

**EMPLOYER PARTICIPATION AGREEMENT/APPLICATION**

**TIME INSURANCE COMPANY**

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

**Instructions for completing this agreement:**

- 1) The employer or employer representative and agent must sign and date this agreement.
- 2) A current copy of the employer's state quarterly wage & tax statement must accompany this submission.
- 3) Note on your state quarterly statement each employee's current status (full-time, part-time, etc.) and hours worked per week.
- 4) A signed copy of the proposal/quote must accompany this submission.
- 5) A check for the first month's premium made payable to Time 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 the Premium:    Medical \_\_\_\_\_%    Dental \_\_\_\_\_%
14. Waiting/Affiliation Period (the length of time future employees must be employed before becoming eligible for insurance):  
 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 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.

**SECTION B – ELIGIBILITY**

An employee will be considered eligible if he/she works at least 30 hours per week, 48 weeks a year. A partner, proprietor or corporate officer of the employer must be working the specified number of hours and weeks for eligibility in connection with conducting the employer’s business, as specified above.

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 fewer than 48 weeks a year.

**TOTAL # OF EMPLOYEES**

1. How many people, including owners are employed by your business? \_\_\_\_\_

  - a) How many are eligible/full-time employees, including owners on your payroll? \_\_\_\_\_
  - b) How many are eligible/full-time employees not on your payroll (contractors/1099/leased)? \_\_\_\_\_
  - c) How many are not eligible/part-time employees? \_\_\_\_\_

- d) Number of employees not identified above (*explain, if any*): \_\_\_\_\_

2. Is there a class of employees that you are not including (*explain, if any*)? \_\_\_\_\_  Yes  No

3. Include each employee’s hours worked per week and current status on the state quarterly wage & tax statement that you are attaching to this application.

**Indicate their current status using the following status codes:**

- |  |  |   |
|--|--|---|
| F – Eligible/Full-time ( <i>as defined above</i> ) | P – Not Eligible/Part-time                 | R – Retired   |
| C – Continuation ( <i>State/Federal</i> )          | A – Active Partner                         | T – Temporary or Seasonal ( <i>fewer than 48 wks/yr</i> ) |
| I – Independent Contractor                         | D – Totally Disabled Employee              | W – Within Waiting/Affiliation Period                     |
| L – Leased Employee                                | O – Other ( <i>Please explain</i> ): _____ |   |

4. List all employees in your company not shown on your most current state quarterly wage & tax statement, including:

- a) Employees still in their waiting/affiliation period.
- b) Owners, partners and managers who are actively working for this firm on a regular basis.
- c) Employees who are not working but are currently covered under your group health insurance plan for reasons such as retirement, requirements of law, etc.

If group is not required to file a state quarterly wage & tax statement, this census must be completed, listing all employees.

Name	Hours Worked per Week	Status	Name	Hours Worked per Week	Status
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

(Use a separate sheet of paper if more space is needed.)

If additional eligible employees are hired between the date this application is completed and the date coverage is issued, you must submit an enrollment form for these employees within 5 days of their date of hire.

5. Are any former employees or dependents currently on or eligible to elect COBRA/state continuation? \_\_\_\_\_  Yes  No  
If “Yes,” provide the following information.

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

6. Are there any employees who are not currently working due to injury or disability? \_\_\_\_\_  Yes  No  
If “Yes,” provide the following information.

Name	Reason	Not Working Since (Date of Injury/Disability)	Expected Date of Return
_____	_____	_____	_____
_____	_____	_____	_____

7. Do any employees travel outside the United States for business or pleasure, for more than 60 consecutive days a year? \_\_\_\_\_  Yes  No

If “Yes,” list employees. \_\_\_\_\_

**SECTION C – 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(s)</u>	<u>Policy Number</u>	<u>Effective Date</u>	<u>Termination Date</u>	<u>Major Medical Plan?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Prior Dental Carrier</u>	<u>Policy Number</u>	<u>Effective Date</u>	<u>Termination Date</u>	<u>Orthodontics?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<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?  
 If "Yes," please provide carrier and effective date: \_\_\_\_\_  Yes  No

**SECTION D – 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 E – AGREEMENT**

The participating employer hereby applies for participation under the Trust sponsored by Time 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 Time 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 Time 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 Time 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 Time 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 Time 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 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 Time Insurance Company and that insurance may be terminated if the percentage falls below the participation requirements. (10) Time 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 Time Insurance Company; (b) notice of effective date has been furnished by Time 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 Time 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.

Time 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, with intent to defraud or knowing that they are facilitating against Time Insurance Company in submitting an enrollment form or claim containing a false or deceptive statement, may be guilty of insurance fraud as specified by any applicable State law.

Signature and Title \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signed at (city/state) \_\_\_\_\_

## 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
- Copy of the most current state quarterly wage & tax statement (state quarterly unemployment withholding form), including notation as to current status and hours worked per week of all employees listed**
- Groups not required to file a state quarterly wage & tax statement must provide a copy of their most current business federal tax return and associated schedules
  - Sole Proprietors - Form 1040 & Schedule C (farms use Schedule F)
  - C-Corporations - Form 1120
  - S-Corporations - Form 1120S and Schedule K-1
  - Partnerships - Form 1065 and Schedule K-1
- A business check, made payable to Time Insurance Company.
- Copy of the prior carrier's most recent list billing statement, if replacing coverage

## SECTION G – AGENCY INFORMATION

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

## SECTION H – 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 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's Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_  
Agent's City, State, Zip: \_\_\_\_\_ Agent's Fax #: ( \_\_\_\_\_ ) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

## SECTION I – SPECIAL MAILING INSTRUCTIONS

If no address is indicated below, the group kit will be mailed to the General Agency.

Mail New Business Kit to the Writing Agent at Address Specified: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Future certificates will be mailed directly to the business unless checked below.

Mail future certificates to the Writing Agency:  Yes