

SFL EPIC WELFARE BENEFIT PLAN AND TRUST

P.O. Box 82248 • Lincoln, Nebraska 68501-2248 • Telephone: (800) 378-4307 • FAX: (402) 434-9634

PARTICIPATION AGREEMENT

New Revision Requested Participation or Revision Date _____

Employer _____

Address _____
Street City State Zip

Phone () _____ FAX () _____ Employer Tax ID# _____

Type of Entity: C Corporation S Corporation LLC PC Other _____

Date Business Started _____ Number of Employees _____ Number Eligible _____

Death Benefit: (Select Multiple of W-2 Compensation *or* Class I amount)

Multiple of W-2 Compensation: 2 x 3 x 4 x 5 x 7.5 x 10 x

OR; Class I amount: \$500,000 \$1,000,000 \$2,000,000 \$4,000,000

Description of work related duties and responsibilities:

Class I	(for example, Senior Officers)	_____	= Class I amount
Class II	(for example, Junior Officers)	_____	= 40% of Class I amount
Class III	(for example, Managers)	_____	= 16% of Class I amount
Class IV	All Others	_____	= 10% of Class I amount

The Employer understands and agrees that:

- This agreement does not become final unless and until the employer is accepted as a Participating Employer.
- This agreement shall not cause insurance coverage to become effective on any person. For coverage to take effect:
 - The employer must be accepted as a Participating Employer,
 - The employer and each employee must be approved by Security Financial Life Insurance Co., and
 - Each employee must satisfy the eligibility requirements of the Plan document and Master Policy.
- The Plan Administrator and Trustee recommend that the employer obtain independent tax advice regarding the tax consequences of participating in this Plan and Trust prior to such participation.
- All of the terms, conditions and limitations of the SFL EPIC Welfare Benefit Plan and Trust will apply.
- The Plan Administrator is authorized to disclose to the Internal Revenue Service, without limitation of any kind, every aspect of the Plan and the Participating Employers' participation in the Plan.

I have read and understand this agreement and the information provided above is complete and true.

Signed at _____ Date _____
City State

By _____ Title _____
Duly Authorized Official of Entity

Agent _____ Date _____

ACCEPTANCE:

This Participation Agreement is accepted.

By _____ Participation or Revision Date _____
Plan Administrator

Agreement Number _____