



# EMPLOYER APPLICATION AND REQUEST FOR PARTICIPATION IN TRUST

**WARNING:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance or health care fraud under state and/or federal law.

To speed the processing of your application, please be sure to include the following items:

- A copy of the most recent bill from your current carrier.
- A copy of your most recent employment services statement.
- A deposit check for the first month's premium.
- All completed Employee Applications.

If you need assistance in completing this form, please call Medical Benefits Mutual at (740) 522-8425 or 1-800-423-3151 and ask for the Underwriting Department.

Complete all blanks below in full. Where an item does not apply, indicate "N/A".

## PART I - EMPLOYER INFORMATION

Employer's legal name: \_\_\_\_\_

Doing business as (if different from above): \_\_\_\_\_

Business address:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing address (if different):

Post office box or street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name and title of correspondent: \_\_\_\_\_

Telephone number: \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Number of years in business \_\_\_\_\_

Type of Business:  Corporation  Proprietorship  
 Partnership  Other \_\_\_\_\_

SIC Code: \_\_\_\_\_ Industry: \_\_\_\_\_ Federal Tax ID Number: \_\_\_\_\_

Branch offices, subsidiaries or affiliates to be included under coverage (list each by name): \_\_\_\_\_

Are any of the above entities part of a controlled group of corporations or otherwise considered under common control with the employer making application?  Yes  No If "No," list the entities which are not under common control or part of the control group: \_\_\_\_\_

Current carrier:

Name: \_\_\_\_\_

Account name: \_\_\_\_\_

Number of years with this carrier: \_\_\_\_\_ Number of carriers in past 5 years: \_\_\_\_\_

Has your company ever been declined for group insurance?  Yes  No

If "Yes," when and why were you declined? \_\_\_\_\_

Requested effective date of coverage: \_\_\_\_\_

1975 Tamarack Road • Newark, OH 43055 • phone (800) 423-3151 • fax (740) 522-5002

**PART II - EMPLOYEE INFORMATION**

Eligible employees are those individuals who meet the following criteria: 1) are active, full-time employees working at least 30 hours per week (25 hours for Ohio small employer groups) on a regular basis; and 2) are "employees" of the employer for federal tax purposes. Groups with 25 or more covered employees may modify this definition with **approval** from Medical Benefits Mutual. If your group has more than 25 covered employees, and you wish to modify the hours, please indicate the hours required: \_\_\_\_\_

Total number of Eligible Employees, including part-time employees, but excluding temporary or seasonal employees: \_\_\_\_\_

How many are not enrolling? \_\_\_\_\_

How many persons are on COBRA? (include a copy of each election form) \_\_\_\_\_

TEFRA (The Tax Equity and Fiscal Responsibility Act) requires that groups of 20 or more employees offer those active employees age 65 and over the choice between coverage under their employer's plan or coverage under Medicare. (Choice of Medicare coverage waives coverage under the employer's plan.)

Will this plan be subject to TEFRA?  Yes  No *If yes, all employees 65 and older must complete a TEFRA election form.*

**EMPLOYEE EFFECTIVE DATE OF COVERAGE**

Present employees:  Effective on original effective date of group.  Other \_\_\_\_\_

Future employees: *Check the number of days that apply, or complete Option 3.*

Option 1: First of the month following  0  30  60  90\* days of employment.

Option 2:  0  30  60  90 days from date of hire.

Option 3: Other \_\_\_\_\_ (Subject to approval.)

*\*Ohio law prohibits small employer groups from having a waiting period of more than 90 days. Do not select this if your group is an Ohio small employer group.*

**COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR MEDICAL OR DISABILITY COVERAGE**

Are all employees covered by Workers' Compensation?  Yes  No (Coverage may be available for work related injuries for individuals not required to be covered by applicable workers' compensation laws with Medical Benefits Mutual's approval)

Does the employer pay 100% of the premium?  Yes  No (If "Yes," all eligible employees must enroll)

Does the employer contribute at least 50% of the premium?  Yes  No (If "No," contact Medical Benefits Mutual for approval.)

Have any employees, dependents or COBRA participants been diagnosed as having any of the following conditions?

- Claims over \$4,000 in the past 24 months
- Arthritis
- Respiratory conditions
- Severe burns
- Kidney, liver or digestive disorders
- Head or spinal cord injuries
- AIDS, AIDS related complex, HIV positive
- Existing pregnancies
- Stroke
- Severe infections
- Congenital Abnormalities
- Diabetes
- Cancer
- Cardiovascular disorder
- Multiple trauma
- High risk maternity or infants
- Other \_\_\_\_\_

Please provide details for any conditions marked above: \_\_\_\_\_

**PART III - SPLIT SOLUTION**

*If you wish to enroll in the Split Solution Plan, and your group is qualified, please complete the following section. If you do not wish to enroll in Split Solution, or you are not qualified, you may skip this section and move to Part IV.*

<b>Employer Deductible:</b> Per Person \$ _____ Per Family \$ _____	<b>Monthly Premium:</b>	<b>Unit Rates</b>
<b>Claim Reserve Deposit:</b> \$ _____	Employee	\$ _____
<b>Sleep Tight Aggregate:</b> \$ _____	Employee/Spouse	\$ _____
<b>Maximum Exposure:</b> \$ _____	Employee/Child	\$ _____
	Family	\$ _____



**DENTAL**

70% of all eligible employees must enroll for dental coverage regardless of those who have coverage elsewhere.

Does your group currently have dental coverage?  Yes  No If "Yes," what was the original effective date? \_\_\_\_\_

What is the employer contribution? \_\_\_\_\_% per employee; \_\_\_\_\_% per dependent.

	DEDUCTIBLE	COINSURANCE	MAXIMUM
Class I - Preventive	\$	%	Classes I, II, and III, combined
Class II - Basic	Classes II and III, combined		
Class III - Major	\$	%	\$
Class IV - Orthodontic	\$	%	\$

**PART V - AGENT INFORMATION**

Commission Paid To: \_\_\_\_\_ Agent Number: \_\_\_\_\_ %

Commission Paid To: \_\_\_\_\_ Agent Number: \_\_\_\_\_ %

Contact Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

License Number, SSN or Tax ID Number: \_\_\_\_\_ G.A. \_\_\_\_\_ G.A. Number: \_\_\_\_\_

Are you currently licensed with Medical Benefits Mutual?  Yes  No

**PART VI - EMPLOYER'S REQUEST FOR PARTICIPATION IN TRUST**

*The undersigned employer, engaged primarily in the industry described on Part I, hereby requests that it be approved as a participant in the Trust established by other participating employers for the purpose of purchasing group insurance for the benefit of its employees and requests inclusion as a participant under the Group Insurance Plan(s) issued to the Trustee for the plan(s) of insurance shown in Part IV or in any required Supplement.*

*It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees shall become eligible. Full-time employment is defined in Part II of this application. It is further understood that no agent has power on behalf of Medical Benefits Mutual Life Insurance Co. to make or modify any request or application for insurance or to bind said insurance company by making any promise or representation or by giving or receiving any information.*

*It is also understood that, should this application be accepted by Medical Benefits Mutual, coverage will not be provided under the Group Health Insurance(s) beyond any period for which premium payments have been made for such coverage in accordance with the provisions of the policy or policies governing the Group Health Insurance Plan(s).*

*The employer understands that Medical Benefits Mutual is not assuming contractual responsibility for the distribution of Certificates of Creditable Coverage as required by the Health Insurance Portability and Accountability Act of 1996, and that such employer has specific obligations under this law. Medical Benefits Mutual will be providing such certificates to the employer, but the employer understands that it is responsible for reviewing such certificates for accuracy and ensuring that such certificates are properly sent to any terminating employee or dependent's last known address.*

*The employer declares that he/she/it has read the statements and the answers to the questions and that they are complete and true. The employer understands and agrees that this application is offered to Medical Benefits Mutual Life Insurance Co. as an inducement for the issuance of the insurance applied for, such insurance to be in the amounts agreed upon between said insurance company and the employer. The employer understands that withholding information or providing false statements is grounds for rescission of the group's coverage back to the original effective date.*

*Medical Benefits Mutual may make additions, corrections or deletions to this Employer Application as is deemed necessary in order to expedite processing. All such additions, corrections or deletions shall be identified to the employer in writing through an addendum to this application. The employer will retain the right to challenge any changes made and if any disputes are not resolved, the employer may choose to withdraw its application. The employer will also receive a copy of this modified application. Acceptance of the changes is verified by execution of the addendum.*

*It is further understood that no insurance will be effective until the plan is accepted in writing by Medical Benefits Mutual Life Insurance Co. No contract of insurance is to be implied in any way on the basis of the completion and submission of the specifications shown on this form. In case this application is not accepted, any binding premium advanced by the employer shall be refunded.*

**DATED AT** (Location) : \_\_\_\_\_ **DATE:** \_\_\_\_\_

**EMPLOYER'S LEGAL NAME:** \_\_\_\_\_

**EMPLOYER REPRESENTATIVE'S SIGNATURE:** \_\_\_\_\_ **TITLE:** \_\_\_\_\_

**WITNESSED BY:** \_\_\_\_\_

