

Midwest Security Life Insurance Company PARTICIPATING EMPLOYER APPLICATION

(1) **PARTICIPATING EMPLOYER:** _____
(Correct Legal Name)

(2) **ADDRESS:** _____
Street City State Zip

(3) **CONTACT PERSON** regarding Group Insurance Administration:

Name & Title Phone Ext.

(4) **A. TYPE OF OWNERSHIP:** Corporation Partnership Proprietorship Limited Liability Corporation
 Federal I.D. Number: _____ Length of time Company has existed (in years): _____
 B. Nature of Business: _____ NAIC or SIC Code: _____

(5) A. ***TOTAL NUMBER OF EMPLOYEES** employed by Participating Employer: _____
 B. *Total number of full-time employees: _____ Days per calendar year: _____
 C. *Total number of part-time employees: _____ Hours per week: _____ Days per calendar year: _____
 * Please include owners and partners in all total employee numbers.

(6) **INDUSTRY TRUST:** The above Participating Employer requests participation of its Employees under the applicable Group Insurance Policies issued to: *The Trustees of the Michigan Employers Group Insurance Trust*

(7) **SUBSIDIARY, OR OTHER EMPLOYEE LOCATION EMPLOYERS:**
 A. The employees of the following subsidiary, affiliated employers or locations also request participation:

Business Name	Address	City	State	Zip	Total # Employees

B. Please list the names of any other subsidiary and/or affiliated employers not participating in this plan:

Business Name	Reason for not participating	City	State	Zip	Total # Employees

(8) **PRIOR GROUP INSURANCE PLAN:** Will this replace any existing Group Insurance? Yes No
 If YES, give name of prior insurance company and date of termination. Also provide a copy of the prior policy and last premium statement.

(9) **WORKERS COMPENSATION:** Are all eligible employees covered by Workers Compensation? Yes No
 Is the owner or partner covered by Workers Compensation? Yes No

(10) Are any employees or dependents totally **DISABLED OR HOSPITALIZED** at the current time? Yes No
 If YES, give names, ages, and date of disability: _____

(11) **CONTINUATION.** Under federal law if your group had 20 or more employees on at least 50% of the employer's working days of the preceding calendar year, you must provide employees with COBRA continuation. If applicable, please "X" the appropriate box. Cobra Continuation

(12) **MEDICARE.** Under federal law if your group had 20 or more employees on at least 50% of the employer's working days in the preceding calendar year, health plan benefits would be primary. If your group had less than 20 employees, Medicare benefits would be primary. Please "X" the appropriate box. Medicare Primary Health Plan Primary

(13) **EXCLUDED EMPLOYEE CLASSES:** _____

(14) **ELIGIBILITY:** *All employees working at least 30 hours per week are eligible for insurance.*

For Michigan Small Employers only:

All Employees working between 17 ½ and 29 hours per week are eligible for insurance. Yes No

A. PRESENT EMPLOYEES who have completed _____ month(s) (maximum 2 months) of active full-time employment, except those excluded below, shall be eligible for insurance on the desired effective date of coverage requested in Section 19.

B. ALL OTHER EMPLOYEES who have completed _____ month(s) (maximum 2 months) of active full-time employment shall be eligible for insurance on the first day of the insurance month immediately following the day the employee completes the required period.

(15) **INSURED COVERAGES SELECTED:**

A. SELECT COVERAGE (available for HRA) 100%/70% Plus – 90%/80% – 90%/70% – 80%/60%
 100%/70% – 100%/50% Select 3000 90%/60% – 80%/50% – 70%/40%

B. QUALIFIED HIGH DEDUCTIBLE PLANS (available for HSA or HRA) 100%/80% – 80%/60%

HRA Health Reimbursement Account (available on all Select Coverage plans)

Auto Claims download with Midwest Security preferred administrator

FSA Flexible Spending Account

Auto Claims download with Midwest Security preferred administrator

Please indicate all of the benefit options that you want to elect for your plan and attach a copy of the proposal.

Consult the Select Coverage brochure for the benefit options available.

	Benefit Plan Option 1	Benefit Plan Option 2	Benefit Plan Option 3
<i>Deductible</i>			
<i>Coinsurance</i>			
<i>Out-of-Pocket Maximum</i>			
<i>Managed Care Network</i>			
<i>HRA/FSA Auto Claims Download (yes/no)</i>			

C. SPLIT FUNDING:

Deductible Option: \$7,500 \$10,000 \$15,000
 \$20,000 \$25,000 (groups enrolling 51 or more employees)

Aggregate Excess Loss Insurance Aggregate Terminal Liability Option

Monthly Aggregate Accommodation Option

Deductible Accumulation Method: Contract Year or Calendar Year

(Complete Split-Funded Adoption Agreement, Administrative Services Agreement, and Self-Funded Adoption Agreement, if necessary.)

Underlying Plan

	PPO/NPPO
Deductible:	____/____
Coinsurance:	____/____
Coinsurance Max.:	____/____
RX Drug Card:	____/____/____

D. OPTIONAL \$500 SUPPLEMENTAL ACCIDENT BENEFIT

E. OPTIONAL PRESCRIPTION DRUG CARD

Buy-up \$____/____/____ if other than standard in-plan benefit. (Buy-up not available on Select 2000 or HSA.)

F. LIFE & ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (see schedule Section 14-A)

G. WEEKLY DISABILITY INCOME BENEFITS (See Section 14-A&B)

H. DEPENDENT LIFE INSURANCE (see Section 14-C) Schedule A Schedule B

I. CLASSIC DENTAL: Gold Silver Bronze

Deductible \$: _____ Annual Maximum \$: _____

Number of Eligible Employees: single _____ limited family _____ family _____

Number of Participating Employees: single _____ limited family _____ family _____

Optional Orthodontic (requires 16 employees taking dental coverage) maximum: _____

J. VOLUNTARY DENTAL Enrollment: Open(Complete Section 13) Late applicant provision

REMARKS:

(19) **PREMIUM PAYMENT AND GRACE PERIOD:** The premium is to be payable monthly in advance. This may include an applicable billing fee. If a Participating Employer has not previously given written notice to the Company that the Employer's coverage is to be discontinued, a grace period of thirty-one days, without interest charge, shall be granted to the Participating Employer for payment for every premium after the first. If, however, written notice is given by the Participating Employer to the Company during the grace period that the Employer's coverage under the Policy is to be discontinued, the Policy shall then be discontinued on the date of receipt by the Company of such written notice, with the effective date of the termination being the 1st day of the insurance month.

If the Employer does not give written notice of discontinuance in accordance with the terms stated above, and the grace period premium is not received by the end of the grace period, the Company shall not be liable for any claims incurred during the grace period.

(20) **DESIRED EFFECTIVE DATE:** The _____ Day of _____, _____, provided this application has been accepted in writing by Midwest Security Life Insurance Company at its Home Office, 2700 Midwest Drive, Onalaska, Wisconsin 54650-8764. It is agreed the Coverages cannot become effective until the first month's premium has been paid and;

a. 75% of the total number of eligible employees have subscribed to the Plan or 50% of the total number of employees have subscribed to the Plan.

b. For Small Employers (2-50 eligible employees), the following participation must be met:

- Groups with 2-10 eligible employees – 100% of the total number of eligible employees.
- Groups with 11-25 eligible employees – 75% of the total number of eligible employees seeking employer sponsored coverage.
- Groups with 26-50 eligible employees – 50% of the total number of eligible employees seeking employer sponsored coverage.

The Coverage issued shall be subject to all the terms and conditions of the Policy to which this Application is attached.

Dated at _____, this _____ day of _____, _____

By: _____
Name and Title

SUBSCRIPTION AGREEMENT

The Undersigned Employer, certifies all the information shown on this application and any attachments is correct and complete, and understands that the Insurance Company intends to rely on this information in determining whether or not the enrolling employees may become insured. If the information is not disclosed or incorrect, the Insurance Company has the right to either rescind coverages or re-rate the group retroactive to the effective date. It is further understood and agreed that NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED AND ACCEPTED BY MIDWEST SECURITY LIFE INSURANCE COMPANY, and that no field representative of the Insurance Company has the authority to modify any conditions of applications, policies, nor bind the Insurance Company by making any promises or representation, written or verbal. It is understood that the Insurance as to any employee will NOT become effective on the date such insurance would otherwise become effective if the employee is not at work on such date performing all duties of his/her occupation and otherwise meets the underwriting requirement of the Insurance Company.

The Undersigned Employer desiring group insurance coverage for his/her Employees hereby accepts and agrees to the provisions contained in the Michigan Employers Group Insurance Trust.

Do not cancel existing group coverage until written notification is received of the approval of this application.

The Undersigned Employer understands that this plan is subject to the Employee Retirement Income Security Act (ERISA).

Dated: _____, _____ By: _____
Name and Title

AGENT'S STATEMENT

I certify that all of the information contained in the Participating Employers Application and on the Group Enrollment Cards is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for insurance, except as noted herein or on the Health Statements. I have complied with all underwriting rules and regulations, and have explained in detail the coverages to this firm.

WITNESS _____
Licensed Resident Agent Signature
State in which application was signed

Agent Printed Name