



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 \_\_\_\_\_

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to the questions contained therein, and where there have been material misrepresentations of facts, coverage can be rescinded. In such event the sole liability of the Insurer will be a refund of premiums less any claims paid or a retroactive adjustment of premium may be made. 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.

If approved, the employer understands and agrees that the Administrator and the Insurer, jointly or severally, are not now and shall not become 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 participation requirements must be met and maintained for coverage to be in effect. I understand that the agent represents myself, not the Insurer.

Employer's Signature \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_  
*Month Day Year*

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 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 Group Application for Life Insurance
- ✓ Employer's Group Application for Medical Insurance
- ✓ An Employee Application for Life Insurance for each eligible employee
- ✓ An Employee Application for Medical Insurance 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