GROUP HEALTH PLANS
EMPLOYER APPLICATION

INSURERS ADMINISTRATIVE CORPORATION

For use in Arkansas

EMPLOYER GROUP NAME:_____

THIS PLAN REQUEST WAS PREVIOUSLY PRE-SCREENED ON: _____

PRODUCER INFORMATION (to be filled out by the producer ONLY)

1. ☐ YES ☐ NO Are you currently licensed in the state in which you solicited this application?
2. ☐ YES ☐ NO Are you currently appointed with Avemco Insurance Company through IAC?
3. ☐ YES ☐ NO Are you currently appointed with Fidelity Security Life Insurance Company through IAC?
4. ☐ YES ☐ NO Do you carry an Errors & Omission Policy? If yes, who is the carrier: _____

_____

PRODUCER'S STATEMENT:
To the best of my knowledge:

- ☐ I hereby represent that all the information contained in the Employer Agreement and Application is correct and I know of nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the Employee Applications) that has not already been disclosed;
- ☐ I have complied with the underwriting rules and regulations and have explained in detail the proposed coverage for the member firm and its employees.
- ☐ I have explained to the Employer and employees the pre-existing condition limitation and the late applicant extended pre-existing limitation for those employees not applying at this time.

_____ Signature of Producer

_____ Date Application(s) sent to General Agency

PRODUCER'S INFORMATION:

Company Name: _____ Street Address: _____

Producer's Name: _____ City/State/Zip: _____

IAC Agent #: _____ Business Phone:_____

Social Security #: _____ Home Phone: _____

Federal ID #: _____ E-mail Address:_____

State License #: _____ Fax #: _____

Web Site Address: _____ Mobile #: _____

GENERAL AGENT INFORMATION (to be filled out by the GA ONLY)

General Agency #:_____ GA's Phone #:_____

Name of Agency: _____ GA's Fax #: _____

Name of General Agent:_____ Date Application(s) Sent to IAC: _____

GROUP HEALTH PLANS

EMPLOYER APPLICATION AND ADOPTION & PARTICIPATION AGREEMENT

Health Insurance underwritten by **Avemco Insurance Company**, Frederick, Maryland
Life, Vision and Dental Insurance underwritten by **Fidelity Security Life Insurance Company,** Kansas City, Missouri

A. EMPLOYER INFORMATION (please print in ink)

COMPANY NAME: (LEGAL NAME)	TYPE OF BUSINESS: ❑Corporation ❑Sole Proprietor ❑Partnership ❑Other_____	
DBAs:	PHONE NUMBER:	FAX NUMBER:
COMPANY ADDRESS: (STREET)	TAX ID NUMBER:	SIC:
CITY: STATE: ZIP:	LENGTH IN BUSINESS:	WEB SITE ADDRESS:
COUNTY:	NATURE OF BUSINESS:	E-MAIL ADDRESS:
CHIEF EXECUTIVE OFFICER OR PROPRIETOR:	NAME AND ADDRESS OF SUBSIDIARIES, AFFILIATES, OR SEPARATE LOCATIONS TO BE INSURED.	
NAME OF COMPANY CONTACT:	# OF EMPLOYEES BY LOCATION:	

B. COVERAGE INFORMATION

PLEASE COMPLETE *THE PLAN SELECTION FORM* AND ATTACH TO THIS APPLICATION.

C. EMPLOYER EFFECTIVE DATE AND WAITING PERIOD

1. WAITING PERIOD: ❑ 30 ❑ 60 ❑ 90 Days _____
2. REQUESTED EFFECTIVE DATE: ❑ 1st ❑ 15th of _____, _____ (month, year)

D. PROVIDER NETWORK SELECTION

1. Primary Health Provider Network:

   _____

2. Will more than one provider network be needed due to other Employer locations outside of the primary provider service area? ❑ YES ❑ NO

   Please identify business location and Network desired:_____

E. PRIOR COVERAGE CREDIT

❑ YES ❑ NO Will this Plan replace an existing Employer sponsored Health Plan of coverage?

If yes, in order for those individuals who are eligible to receive credit towards the pre-existing limitations waiting period, Evidence of Creditable Coverage should be provided by the prior carrier. **If you are replacing an employee group health plan with this Plan, please help ensure your employees get appropriate credit by providing a copy of the present carrier's billing for the month in which coverage is being requested, a copy of the prior carrier's outline of coverage including the prior plan's effective date, or Certificates of Creditable Coverage required under HIPAA.**

Date Coverage Will Terminate: _____ Carrier's Name: _____ Carrier's Phone Number: _____

F. EMPLOYER CONTRIBUTION AND PARTICIPATION PERCENTAGES

1. Choose a Method:

❑ Defined Contribution Amount = $_____/per employee per month

This is a fixed dollar amount that you will contribute toward the monthly cost of your employee's (and their dependents, if any) benefit purchases.

OR

❑ % of Premium Contribution:

_____% of Employee Health Premium / _____% of Dependent Health Premium

_____% of Employee Dental Premium / _____% of Dependent Dental Premium

_____% of Employee Vision Premium / _____% of Dependent Vision Premium

2. Please calculate the Participation of employees in the Plan

	a. Total of all full time employees (including owners).
-	b. Minus full-time employees who are declining coverage because of other group health insurance.
	c. Result is total "eligible" full-time employees. (a minus b)
-	d. Minus full time employees who are declining health coverage and have no other coverage.
	e. Result is total eligible full time employees applying for coverage.
%	f. Percentage of "eligible" employees participating in the plan. (e divided by c)

Dependent "units" are counted as one "unit" if they are a family, spouse or child.

	a. Total of dependents units (spouse and/or children).
-	b. Minus dependent units declining coverage because of other group health insurance.
	c. Result is total "eligible" dependent units. (a minus b)
-	d. Minus eligible dependents units who are declining health coverage and have no other coverage.
	e. Result is the total eligible dependent units applying for coverage.
%	f. Percentage of "eligible" dependent units participating in the plan. (e divided by c)

Participation Requirements

All eligible Employees are expected to apply for coverage during the Employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in their "benefit waiting" period. The Employer may waive the benefit waiting period at the initial enrollment period to maximize plan participation.

Size of Group Participation	Minimum Required Participation	Minimum Required Participation (No Maternity)	Minimum Required Participation (With Maternity)
2-4 Employees	100%	50% dependent units	N/A
5-9 Employees	75%	50% dependent units	75% dependent units
10+ Employees	75%	N/A	N/A

G. EMPLOYEES ON CONTINUATION INFORMATION

1.	❑ YES ❑ NO	Is your firm subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and has it had more than 20 employees (full and part-time) in the past year?
2.	❑ YES ❑ NO	Are any employees or dependents currently on COBRA continuation of coverage or in the election period due to COBRA?

If yes, please name the individuals

_____

An application form and a copy of the COBRA election form needs to be submitted for each person covered under your group because of COBRA.

J. YOUR ACKNOWLEDGEMENTS

AS THE UNDERSIGNED EMPLOYER:

INITIAL PREMIUM RATE TABLE GUARANTEE: I understand that the rate tables which were in effect at the effective date of my employer plans coverage will remain in effect for the first 6 months of coverage unless I have elected the 12-month rate table plan. Premiums or Rates may change if: the employer adds or deletes employees; existing employees move into a higher age bracket; the business moves to another geographic area; the employer modifies the plan of benefits; the Provider Access or other Administrative fees change or any benefit changes occur during the period.

PREMIUM PAYMENT: The first premium payment is due on the date of issue. Subsequent premiums are due on the first of each succeeding month. A Grace Period of 31 days will be allowed for the payment of any premium due after the initial premium. If not paid within that period, coverage will terminate automatically as of the due date of the unpaid premium.

PRE-CERTIFICATION: I understand that failure to meet pre-certification requirements will reduce benefits pursuant to the terms of the Group Master Policy.

BENEFIT AVAILABILITY: I understand that my benefits under this plan begin with a specific effective date of coverage applicable to me and coverage ends at the end of a month in which due premium has not been paid. I understand if I attempt to utilize the benefit plan or prescription drug card when coverage is no longer effective under the plan, I will be personally responsible for those expenses incurred and can be billed by the providers or insurance company for those services.

U.S. RESIDENT: I understand that the coverage under this plan is available for United States residents and benefits are not payable for medical expenses outside of the United States except when traveling.

MY ANSWERS ARE TRUE AND CORRECT: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any material misstatements or failure to report information by me or my employees may be used for the basis of rescission or termination of coverage on me, or my employees. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; or (b) permit me to inaccurately answer any questions. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

MINIMUM EMPLOYEE/DEPENDENT PARTICIPATION REQUIREMENTS: I understand that all eligible employees are encouraged to apply for coverage during the employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in their "benefit waiting period." I understand as the employer, I may waive the "benefit waiting period" for my employees only at the initial enrollment period.

I understand I must maintain at least the minimum employee and dependent participation requirements of the Plan that were in effect at the time this application was completed. I understand that periodically I may be requested to verify employee participation through providing documentation, such as state quarterly unemployment report or other means. Failure to cooperate with the participation verification or failure to meet minimum participation requirements may result in coverage termination or loss of protection under the Health Insurance Portability and Accountability Act.

APPLICATION FOR GROUP: I understand that I am applying for a plan of insurance coverage(s) to which I and my employees and their dependents are now or may be eligible for under the provisions of the Group Master Policy issued to the Trust by Avemco Insurance Company and Fidelity Security Life Insurance Company (**for Life and Dental, if elected)**. I hereby adopt the Multiple Unit Security Trust for the purpose of establishing a plan of group insurance coverage(s) for my employees providing the benefits indicated in the section entitled "COVERAGE INFORMATION" of this Adoption and Participation Agreement, and agree to be bound by all of the terms, provisions, and limitations of said Trust and the master insurance policy issued thereto.

I agree that: (1) participation in the Multiple Unit Security Trust is subject to written approval of this application to participate by Avemco Insurance Company and Fidelity Security Life Insurance Company or their authorized administrators; (2) no liability is created or assumed by the Multiple Unit Security Trust until this application has been approved in writing; and (3) if for any reason this application is not so approved in writing, the sole obligation of the Multiple Unit Security Trust will be, and the employer shall be entitled to only, a refund of any monies paid; (4) I understand that termination of the insurance also terminates my status as a participating employer under the Trust; and (5) for purposes of the Employee Retirement Income Security Act (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the employer is deemed Plan Administrator. I understand that acceptance of the check submitted with the application does not constitute approval or guarantee coverage. I agree and understand the insurance coverage which is to be placed in force is subject to all of the provisions of the group policy issued to Multiple Unit Security Trust including, without limitation to the foregoing, the right of the Insurance Company to periodically request and 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.

Any person who, knowingly presents a false or fraudulent claim for payment of loss or benefit, or, knowingly presents for payment information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I acknowledge I am advised not to terminate any existing health coverage plans on me and my employees until my Agent receives notification this Plan has been approved by Insurers Administrative Corporation.

K. SIGNATURE

Owner or Officer Signature	Date	Owner or Officer Name and Title (printed)