



MICHIGAN EMPLOYER APPLICATION AND REQUEST FOR PARTICIPATION IN TRUST

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance or health care fraud under state and/or federal law.

To speed the processing of your application, please be sure to include the following items:

- Checkboxes for: A copy of the most recent bill from your current carrier, A copy of your most recent employment services statement, A deposit check for the first month's premium, All completed Employee Applications.

If you need assistance in completing this form, please call Medical Benefits Mutual at (740) 522-8425 or (800) 423-3151 and ask for the Underwriting Department.

Complete all blanks below in full. Where an item does not apply, indicate "N/A".

PART I - EMPLOYER INFORMATION

Employer's legal name: _____

Doing business as (if different from above): _____

Business address:

Street: _____

City: _____ State: _____ Zip Code: _____

Mailing address (if different):

Post office box or street: _____

City: _____ State: _____ Zip Code: _____

Name and title of correspondent: _____

Telephone number: () - _____

Number of years in business _____

Type of Business:

- Checkboxes for: Corporation, Partnership, Proprietorship, Other

SIC Code: _____ Industry: _____ Federal Tax ID Number: _____

Branch offices, subsidiaries or affiliates to be included under coverage (list each by name): _____

Are any of the above entities part of a controlled group of corporations or otherwise considered under common control with the employer making application? Yes No If "No," list the entities which are not under common control or part of the control group: _____

Current carrier:

Name: _____

Account name: _____

Number of years with this carrier: _____ Number of carriers in past 5 years: _____

Has your company ever been declined for group insurance? Yes No

If "Yes," when and why were you declined? _____

Requested effective date of coverage: _____

PART II - EMPLOYEE INFORMATION

Eligible employees are those individuals who meet the following criteria: 1) are active, full-time employees working at least 30 hours per week on a regular basis; and 2) are "employees" of the employer for federal tax purposes. Groups may modify this definition to as low as 17 hours per week with **approval** from Medical Benefits Mutual. If you wish to modify the hours, please indicate the hours required: _____

Total number of Eligible Employees, including part-time employees, but excluding temporary or seasonal employees: _____

How many are not enrolling? _____

How many persons are on COBRA? (Include a copy of each election form) _____

TEFRA (The Tax Equity and Fiscal Responsibility Act) requires that groups of 20 or more employees offer those active employees age 65 and over the choice between coverage under their employer's plan or coverage under Medicare. (Choice of Medicare coverage waives coverage under the employer's plan.)

Will this plan be subject to TEFRA? Yes No *If "Yes", all employees 65 and older must complete a TEFRA election form.*

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Present employees: Effective on original effective date of group. Other _____

Future employees: *Check the number of days that apply, or complete Option 3.*

Option 1: First of the month following 0 30 60 90 days of employment.

Option 2: 0 30 60 90 days from date of hire.

Option 3: Other _____ (Subject to approval.)

COMPLETE THIS SECTION ONLY IF YOU ARE APPLYING FOR MEDICAL OR DISABILITY COVERAGE

Are all employees covered by Workers' Compensation? Yes No *(Coverage may be available for work related injuries for individuals not required to be covered by applicable workers' compensation laws with Medical Benefits Mutual's approval)*

Does the employer pay 100% of the premium? Yes No *(If "Yes," all eligible employees must enroll)*

Does the employer contribute at least 50% of the premium? Yes No *(If "No," contact Medical Benefits Mutual for approval.)*

Have any employees, dependents or COBRA participants been diagnosed as having any of the following conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> Claims over \$4,000 in the past 24 months | <input type="checkbox"/> Head or spinal cord injuries | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS, AIDS related complex, HIV positive | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Respiratory conditions | <input type="checkbox"/> Existing pregnancies | <input type="checkbox"/> Cardiovascular disorder |
| <input type="checkbox"/> Severe burns | <input type="checkbox"/> Stroke | <input type="checkbox"/> Multiple trauma |
| <input type="checkbox"/> Kidney, liver or digestive disorders | <input type="checkbox"/> Severe infections | <input type="checkbox"/> High risk maternity or infants |
| | <input type="checkbox"/> Congenital Abnormalities | <input type="checkbox"/> Other _____ |

Please provide details for any conditions marked above: _____

PART III - SPLIT SOLUTION

If you wish to enroll in the Split Solution Plan, and your group is qualified, please complete the following section. If you do not wish to enroll in Split Solution, or you are not qualified, you may skip this section and move to Part IV.

Employer Deductible: Per Person \$ _____ Per Family \$ _____	Monthly Premium:	Unit Rates
Claim Reserve Deposit: \$ _____	Employee	\$ _____
Sleep Tight Aggregate: \$ _____	Employee/Spouse	\$ _____
Maximum Exposure: \$ _____	Employee/Child	\$ _____
	Family	\$ _____

PART IV - PLAN INFORMATION

Product Name. (Enter the name as it appears on the top of your proposal. The product name is followed by the words "rate exhibit."): _____ rate exhibit.

PLAN COVERAGES:

Enter the deductible, coinsurance and other benefit information as it appears on the proposal. For responses that do not apply, write "N/A" in those fields. **No coverage is available for retirees, independent contractors, leased employees or Board Members without Medical Benefits Mutual's prior approval.**

MEDICAL

Non-Panel (applies to PPO plans only)

Deductible \$_____ per person; \$_____ per family \$_____ per person; \$_____ per family

Coinsurance _____% of the first \$_____; 100% thereafter _____% of the first \$_____; 100% thereafter

Maternity and Prescription Drug Card Coverage are included with all medical coverage.

PPO Network. With some PPO plans there are optional networks available. If an option exists, please list the requested network: _____

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

If you are requesting a flat amount for life, enter that amount in the line below. If using classifications, enter the amount and a description of the class. All eligible employees must take Life and AD & D coverage.

Benefit

Classification

Flat amount: \$_____

All Employees

Classifications

Class I: \$_____

Class II: \$_____

Class III: \$_____

Class IV: \$_____

Life reduction and termination (select only one):

35% at age 65 and an additional 35% every 5 years thereafter. Terminates at retirement.

50% at age 70. Terminates at retirement.

Other _____ (with approval from Medical Benefits Mutual.)

SHORT TERM DISABILITY All disability benefits terminate at retirement or age 70, whichever occurs first.

Benefit period: _____ weeks **Benefit:** _____% of weekly earnings to maximum of \$_____ per week.

Waiting Period: _____ day of hospitalization _____ day of sickness _____ day of injury

VISION All benefits are based upon plan year.

Plan Type (exam, lenses, frames): (24/24/24) (12/24/24) (12/12/24) (12/12/12)

Other _____

Panel Deductible \$ _____ / \$ _____ Apply to Non-Panel benefits? Yes No

Plan Allowances: Frame: \$ _____ Contact Lenses: \$ _____

Covered Extras: _____

Non-Panel benefits will be paid in accordance with the following schedule unless otherwise indicated:

Examinations:	\$25	Single Vision Lenses:	\$25	Bifocal Lenses:	\$ 40
Frames, up to:	\$30	Trifocal Lenses:	\$50	Lenticular Lenses:	\$ 80
		Elective Contact Lenses:	\$80	Necessary Contact Lenses:	\$160

DENTAL

70% of all eligible employees must enroll for dental coverage regardless of those who have coverage elsewhere.

Does your group currently have dental coverage? Yes No If "Yes," what was the original effective date? _____

What is the employer contribution? _____% per employee; _____% per dependent.

	DEDUCTIBLE	COINSURANCE	MAXIMUM
Class I - Preventive	\$	%	Classes I, II, and III, combined
Class II - Basic	Classes II and III, combined	%	
Class III - Major	\$	%	\$
Class IV - Orthodontic	\$	%	

PART V - AGENT INFORMATION

Commission Paid To: _____ Agent Number: _____ %

Commission Paid To: _____ Agent Number: _____ %

Contact Name: _____ Telephone Number: _____

Address: _____

License Number, SSN or Tax ID Number: _____ G.A. _____ G.A. Number: _____

Are you currently licensed with Medical Benefits Mutual? Yes No

PART VI - EMPLOYER'S REQUEST FOR PARTICIPATION IN TRUST

The undersigned employer, engaged primarily in the industry described on Part I, hereby requests that it be approved as a participant in the Trust established by other participating employers for the purpose of purchasing group insurance for the benefit of its employees and requests inclusion as a participant under the Group Insurance Plan(s) issued to the Trustee for the plan(s) of insurance shown in Part IV or in any required Supplement.

It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees shall become eligible. Full-time employment is defined in Part II of this application. It is further understood that no agent has power on behalf of Medical Benefits Mutual Life Insurance Co. to make or modify any request or application for insurance or to bind said insurance company by making any promise or representation or by giving or receiving any information.

It is also understood that, should this application be accepted by Medical Benefits Mutual, coverage will not be provided under the Group Health Insurance(s) beyond any period for which premium payments have been made for such coverage in accordance with the provisions of the policy or policies governing the Group Health Insurance Plan(s).

The employer understands that Medical Benefits Mutual is not assuming contractual responsibility for the distribution of Certificates of Creditable Coverage as required by the Health Insurance Portability and Accountability Act of 1996, and that such employer has specific obligations under this law. Medical Benefits Mutual will be providing such certificates to the employer, but the employer understands that it is responsible for reviewing such certificates for accuracy and ensuring that such certificates are properly sent to any terminating employee or dependent's last known address.

The employer declares that he/she/it has read the statements and the answers to the questions and that they are complete and true. The employer understands and agrees that this application is offered to Medical Benefits Mutual Life Insurance Co. as an inducement for the issuance of the insurance applied for, such insurance to be in the amounts agreed upon between said insurance company and the employer. The employer understands that withholding information or providing false statements is grounds for rescission of the group's coverage back to the original effective date.

Medical Benefits Mutual may make additions, corrections or deletions to this Employer Application as is deemed necessary in order to expedite processing. All such additions, corrections or deletions shall be identified to the employer in writing through an addendum to this application. The employer will retain the right to challenge any changes made and if any disputes are not resolved, the employer may choose to withdraw its application. The employer will also receive a copy of this modified application. Acceptance of the changes is verified by execution of the addendum.

It is further understood that no insurance will be effective until the plan is accepted in writing by Medical Benefits Mutual Life Insurance Co. No contract of insurance is to be implied in any way on the basis of the completion and submission of the specifications shown on this form. In case this application is not accepted, any binding premium advanced by the employer shall be refunded.

DATED AT (Location) : _____ DATE: _____

EMPLOYER'S LEGAL NAME: _____

EMPLOYER REPRESENTATIVE'S SIGNATURE: _____ TITLE: _____

WITNESSED BY: _____



ADDENDUM TO THE EMPLOYER APPLICATION AND REQUEST FOR PARTICIPATION IN TRUST

As provided under Part VI of the Employer Application and Request for Participation in Trust, Medical Benefits Mutual Life Insurance Co. has elected to make additions, corrections or deletions to the original forms as submitted. These additions, corrections or deletions were made in order to expedite the processing of the application.

It is the intention of this addendum to identify to the employer all additions, correction or deletions that were made and to secure acceptance of those items identified.

PART I - ADDITIONS, CHANGES OR DELETIONS

The following changes have been made to the Employer Application:

Section	Changes

PART II - ACCEPTANCE

The employer acknowledges that the above additions, corrections or deletions have become a part of the original Employer Application and Request for Participation in Trust. The employer declares that he/she understands and accepts the changes as outlined. Further, the employer acknowledges that he/she has received a revised copy of the Employer Application.

DATED AT (Location) : _____ **DATE:** _____

EMPLOYER'S LEGAL NAME: _____

EMPLOYER'S SIGNATURE: _____ **TITLE:** _____

WITNESSED BY: _____

WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance or health care fraud under state and/or federal law.