Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employer's Subscription Agreement

Administered by:

CORPORATE BENEFIT SERVICES OF AMERICA, INC.
400 Highway 169 South, Suite 800
Minneapolis, Minnesota 55426-1141

Medical, Dental and Disability Insurance Underwritten by:
Unified Life Insurance Company
Overland Park, Kansas

Life and AD&D Insurance Underwritten by:
Jefferson Pilot Financial Ins. Company
Omaha, Nebraska

PLEASE COMPLETE ENTIRE APPLICATION USING INK.

❑ New Group ❑ Change to Existing Group Group Number _____
(Please complete Section One and any other sections applicable to your requested change.)

Requested Effective Date _____ **Important**—coverage will not become effective until we notify you in writing.

1 General Information

Employer's Legal Name _____

Billing Address _____
City *State* *Zip*

Mailing Address _____
City *State* *Zip*

Telephone Number ( ) _____ FAX Number ( ) _____

Name/Title of Contact Person _____ Email Address _____

Business Type ❑ Sole Proprietorship ❑ Partnership ❑ Corporation ❑ Other

Federal Tax ID Number _____ Nature of Business _____

2 Eligibility

Total number of employees on payroll _____ Minimum number of hours worked per week for full-time eligibility _____

Total number of permanent full-time eligible employees _____
(Please include a copy of your most recent quarterly wage and tax statement)

Employer will: ❑ Pay entire cost
❑ Share cost with insureds: _____ % of employee cost (25% minimum); _____ % of dependent cost

Probationary period for new employees – the first of the month following: ❑ Full-time hire date ❑ 30 days
❑ 60 days ❑ 90 days ❑ Other ___

Are there new full-time employees that are currently in their probationary period? ❑ Yes ❑ No
If yes, list employee(s) name below and submit an employee application

_____

3 Continuation/ Disability

A. Are any former employees and/or dependents eligible for medical coverage through COBRA? ❑ Yes ❑ No
If yes, please identify and provide a copy of a signed acceptance and completed application or rejection form.
(Include those in 60-day election period)

_____

B. To the best of your knowledge, are any employees or dependents proposed for coverage, disabled, unable to work, or not at work because of a current or approaching hospital confinement, leave of absence, or are otherwise incapacitated? ❑ Yes ❑ No

If yes please provide the person's name/status _____

4 About Your Current Plan

A. Are you replacing existing group insurance? ❑ Yes ❑ No Name of Current Insurance Carrier _____

Effective Date of Existing Coverage _____ Reason for Changing Carriers _____

If coverage was terminated, who terminated it? ❑ Employer ❑ Carrier Termination Date _____

B. Are all employees, including owners, partners and officers, covered by Workers' Compensation? ❑ Yes ❑ No

If no, list names of employees not covered _____

5 Benefit Plan Selection

Product applied for: ❑ Bravo ❑ CBSA 50/50 ❑ Common Sense ❑ Core ❑ _____

Preferred Provider Plan	Name of Network	Prescription	Office Visit
❑ 90/70% ❑ 80/60% ❑ Other _____		❑ Option1 ❑ Option2 ❑ Other _____	❑ Option1 ❑ Option2 ❑ Other _____

In-Network Coinsurance Limit
❑ $5,000 ❑ $10,000 ❑ Other _____

Mental Health - paid as any other illness *(optional for groups of 2-50)* ❑ Yes ❑ No

Major Medical Deductible	Maternity *(Optional for groups of 2-14)*	Weekly Disability Income	24-hour Coverage	Dental
❑ $250 ❑ $300 ❑ $500 ❑ $1,000 ❑ $2,000 ❑ Other _____	❑ Yes ❑ No	❑ Yes ❑ No Amount _____	❑ Yes ❑ No	❑ Yes ❑ No ❑ Plan 1 (Ortho) ❑ Plan 2 (No Ortho)

Employee Life Insurance *(Optional in some states)* ❑ Yes ❑ No

Dependent Life ❑ Yes ❑ No

❑ Flat Amount		❑ Earnings Schedule		❑ Class Schedule	
$ _____	**OR**	❑ 1x Earnings ❑ 2x Earnings ❑ 3x Earnings	**OR**	$25,000 $15,000	Class 1 Class 2

6 Premium and Disclosure

$ _____ is included with this application to be applied toward the premium when and if coverage is issued. The premium must be paid by the premium due date.

Medical, dental and disability coverages are guaranteed renewable. However, your coverage could be canceled if the Insurer terminates all policies for this group class, or if you • Fail to pay your premium • Engage in fraud or misrepresentation • Breach your contract • Fail to meet minimum contribution or participation requirements • Become ineligible as a group due to a) ceasing active business operations, b) losing status of legal entity, or c) moving the business to a state where this type of policy is not offered by the Insurer.

The Insurer or the Administrator may investigate the information on this application. Any findings may be used to deny coverage for one or more employees of the group or the entire group. Please indicate the name, title, and telephone number of an employee in your firm who can provide necessary clarification of the employee and group information provided on this application.

Name _____ Position _____ Telephone Number _____

7 Employer Certification

I hereby confirm that the preceding information is accurate to the best of my knowledge and belief. I understand that the underwriting of these applications is predicated upon the answers to the questions contained therein, and where there have been material misrepresentations of facts, coverage can be rescinded, a retroactive adjustment of premium may be made or coverage may not be renewed. I further agree to and understand the right of the Insurer or the Administrator to inspect payroll and personnel records which may have a bearing on or be the basis for any insurance coverage requested, placed in force or maintained.

The undersigned hereby subscribes to, adopts, and agrees to be bound by all the terms and conditions of the Declaration of Trust known as the National Health Care Trust for the industry into which the undersigned appropriately falls, as determined by the Insurer. It is understood and agreed by the undersigned that the Trustee is not an Insurer, nor does it have any obligation under any policy of insurance and that all claims for and benefits provided by insurance being applied for herein shall be made to and payable by the Insurer issuing group policy(ies) to the Trustee, but only to the extent provided in and in strict accordance with the provisions of such policy(ies). It is also understood and agreed that the Trustee, Administrator or the Insurer does not assume the employer's responsibilities for compliance with the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

If approved, the employer understands and agrees that the Trustee, Administrator and the Insurer, jointly or severally, are not now and shall not become under the Trust Agreement an administrator or fiduciary for any purpose whatsoever under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, or any other law. In addition, the employer understands and agrees the employer is solely responsible and fully liable for carrying out any duty and/or obligation to the extent such duty and/or obligation is created, required or imposed by ERISA, as amended, or any other law, with respect to the employer or the employer's employees and dependents under any certificate issued under such group policy or policies. By purchasing this coverage, an employer is establishing an Employee Welfare Plan, and may therefore be subject to compliance with ERISA.

I understand that only the Insurer or its authorized Administrator can approve this application and set an effective date. I understand that the employee and dependent contribution and participation requirements must be met and maintained for coverage to be in effect. I further understand that this plan may contain a pre-existing condition limitation and pre-certification requirement which have been explained to me. I understand that the agent represents myself, not the Insurer.

Employer's Signature _____ Title _____

Date _____
Month *Day* *Year*

8 Agent Certification

I hereby certify • I asked all questions and accurately and fully recorded all information given by the applicant • I advised the applicant not to terminate existing coverage unless, and until, the Administrator notifies him/her, in writing, that this application has been approved • I used only advertising approved by the Insurer to solicit this application, I told the applicant nothing inconsistent with the approved advertising about the benefits/coverage(s) • I didn't guarantee the Insurer's approval of the application or issuance of coverage(s) • I didn't tell the applicant that the Insurer will cover any pre-existing condition(s) • I made no false, misleading, or deceptive statements and complied with all applicable insurance laws, underwriting requirements, and the market/sales standards maintained by the Insurer.

I understand that I'm liable for my acts and omissions to the extent provided by law, I understand I have no authority to alter this application, bind the Insurer by making promises and/or representations, or to waive or change the terms, conditions, and/or provisions of the policy(ies) or any requirement imposed by the Insurer. I understand I represent the employer, not the Insurer.

Signature of Writing Agent _____ Date _____
Month *Day* *Year*

Agent's Social Security Number _____

New Group Enrollment materials should include the following information:

✓ Employer's Subscription Agreement

✓ An Employee Application for each eligible employee

✓ A check for the first month's premium, made payable to CBSA

✓ Quote

✓ A copy of the group's most recent Quarterly Wage and Tax Report (Account for any employee that appears on the statement but did not enroll for coverage)

✓ A copy of the most recent prior carrier's bill (Account for any employee that appears on the bill but did not enroll for coverage)

✓ Each employee's effective date of coverage with the prior carrier for pre-existing credit

✓ Copies of HIPAA Certificates of Creditable Coverage for those employees/dependents who had health insurance with a carrier other than through the employer's plan

Medical, Dental and Disability Insurance
Underwritten by
Unified Life Insurance Company
Overland Park, Kansas

Life and AD&D Insurance
Underwritten by
Jefferson Pilot Financial Ins. Company
Omaha, Nebraska

Administered by

CORPORATE BENEFIT SERVICES OF AMERICA, INC.
400 Highway 169 South, Suite 800 ■ Minneapolis, MN 55426-1141
(952) 541-0444 ■ Toll Free (888) 969-4605 ■ www.cbsainc.com

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