

EMPLOYER PARTICIPATION
AGREEMENT/APPLICATION



CASE

EMPLOYER INFORMATION (Please Print)

Business Name _____
Contact At Firm _____ Telephone () _____
First Name Last Name
Business Address _____ Mailing Address _____

(If Different) _____
City, State, Zip _____
Nature of Business _____

PARTICIPATION

Current number of full-time employees _____ Requested effective date ____/____/____ 1st or 15th /____
Number of employees applying for medical _____ Number of Applicants on (MO) (DAY) (YR)
(minimum of 50% medical participation required) State/Federal Continuation _____
Percent of Employer's Contribution: _____ During the preceding year did you employ 20 or more
Employee _____ Dependent _____ employees (full or part time) on a typical business day?
 Yes No

COVERAGE

MedicaPlan: Yes No

If yes, select:

Deductibles (choose 1 within each row):

- Annual: \$100 \$250 \$500 \$1,000
- Inpatient: \$0 \$500 \$1,000
- Annual Prescription Drug: \$0 \$100

Rate of Payment: 50/50 80/20 90/10

Stop Loss Limit: \$2,500 \$5,000 \$10,000

OPTIONS:

\$300 Accident Medical Expense: Yes No

Maternity Coverage: Yes No

PPO: No PPO

Hospital Only PPO

Hospital & Physician PPO

Hospital & Physician PPO with MD co-pay

\$10 \$25

Additional Coverage Options:

Dental Plan Yes No

- If yes, select:
- Plan A (80/80/0%)
 - Plan B (80/80/50%)
 - Plan C (100/80/50%)

Deductible: \$35 \$75

Orthodontic

Benefit: Yes No

(available to groups of 10 or more under Plans B & C only)

Disability Coverage Yes No

If yes, select: 26 weeks (8/8/26)

52 weeks (15/15/52)

New Employees Waiting Period: effective 1st day of the month after: 0 30 60
 90 120 180
 365 days of employment.

Please mail certificates for new employees to Business Agent

Group Replacement: Does this plan replace other group coverage? If yes, submit copy of last billing and benefit booklet.

Medical Plan

No Yes: List effective date of prior group plan _____

Disability Plan: No Yes

Dental Plan: No Yes

Worker Compensation Coverage in force? Yes No

Name of Workers Compensation Carrier: _____

SIGNATURE REQUIRED ON REVERSE SIDE

AGREEMENT

The employer adopts the Trust Agreement and agrees to be bound by all the terms and conditions of it and any amendments to it. The employer and all persons insured agree to be bound by the relative terms and conditions of the Group Policy(ies). The Trust Agreement, any other written instrument, and the Group Policy(ies) are available for inspection by any person insured through or under this Trust by contacting Fortis Insurance Company.

It is understood and agreed that no agent has the authority to alter or amend the Trust Policy(ies) or bind Fortis Insurance Company by making any promise or representation. It is understood that no insurance will become effective without the written approval of Fortis Insurance Company.

The Employer understands that only full-time employees and their dependents are eligible for coverage. It is agreed that the employer will pay at least the required premium for the employees. It is further agreed that eligibility, participation requirements, and pre-existing condition limitations, if any, have been discussed with the agent and have been explained to the employees.

The employer may withdraw from the Trust upon 30 days prior written notice to Fortis Insurance Company and subject to the rules of the Trust. Failure to pay premium when due will constitute such withdrawal. Withdrawal ends all insurance coverage and benefits.

The employer agrees that all of the information shown above and on the attached pages is correct and complete. It is understood that Fortis Insurance Company intends to rely on this information in determining whether or not the insurance is to be issued.

I, the undersigned, with authority to represent and bind the employer, do make application to participate in the trust.

OWNER'S SIGNATURE _____ PRINT NAME _____

Date: _____ Dated At: _____ Title: _____

AGENT'S STATEMENT

I certify that all of the information contained in the Employer Agreement and any attached papers is correct to the best of my knowledge. I know nothing unfavorable about this firm or any individual proposed for insurance. I have complied with all of the underwriting rules and have explained the coverage fully.

Agent's Signature _____ Agent # _____ Date _____

Print Agent's Name _____ Phone No. () _____

Agent's Address _____

AGENCY INFORMATION

NAME #
NUMBER