

# Employer's Group Application

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:  
**Guarantee Trust Life  
Insurance Company**  
Glenview, Illinois

Life and AD&D  
Insurance Underwritten by:  
**Jefferson Pilot Financial  
Insurance 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 \_\_\_\_\_

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  Full-time hire date  30 days  
– the first of the month following:  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 \_\_\_\_\_



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 \_\_\_\_\_

**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

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