

<b>HOME OFFICE USE ONLY</b> Group Number: _____
-------------------------------------------------

**Instructions for completing this agreement:**

- 1) The employer or employer representative and agent must sign and date this agreement.
- 2) A signed copy of the proposal/quote must accompany this submission.
- 3) The first month's premium made payable to Assurant Health must accompany this submission.

Requested Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **(Must be 1st or 15th)**

**SECTION A – EMPLOYER INFORMATION**

1. Company Name: \_\_\_\_\_  
*Full Legal Name of Company*
2. Street Address: \_\_\_\_\_      Mailing Address: \_\_\_\_\_  
*(if different)*
3. City, State, Zip: \_\_\_\_\_
4. Phone Number: (\_\_\_\_) \_\_\_\_\_      Fax Number: (\_\_\_\_) \_\_\_\_\_
5. Contact Person and Title: \_\_\_\_\_
6. E-mail Address: \_\_\_\_\_
7. Owner(s) Name(s): \_\_\_\_\_
8. Nature of business/articles sold, manufactured, or service rendered: \_\_\_\_\_
9. Type of Ownership/Filing Status:     Proprietorship     Partnership     C-Corporation     S-Corporation  
 For Profit     Non-Profit     Government Agency/Entity  
 Other (specify) \_\_\_\_\_
10. Federal Tax Identification Number: \_\_\_\_\_    How long has this company been in business? \_\_\_\_\_
11. Does your company have more than one Federal Tax Identification Number or associated business organizations (i.e., parent-subsidiary, brother-sister relationships, affiliated groups, etc.)? .....  Yes  No
12. Does your business have more than one physical location? .....  Yes  No  
If "Yes," to either of the above, complete the following. Write the number of Full-time and Part-time employees whether they are enrolling or not.

Location #1	Address	Nature of Business	Business Relationship	Tax ID #	# PT	# FT
Location #2	Address	Nature of Business	Business Relationship	Tax ID #	# PT	# FT
Location #3	Address	Nature of Business	Business Relationship	Tax ID #	# PT	# FT

13. Waiting/Affiliation Period (*the length of time future employees must be employed before becoming eligible for insurance*):  
 0 days     30 days     60 days     90 days     180 days
14. Are you waiving the waiting/affiliation period for all employees enrolling for the group's original effective date? .....  Yes  No

The waiting/affiliation period cannot be changed more than once every 12 months. If you do not select a waiting/affiliation period, a 30-day waiting/affiliation period will automatically be selected for your group.

**Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.**

**SECTION B – PRIOR COVERAGE INFORMATION**

1. Will this plan replace other group coverage?.....  Yes  No  
 If "Yes," how many group medical/dental insurance carriers have you had coverage with over the last 24 months? \_\_\_\_\_  
 If "Yes," please provide 12 months of information below and attach a copy of the most recent billing for both medical and dental.

<u>Prior Medical Carrier(s)</u>	<u>Policy Number</u>	<u>Effective Date</u> (MM/DD/YYYY)	<u>Termination Date</u> (MM/DD/YYYY)	<u>Major Medical Plan?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	
_____	_____	_____	_____	<u>Orthodontics?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Prior Dental Carrier</u>	<u>Policy Number</u>	<u>Effective Date</u> (MM/DD/YYYY)	<u>Termination Date</u> (MM/DD/YYYY)	<u>Major Services?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	

2. Will you be or are you offering another group plan in addition to this group plan? .....  Yes  No  
 If "Yes," please provide carrier and effective date: \_\_\_\_\_

**SECTION C – WORKERS’ COMPENSATION INFORMATION**

Name of Workers’ Compensation Carrier: \_\_\_\_\_

Policy and Phone Number: \_\_\_\_\_

- Do you provide Workers’ Compensation for all employees? .....  Yes  No  
 If "No," list employees not covered.

<u>Name</u>	<u>Title (Owner, Partner, Officer, etc.)</u>	<u>Reason Not Covered</u>
_____	_____	_____
_____	_____	_____

**SECTION D – AGREEMENT**

The participating employer hereby applies for participation under the Trust sponsored by Time Insurance Company and agrees to be bound by all the terms and conditions of the Group Policy issued to the Trustee policyholder. The participating employer acknowledges that the Trust Agreement and the Group Policy are available for inspection by any person insured through or under the Trust by contacting Time Insurance Company. The participating employer understands that the benefits selected are reflected on the attached signed proposal which is part of this request for participation.

I have read the group plans brochure, any applicable Supplements, and the dental plans brochure, and understand the coverages they describe.

I hereby represent as the participating employer or the person acting with the authority of the participating employer, that this information is complete and true to the best of my knowledge and belief. **The participating employer fully understands that no insurance will become effective without the approval of Time Insurance Company and that any material falsification or omission may nullify coverage for employees and dependents.** It is further understood that no agent has the authority to alter or amend either the Trust Agreement or the Group Policy, to adjust any claim for benefits, or to bind Time Insurance Company by making any promise or representation.

The coverages applied for provide benefits for an employee welfare benefit plan established and maintained by the employer under the Employee Retirement Income Security Act (ERISA), unless the plan is specifically exempt from the terms of ERISA. For purposes of this agreement, the participating employer acknowledges and accepts full and complete responsibility for the operation, administration, and maintenance of the insurance plan in a prudent and diligent manner in the interest of the plan participants and beneficiaries. Unless this plan is specifically exempted, the participating employer also agrees to comply with the fiduciary, reporting, and filing requirements of ERISA and to act in accordance with the duties and obligations set forth under ERISA, this agreement and any other applicable state or federal laws or regulations. The participating employer agrees to be solely responsible for compliance with the laws, including the payment of any required benefits that are not covered by this insurance plan.

It is further understood and agreed that: (1) benefits under the Group Policy and the cost of providing those benefits may change; (2) renewal rates will be based on several factors which will include, but will not be limited to the projected future claims experience of the participating employer group, except where prohibited by law; (3) those subject to evidence of eligibility must receive prior approval by Time Insurance Company at its home office before coverage becomes effective; (4) no insurance will become effective until the first full premium has been paid; (5) the cancelled check tendered as the first premium will be a receipt for deposit; (6) the Group Policy may be discontinued by Time Insurance Company under certain circumstances identified in the Group Policy and Certificates of Coverage; (7) only full-time employees and their dependents are eligible; (8) **I must enroll all eligible employees now and in the future according to the participation rules of Time Insurance Company and that insurance may be terminated if the percentage falls below the participation requirements;** (9) Time Insurance Company reserves the right to request a state wage and tax statement or other documentation at any time to verify current and future participation and eligibility; (10) I also understand that rates are subject to change until all of the following have occurred: (a) the group insurance contract has been approved by Time Insurance Company; (b) notice of effective date has been furnished by Time Insurance Company; and (c) the first premium for insurance provided under the plan is paid; (11) The benefits under the Group Policy will terminate under certain conditions, as set forth in the Group Policy and/or Certificates of Insurance, and I understand that the failure to pay premiums in a timely manner will result in termination of the group coverage. I understand that I must give notice to Time Insurance Company within 30 days of any participating employee who ceases working the established eligible hours as defined on this application, including, but not limited to those on paid or unpaid leave, disability, salary continuation or worker’s compensation.

Time Insurance Company relies on group and individual information as disclosed on the enrollment materials to set premium rates for the entire group. Therefore, any incomplete or untruthful information may result in insurance coverage being voided or an adjustment to the rates may be required if information is found to be inaccurate.

Any person who, with intent to defraud or knowing that they are facilitating against Time Insurance Company in submitting an enrollment form or claim containing a false or deceptive statement, may be guilty of insurance fraud as specified by any applicable State law.

**SECTION E – ELIGIBILITY**

All eligible full-time employees, including those in the new employee waiting/affiliation period, must submit an Enrollment Form or a Waiver of Coverage Form. If additional employees are hired between the date this application is completed and the date coverage is issued, completed Enrollment Forms or Waiver of Coverage Forms must be submitted within 5 days of date of hire.

Total number of employees (including owners, partners, etc.) working in your business? \_\_\_\_\_

How many are full-time employees? \_\_\_\_\_ How many are part-time employees? \_\_\_\_\_

Are any former employees or dependents on or eligible to elect continuation (COBRA or other)? .....  Yes  No

If "Yes," provide the following information.

Name	Start Date	End Date	Type of Continuation	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are any employees currently absent due to illness or injury, family medical leave, or receiving disability benefits? .....  Yes  No

If "Yes," give names and details. \_\_\_\_\_

**ELIGIBLE EMPLOYEES**

The Employer has the right to establish eligibility requirements for the group by selecting 17.5 or 30 hours for an employee to be considered eligible for coverage. If the employer does not request different requirements, eligibility will be administered based on the following: an eligible employee is any person who performs services on a full-time basis (defined as at least 30 hours per week) and is considered an employee for federal employment tax purposes, at any of the employer's business establishments.

A partner, proprietor or corporate officer of the employer is eligible if he/she performs services for the employer on a full-time basis (defined as at least 30 hours per week), at any of the employer's business establishments.

The term "Employee" does not include: a) retirees or employees who are not expected to perform any duties, responsibilities or services for the employer; or b) "part-time" employees; or c) any "seasonal" or "temporary" employees who work only part of the calendar year on the basis of natural or suitable times or circumstances.

If electing 17.5 hours for an employee to be considered eligible for coverage, please check this box.

**List all eligible employees below, as defined above, whether or not enrolling**

Employee Name	E = Enrolling W = Waiving	Employee Name	E = Enrolling W = Waiving
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

*If additional space is needed, attach another sheet of paper.*

I certify that all employees currently working for me are compensated in a manner that complies with all applicable federal and state minimum wage requirements.

I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish eligibility and participation are met at all times while coverage is provided by Time Insurance Company (i.e. Wage & Tax Form, Payroll Records, Business License, etc.).

I understand that providing incomplete, inaccurate or untimely information may void or terminate any individual or group coverage.

By signing below, I certify that I have read the Employer Participation Agreement/Application, agree to all terms and conditions contained therein and that all information provided is true and accurate.

Signature of Employer \_\_\_\_\_ Title \_\_\_\_\_

Print Name of Employer \_\_\_\_\_ Date \_\_\_\_\_

**SECTION F – AGENT CHECKLIST**

- Fully completed, signed and dated Employer Participation Agreement/Application
- Fully completed, signed and dated Employee Enrollment Forms, including waivers as needed
- State-specific forms (if required)
- A proposal signed and dated by the employer or employer’s representative
- A business check, made payable to Assurant Health
- Copy of the prior carrier’s most recent list billing statement, if replacing coverage

Time Insurance Company may request that the employer provide documentation (i.e. Wage & Tax Form, Payroll Records, Business License, etc.) during the underwriting process or at any time while coverage is provided by Time Insurance Company to support that eligibility and participation requirements are met.

**SECTION G – AGENT’S STATEMENT**

I certify that all of the information contained in this Employer Participation Agreement/Application and any attached papers is correct to the best of my knowledge. I have complied with all of the underwriting rules and have explained the coverage fully.

Agent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Agent’s Name: \_\_\_\_\_ Agent #: \_\_\_\_\_  
Agent’s Address: \_\_\_\_\_ Agent’s Phone #: (\_\_\_\_\_) \_\_\_\_\_  
Agent’s City, State, Zip: \_\_\_\_\_ Agent’s Fax #: (\_\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**SECTION H – DISTRIBUTION PARTNER’S INFORMATION (Complete all applicable fields)**

Office Name: \_\_\_\_\_ Office #: \_\_\_\_\_ DA #: \_\_\_\_\_  
Representative Name: \_\_\_\_\_ Representative #: \_\_\_\_\_  
Representative Phone #: (\_\_\_\_\_) \_\_\_\_\_ Representative Fax #: (\_\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**SECTION I – SPECIAL MAILING INSTRUCTION**

If no address is indicated below, the group kit will be mailed according to the distribution partner’s policy.

Mail New Business Kits to: \_\_\_\_\_  
At Address Specified: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Mail future certificates to: \_\_\_\_\_  
At Address Specified: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_