Employer's Subscription Agreement

Administered by:
CBSA
CORPORATE BENEFIT SERVICES OF AMERICA, INC.
Your Strategic Benefits Partner
400 HWY 169 South, Ste. 800
Minneapolis, MN 55428-1141

Insurance Underwritten by:
North Carolina Mutual Life Insurance Company
Durham, North Carolina

PLEASE COMPLETE ENTIRE AGREEMENT 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 state quarterly wage and tax statement report)

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

Waiting 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 waiting period? ☐ Yes ☐ No
If yes, list employee(s) name below and submit an employee application

____

During this initial group enrollment, do you want the waiting period waived so that all enrolling employees are issued with the same effective date? (The waiting period will apply to any new employees that enroll after this initial group enrollment.) ☐ Yes ☐ No

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

5 Benefit Plan Selection

In-Network/Out-of-Network Plan Percentage	Name of Network	Prescription Option No. _______
☐ 90/70% ☐ 80/60% ☐ 90/60% ☐ 80/50% ☐ Other ___________		Office Visit Option No. _______

In-Network Out-of-Pocket Maximum:
☐ $500 ☐ $1,000 ☐ $2,000 ☐ $5,000 ☐ Other ___________

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 ________	Employee ☐Yes ☐No Spouse ☐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 Class 1 $15,000 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 intentional misrepresentation of a material fact • Breach your contract • Fail to meet minimum 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. 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 have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any material misstatements or misrepresentations or failure to report information by my Employees or me may be used for the basis of a retroactive adjustment of premium, rescission or non-renewal of coverage on me, or my Employees. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; or (b) permit me to inaccurately answer any questions. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy or Certificate. 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. FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

The undersigned hereby subscribes to, adopts, and agrees to be bound by all 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).

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 is subject to compliance with ERISA.

The Insurer, in performing its obligations under the Policy, is acting as a fiduciary as prescribed by ERISA. The Administrator, in performing its obligations under the Policy, is acting as a fiduciary as prescribed by ERISA and under the terms and conditions of the Administrative Services Agreement between the Insurer and the Administrator. Neither the Insurer nor the Administrator control funds not yet transmitted by the Plan Sponsor to the Administrator's designated lock box account.

The Employer as the Plan Sponsor grants full and complete discretionary authority to the Insurer and its Administrator to make all decisions concerning the plan and benefits.

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*

Print Name ______________________________

Agent's Social Security Number ______________________________

New Group Enrollment materials should include the following information:

- ☐ **Employer Subscription Agreement** - fully completed
- ☐ **Application for Insurance** for each employee - fully completed. A **Waiver of Insurance** must be completed by every eligible employee who is waiving employee and/or dependent coverage. The Waiver is located within the Application for Insurance.
- ☐ Copy of **Quote with final census**.
- ☐ **Check** for total monthly cost, payable to CBSA and submitted on the employer's company check stock. In the event that premium rates are adjusted during the underwriting process, the employer must remit the additional amount due prior to case issuance. The check(s) will be deposited after the Underwriter has approved coverage.
- ☐ Copy of the employer's most recent filed **State Quarterly Wage and Unemployment Tax Report** which includes the listing of employee names. Account for any employee that appears on the report but did not enroll for coverage.
- ☐ Copy of the **current carrier's monthly billing statement** for the month immediately preceding requested effective date. Account for any employee that appears on the bill but did not enroll for coverage.
- ☐ Give each **employee's effective date** with the current carrier for prior coverage credit. Supply one year's worth of prior insurance information for medical coverage and two year's for dental coverage.
- ☐ Copies of **HIPAA Certificate of Creditable Coverage** for those employees/dependents covered under a plan other than the employer's plan. Supply one year's worth of prior insurance information.
- ☐ For employers electing dental, a copy of the employer's current dental **Schedule of Benefits**.
- ☐ Renewal rates on groups of 26 or more medical lives.
- ☐ Three years of claim experience and renewal rates if group is 50 or more medical lives.

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Durham , North Carolina

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400 Highway 169 South, Suite 800 □ Minneapolis, MN 55426-1141

(952) 541-0444 □ Toll Free (888) 969-4605 □ www.cbsainc.com