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|---|
| <b>HOME OFFICE USE ONLY</b> Group Number: _____ |
|---|

**Instructions for completing this agreement:**

- 1) The employer or employer representative and agent must sign and date this agreement.
- 2) A signed copy of the proposal/quote must accompany this submission.
- 3) The first month's premium made payable to Assurant Health must accompany this submission.

Requested Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Must be 1st or 15th)

**SECTION A – EMPLOYER INFORMATION**

1. Company Name: \_\_\_\_\_  
*Full Legal Name of Company*
2. Street Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_  
*(if different)*
3. City, State, Zip: \_\_\_\_\_
4. Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_
5. Contact Person and Title: \_\_\_\_\_
6. E-mail Address: \_\_\_\_\_
7. Owner(s) Name(s): \_\_\_\_\_
8. Nature of business/articles sold, manufactured, or service rendered: \_\_\_\_\_
9. Type of Ownership/Filing Status:     Proprietorship     Partnership     C-Corporation     S-Corporation  
     For Profit             Non-Profit             Government Agency/Entity  
     Other (specify) \_\_\_\_\_
10. Federal Tax Identification Number: \_\_\_\_\_ How long has this company been in business? \_\_\_\_\_
11. Does your company have more than one Federal Tax Identification Number or associated business organizations (i.e., parent-subsidiary, brother-sister relationships, affiliated groups, etc.)? .....  Yes  No
12. Does your business have more than one physical location? .....  Yes  No  
 If "Yes," to either of the above, complete the following. Write the number of Full-time and Part-time employees whether they are enrolling or not.

| Location #1 | Address | Nature of Business | Business Relationship | Tax ID # | # PT | # FT |
|-------------|---------|--------------------|-----------------------|----------|------|------|
|             |         |                    |                       |          |      |      |
| Location #2 | Address | Nature of Business | Business Relationship | Tax ID # | # PT | # FT |
|             |         |                    |                       |          |      |      |
| Location #3 | Address | Nature of Business | Business Relationship | Tax ID # | # PT | # FT |
|             |         |                    |                       |          |      |      |

13. Employer contribution to premium (must be a minimum of 50% of employee's premium): Medical \_\_\_\_% Dental \_\_\_\_%
14. Waiting/Affiliation Period (the length of time future employees must be employed before becoming eligible for insurance):  
 0 days     30 days     60 days     90 days     180 days
15. Are you waiving the waiting/affiliation period for all employees enrolling for the group's original effective date? .....  Yes  No

The waiting/affiliation period cannot be changed more than once every 12 months. If you do not select a waiting/affiliation period, a 30-day waiting/affiliation period will automatically be selected for your group.

**Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.**



**SECTION E – ELIGIBILITY**

All eligible full-time employees, including those in the new employee waiting/affiliation period, must submit an Enrollment Form or a Waiver of Coverage Form. If additional employees are hired between the date this application is completed and the date coverage is issued, completed Enrollment Forms or Waiver of Coverage Form must be submitted within 5 days of date of hire.

Total number of employees (including owners, partners, etc.) working in your business? \_\_\_\_\_

How many are full-time employees? \_\_\_\_\_ How many are part-time employees? \_\_\_\_\_

Are any former employees or dependents on or eligible to elect continuation (COBRA or other)? .....  Yes  No

If "Yes," provide the following information.

| Name  | Start Date | End Date | Type of Continuation | Reason |
|-------|------------|----------|----------------------|--------|
| _____ | _____      | _____    | _____                | _____  |
| _____ | _____      | _____    | _____                | _____  |

Are any employees currently absent due to illness or injury, family medical leave, or receiving disability benefits? .....  Yes  No

If "Yes," give names and details. \_\_\_\_\_

**ELIGIBLE EMPLOYEES**

An eligible employee is any person who performs services on a full-time basis (defined as at least 30 hours per week) and is considered an employee for federal employment tax purposes, at any of the employer's business establishments.

A partner, proprietor or corporate officer of the employer is eligible if he/she performs services for the employer on a full-time basis (defined as at least 30 hours per week), at any of the employer's business establishments.

The term "Employee" does not include: a) retirees or employees who are not expected to perform any duties, responsibilities or services for the employer; or b) "part-time" employees; or c) any "seasonal" or "temporary" employees who work only part of the calendar year on the basis of natural or suitable times or circumstances.

**List all eligible employees below, as defined above, whether or not enrolling**

| Employee Name | E = Enrolling<br>W = Waiving | Employee Name | E = Enrolling<br>W = Waiving |
|---------------|------------------------------|---------------|------------------------------|
| 1.            |                              | 11.           |                              |
| 2.            |                              | 12.           |                              |
| 3.            |                              | 13.           |                              |
| 4.            |                              | 14.           |                              |
| 5.            |                              | 15.           |                              |
| 6.            |                              | 16.           |                              |
| 7.            |                              | 17.           |                              |
| 8.            |                              | 18.           |                              |
| 9.            |                              | 19.           |                              |
| 10.           |                              | 20.           |                              |

*If additional space is needed, attach another sheet of paper.*

I certify that all employees currently working for me are compensated in a manner that complies with all applicable federal and state minimum wage requirements.

I certify that the information provided can be substantiated by business documents. Upon request, I agree to provide the documentation requested to establish eligibility and participation are met at all times while coverage is provided by Time Insurance Company (i.e. Wage & Tax Form, Payroll Records, Business License, etc.).

I understand that providing incomplete, inaccurate or untimely information may void or terminate any individual or group coverage.

By signing below, I certify that I have read the Employer Participation Agreement/Application, agree to all terms and conditions contained therein and that all information provided is true and accurate.

Signature of Employer \_\_\_\_\_ Title \_\_\_\_\_

Print Name of Employer \_\_\_\_\_ Date \_\_\_\_\_

## SECTION F – AGENT CHECKLIST

- Fully completed, signed and dated Employer Participation Agreement/Application
- Fully completed, signed and dated Employee Enrollment Forms, including waivers as needed
- State-specific forms (if required)
- A proposal signed and dated by the employer or employer's representative
- A business check, made payable to Assurant Health
- Copy of the prior carrier's most recent list billing statement, if replacing coverage

Time Insurance Company may request that the employer provide documentation (i.e. Wage & Tax Form, Payroll Records, Business License, etc.) during the underwriting process or at any time while coverage is provided by Time Insurance Company to support that eligibility and participation requirements are met.

## SECTION G – AGENT'S STATEMENT

I certify that all of the information contained in this Employer Participation Agreement/Application and any attached papers is correct to the best of my knowledge. I have complied with all of the underwriting rules and have explained the coverage fully.

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Agent's Name: \_\_\_\_\_ Agent #: \_\_\_\_\_  
Agent's Address: \_\_\_\_\_ Agent's Phone #: (\_\_\_\_\_) \_\_\_\_\_  
Agent's City, State, Zip: \_\_\_\_\_ Agent's Fax #: (\_\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

## SECTION H – DISTRIBUTION PARTNER'S INFORMATION (Complete all applicable fields)

Office Name: \_\_\_\_\_ Office #: \_\_\_\_\_ DA #: \_\_\_\_\_  
Representative Name: \_\_\_\_\_ Representative #: \_\_\_\_\_  
Representative Phone #: (\_\_\_\_\_) \_\_\_\_\_ Representative Fax #: (\_\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

## SECTION I – SPECIAL MAILING INSTRUCTION

If no address is indicated below, the group kit will be mailed according to the distribution partner's policy.

Mail New Business Kits to: \_\_\_\_\_  
At Address Specified: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Mail future certificates to: \_\_\_\_\_  
At Address Specified: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_