

**PENNSYLVANIA
EMPLOYER PARTICIPATION AGREEMENT/APPLICATION**

FORTIS BENEFITS INSURANCE COMPANY

<p>HOME OFFICE USE ONLY Group Number: _____</p>
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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) A check for the first month's premium made payable to Fortis Benefits Insurance Company 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. Contact Person and Title: _____ Phone Number: (____) _____
5. E-mail Address: _____ Fax Number: (____) _____
6. Owner(s) Name(s): _____
7. Nature of business/articles sold, manufactured, or service rendered: _____
8. Type of Ownership/Filing Status: Proprietorship Partnership C-Corporation S-Corporation
 For Profit Non-Profit Government Agency/Entity
 Other (specify): _____
9. How long has this company been in business? _____
10. Federal Tax Identification Number: _____
11. Does your company have more than one Federal Tax Identification Number or associated business organization (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. Include all employees whether 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: 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 120 days 150 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 and election of add-on and termination effective dates 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.
16. Check the box to indicate when you would like new employees to be added and terminations to be effective.
If no option is chosen, the election will default to Option a.
 a.) The day after the waiting/affiliation period or termination day,
 b.) First of the month following the waiting/affiliation period and termination at the end of the month.

SECTION B – PRIOR COVERAGE INFORMATION

1. Will this plan replace other group coverage?..... Yes No
 If "Yes," how many group medical/dental insurance carriers have you had coverage with over the last 24 months? _____
 If "Yes," please complete the following and attach a copy of the most recent billing for both medical and dental.

<u>Prior Medical Carrier</u>	<u>Effective Date</u>	<u>Termination Date</u>	<u>Major Medical Plan?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____
<u>Prior Dental Carrier</u>	<u>Effective Date</u>	<u>Termination Date</u>	<u>Orthodontics?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Major Services?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____

2. Will you be or are you offering another group plan in addition to this group plan? Yes No
 If "Yes," please provide carrier and effective date: _____

SECTION C – WORKERS’ COMPENSATION INFORMATION

Name of Workers’ Compensation Carrier: _____

Policy and Phone Number: _____

- Do you provide Workers’ Compensation for all employees? Yes No
 If "No," list employees not covered.

<u>Name</u>	<u>Title (Owner, Partner, Officer, etc.)</u>	<u>Reason Not Covered</u>
_____	_____	_____
_____	_____	_____

SECTION D – AGREEMENT

The participating employer hereby applies for participation under the Trust sponsored by Fortis Benefits Insurance Company and agrees to be bound by all the terms and conditions of the Group Policy issued to the Trustee policyholder. The participating employer acknowledges that the Trust Agreement and the Group Policy are available for inspection by any person insured through or under the Trust by contacting Fortis Benefits Insurance Company. The participating employer understands that the benefits selected are reflected on the attached signed proposal which is part of this request for participation. I hereby represent as the participating employer or the person acting with the authority of the participating employer, that this information is complete and true to the best of my knowledge and belief. **The participating employer fully understands that no insurance will become effective without the approval of Fortis Benefits Insurance Company and that any material falsification or omission may nullify coverage for employees and dependents.** It is further understood that no agent has the authority to alter or amend either the Trust Agreement or the Group Policy, to adjust any claim for benefits, or to bind Fortis Benefits Insurance Company by making any promise or representation.

The coverages applied for provide benefits for an employee welfare benefit plan established and maintained by the employer under the Employee Retirement Income Security Act (ERISA), unless the plan is specifically exempt from the terms of ERISA. For purposes of this agreement, the participating employer acknowledges and accepts full and complete responsibility for the operation, administration, and maintenance of the insurance plan in a prudent and diligent manner in the interest of the plan participants and beneficiaries. Unless this plan is specifically exempted, the participating employer also agrees to comply with the fiduciary, reporting, and filing requirements of ERISA and to act in accordance with the duties and obligations set forth under ERISA, this agreement and any other applicable state or federal laws or regulations. The participating employer agrees to be solely responsible for compliance with the laws, including the payment of any required benefits that are not covered by this insurance plan.

It is further understood and agreed that: (1) benefits under the Group Policy and the cost of providing those benefits may change; (2) renewal rates will be based on several factors which will include, but will not be limited to, the projected future claims experience of the participating employer group, except where prohibited by law; (3) those subject to evidence of insurability must receive prior approval by Fortis Benefits Insurance Company at its home office before coverage becomes effective; (4) no insurance will become effective until the first full premium has been paid; (5) the cancelled check tendered as the first premium will be a receipt for deposit; (6) the Group Policy may be discontinued by Fortis Benefits Insurance Company under certain circumstances identified in the Group Policy and Certificates of Coverage; (7) a minimum of 50% contribution toward the employee cost of insurance is required; (8) only eligible/full-time employees and their dependents are eligible; (9) **I must enroll all eligible employees now and in the future according to the participation rules of Fortis Benefits Insurance Company and that insurance may be terminated if the percentage falls below the participation requirements.** (10) Fortis Benefits Insurance Company reserves the right to request a state wage and tax statement or other documentation at any time to verify current and future participation and eligibility; (11) I also understand that rates are subject to change until all of the following have occurred: (a) the group insurance contract has been approved by Fortis Benefits Insurance Company; (b) notice of effective date has been furnished by Fortis Benefits Insurance Company; and (c) the first premium for insurance provided under the plan is paid. (12) The benefits under the Group Policy will terminate under certain conditions, as set forth in the Group Policy and/or Certificates of Insurance, and I understand that the failure to pay premiums in a timely manner will result in termination of the group coverage. I understand that I must give notice to Fortis Benefits Insurance Company within 30 days of any participating employee who ceases working the established eligible hours as defined on this application, including, but not limited to those on paid or unpaid leave, disability, salary continuation or worker’s compensation.

Fortis Benefits Insurance Company relies on group and individual information as disclosed on the enrollment materials to set premium rates for the entire group. Any incomplete or untruthful information may result in insurance coverage being voided or an adjustment to the rates may be required if information is found to be inaccurate.

Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SECTION E – ELIGIBILITY

All eligible/full-time employees, including those in the new employee waiting/affiliation period, must submit an Enrollment Form. If additional employees are hired between the date this application is completed and the date coverage is issued, a completed Enrollment 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 eligible/full-time employees? _____ How many are non-eligible/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, or receiving disability benefits? Yes No
If "Yes," give names and details. _____

ELIGIBLE EMPLOYEES

The Employer has the right to establish eligibility requirements for the group. If the employer does not request different requirements, eligibility will be administered based on the following: 30 hours per week, 48 weeks per year standard. A partner, proprietor or corporate officer of the employer must be working the specified hours and weeks for eligibility in connection with conducting the employer's business.

The term "Employee" does not include: A) Any person who resides outside the U.S., or who spends more than 60 consecutive days in any year outside the U.S., whether for work or pleasure; or B) Any "seasonal" or "temporary" Employees who work less than 48 weeks a year.

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

Employee Name	E = Enrolling W = Waiving	Employee Name	E = Enrolling W = Waiving
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

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 requirements are met at all times while coverage is provided by Fortis Benefits 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, agree to all terms and conditions contained therein and that all information provided is true and accurate.

Fortis Benefits 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 Fortis Benefits Insurance Company to support that eligibility and participation requirements are being met.

Signature of Employer/Title _____ Date _____

Print Name _____ Signed at (city/state) _____

SECTION F – ROGERS BENEFIT GROUP INFORMATION (Based on the office through which you are appointed)

RBG Office Name: _____ RBG Office # _____ DA # _____
Representative Name: _____ Representative # _____
Representative Phone # (_____) _____ Representative Fax # (_____) _____
Email Address: _____

SECTION G – AGENT’S STATEMENT

I certify that all of the information contained in the Employer Agreement and any attached papers is correct to the best of my knowledge. I know nothing unfavorable about this firm or any individual proposed for insurance. 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 Phone # (_____) _____
Agent City, State Zip: _____ Agent Fax # (_____) _____
Email Address: _____

SECTION H – NEW BUSINESS KIT MAILING INSTRUCTIONS

Special Mailing Instructions for New Business Kit (If different from the assigned RBG Office):

RBG office number _____ Office Name and Address _____

Future certificates will be mailed directly to the business.