

Product applied for: Bravo CBSA 50/50 Common Sense Core

Preferred Provider Plan <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 <input type="checkbox"/> Option1 <input type="checkbox"/> Option2 <input type="checkbox"/> Other _____	Office Visit <input type="checkbox"/> Option1 <input type="checkbox"/> Option2 <input type="checkbox"/> Other _____
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In-Network Coinsurance Limit (*Out-of-Network Limits are Shown in Certificate Schedule*)
 \$5,000 \$10,000 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 (<i>Optional for groups of 2-14</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No	Serious Mental Illness (<i>Optional for groups of 2-50</i>) <input type="checkbox"/> Yes <input type="checkbox"/> No	Weekly Disability Income <input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____	24-hour Coverage <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

<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. 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 intentional material misrepresentations of facts, coverage can be rescinded, a retroactive adjustment of premium may be made or coverage may not be renewed. 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.

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

If approved, the employer understands and agrees that the Trustee, Administrator and the Insurer, jointly or severally, are not now and shall not become under the Trust Agreement 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 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

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

Medical, Dental and Disability Insurance
Underwritten by
Unified Life Insurance Company
Overland Park, Kansas

Life and AD&D Insurance
Underwritten by
Jefferson Pilot Financial Ins. Company
Omaha, Nebraska

Administered by



**CORPORATE BENEFIT
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