understand that:

- (1) The policy is an individual limited policy and not a group, blanket, franchise or Small Employer type coverage, even though your employer may be remitting a premium on your behalf to the Company. Benefits are limited, as shown in your Outline of Coverage.
- (2) The Company assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. In particular, the policy provides no benefits for normal pregnancy and delivery and/or coverage for any individual, newborn, fetus or otherwise that was not extended coverage at the time the policy was originally issued and is subject to Company underwriting in (3) below. The Company also assumes no responsibility for compliance with any State Small Employer Health Insurance Law.
- (3) The policy is not guaranteed issue and will be fully underwritten by the Company. This may result in the exclusion from coverage of certain family members (if applicable), and/or health conditions. Southwest Service assumes no responsibility for the collection of premiums and/or the failure of same to be remitted on a timely basis.
- (4) I further acknowledge that the policy Benefits - Limitations & Exclusions has been explained to me individually and that an Outline of Coverage which explains the coverage which I have applied for has been left with me for my examination.
- (5) If my employer is remitting the premium to the Company, I understand any policy issued on my behalf is on the premium paying mode requested by me. In the event the employer ceases to remit the required premium, for any reason, the policy coverage will terminate at such date and any further coverage after such date of termination of premium payment will become null and void.

Because this is an individual limited benefit policy, I understand I may continue the policy if I personally desire to remit the premium required by the Company within the grace period provided in the policy.

I also understand that it is my personal obligation and responsibility to notify the Company in writing of my desire to arrange for the proper premium to be paid within the time period allowed. If such election is made after expiration of the grace period, the policy is subject to reinstatement review by the Company and coverage may or may not be allowed to remain in force. Any failure to request the privilege for this continuation of coverage will result in the policy being null and void. I understand the Company assumes no responsibility for notifying me that my employer has elected and/or is not remitting a premium on my behalf.

I hereby acknowledge my full understanding of the contents of this disclaimer

Applicant: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_