





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*

Print Name \_\_\_\_\_

Agent's Social Security Number \_\_\_\_\_

We may impose upon a small group a one-time surcharge of up to 25% of the annualized premium in addition to the amount we could otherwise charge under the Utah Insurance Code. The surcharge may be imposed if you change insurance companies on a date other than your plan anniversary. The surcharge will not be imposed if 1) the change in insurance companies occurs on your plan anniversary, 2) your current coverage was terminated because the insurance company elected to discontinue all small employer health plans, or 3) employees from an existing group form a new business.

**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

*Underwritten by*

**Guarantee Trust Life Insurance Company**

1275 Milwaukee Avenue ■ Glenview, Illinois 60025

*Administered by*



**CORPORATE BENEFIT  
SERVICES OF AMERICA, INC.**

*Your Strategic Benefits Partner*

400 Highway 169 South, Suite 800 ■ Minneapolis, MN 55426-1141  
(952) 541-0444 ■ Toll Free (888) 969-4605 ■ [www.cbsainc.com](http://www.cbsainc.com)