



In-Network/Out-of-Network Plan Percentage <input type="checkbox"/> 90/70% <input type="checkbox"/> 80/60% <input type="checkbox"/> 90/60% <input type="checkbox"/> 80/50% <input type="checkbox"/> Other _____	Name of Network _____	Prescription Option No. _____ Office Visit Option No. _____
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In-Network Out-of-Pocket Maximum:  
 \$500     \$1,000     \$2,000     \$5,000     Other \_\_\_\_\_

Major Medical Deductible <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> Other _____	Maternity (Optional for groups of 2-14) <input type="checkbox"/> Yes <input type="checkbox"/> No	Weekly Disability Income <input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____	24-hour Coverage Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Plan 1 (Ortho) <input type="checkbox"/> Plan 2 (No Ortho)
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Employee Life Insurance (Optional in some states)     Yes     No    Dependent Life     Yes     No

<input type="checkbox"/> Flat Amount \$ _____	OR <input type="checkbox"/> Earnings Schedule <input type="checkbox"/> 1x Earnings <input type="checkbox"/> 2x Earnings <input type="checkbox"/> 3x Earnings	OR <input type="checkbox"/> Class Schedule \$25,000    Class 1 \$15,000    Class 2
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\$ \_\_\_\_\_ 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 \_\_\_\_\_

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: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

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.

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

*Administered by*



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*Your Benefits Partner*

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