Request For Participation In The Multiple Employer Group Insurance Trust

Check the company(s) you are applying to:

- ❑ COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY • COMMERCIAL TRAVELERS BUILDING • UTICA, NEW YORK 13502
- ❑ MONITOR LIFE INSURANCE COMPANY OF NEW YORK • COMMERCIAL TRAVELERS BUILDING • UTICA, NEW YORK 13502
- ❑ FIDELITY SECURITY LIFE INSURANCE COMPANY • POLICYHOLDER SERVICE • COMMERCIAL TRAVELERS BUILDING • UTICA, NEW YORK 13502

A. EMPLOYER INFORMATION

FIRM NAME ______	DATE FIRM ESTABLISHED ______
ADDRESS ______ NATURE OF BUSINESS/ SIC CODE ______ TELEPHONE NUMBER ( ) ______ EMPLOYER CONTACT (Please Print) ______ TITLE ______	TYPE OF BUSINESS ❑ Corporation ❑ Partnership ❑ Sole Proprietor ❑ Other ______

B. EMPLOYEE INFORMATION, ELIGIBILITY AND EFFECTIVE DATE

Eligible Employees are: All active full-time employees who devote a minimum of 30 hours per week to the service of the above named employer at their regular and customary place of business.	
Requested Changes to the Definition of Eligibility ❑ None ❑ Details ______	Effective Date ___/___/___
Are all Eligible Employees participating in: Workers' Comp ❑ Yes ❑ No Social Security ❑ Yes ❑ No If no to either question, provide details: ______	Employees on Payroll Total ______
Are all employees currently actively at work? ❑ Yes ❑ No If no, complete form on the reverse side.	Eligible ______
When are employees eligible for coverage? New Employees: ❑ One Month ❑ Two Months ❑ Three Months ❑ Other ______ Current Employees: ❑ Effective Immediately ❑ Same as New Employees	Part-Time ______

C. PLANS SELECTED

C. PLANS SELECTED		% Paid by Employer
Basic Life/AD&D $10,000 Minimum* $75,000 Maximum	**Flat Benefit** ❑ Benefit Amount ______ **Class Schedule** ❑ Plan 1 ❑ $50,000/$25,000; Plan 2 ❑ $30,000/$15,000 **Multiple of Earnings** ❑ 1 Times ❑ 2 Times ❑ Max Benefit ______	______ %
Dependent Life**	Plan 1 ❑ Spouse $5,000/Child $2,000 Plan 2 ❑ Spouse $2,500/Child $1,000	N/A %
Supplemental Life**	Same as Basic Life ❑ (All amounts subject to evidence of insurability)	N/A %
Short Term Disability $750/Weekly Maximum	**Plan Design Options** Benefits begin Accident/Sickness 1st Day/8th Day — Plan 1 ❑ — Maximum Weekly Benefit Period 13 ❑ 26 ❑ 15th Day/15th Day — Plan 2 ❑ — Maximum Weekly Benefit Period 11 ❑ 24 ❑ 52 ❑ **Benefit Amount Options** — **Weekly Maximum** Benefit % 50% ❑ 60% ❑ 66⅔% ❑ — Plan 1 ❑ ______ Flat Amount (Subject to 70% of Earnings) — Plan 2 ❑ ______ Maternity ❑ Yes ❑ No Partial ❑ Yes ❑ No	______ %
Intermediate Disability*** $3,000/Monthly Maximum	**Plan Design Options** Benefits begin on the 31st day for Accident and Sickness Maximum benefit period is 24 months **Benefit Amount Options** — **Monthly Maximum is $3,000** Benefit % 50% ❑ 60% ❑ 66⅔% ❑ Maternity ❑ Yes ❑ No	______ %
Long Term Disability*** $7,500/Monthly Maximum	**Plan Design Options** Benefits begin Accident/Sickness — **Maximum benefit period is to Age 65** 91st day ❑ 181st day ❑ **Benefit Amount Options** — **Monthly Maximum** ______ Benefit % 50% ❑ 60% ❑ 66⅔% ❑ (Employer Must Pay at least 50%)	______ %

*Subject to age reductions. **Minimum of three participants. ***Employer may purchase either IDI or LTD.

D. EXISTING COVERAGE—Current coverage should not be cancelled until you receive written Home Office approval.

Does the employer currently have coverage similar to the coverage applied for? ❑ Yes ❑ No
If "Yes", provide details, or provide a copy of a booklet/certificate.

TYPE OF COVERAGE	SUMMARY OF BENEFITS	INSURANCE COMPANY

E. PREMIUM REQUIREMENTS

Deposit to be applied toward payment of premiums for coverage requested (minimum of one month's premium): $ __________
Premium Mode: ❑ Monthly ❑ Quarterly ❑ Other __________________________

F. EMPLOYEES NOT CURRENTLY ACTIVE AT WORK: ❑ None ❑ See Below

NAME	DOB	SEX	DATE LAST WORKED	DATE EXPECTED BACK	REASON FOR ABSENCE

G. PARTICIPATION AGREEMENT FOR THE MULTIPLE EMPLOYER GROUP INSURANCE TRUST COMPLETED REQUEST FOR COVERAGE ON REVERSE SIDE

The undersigned employer hereby elects to participate in the Multiple Group Insurance Trust, a Missouri Trust, and agrees to be bound by its terms and provisions which, subject to governance of the laws of the state of Missouri, may be amended from time to time. It is agreed that participation under any plan of insurance issued by such Trust will not become effective until the Employer is accepted by the insurance carrier issuing the coverage and notice of approval has been transmitted to the Employer.

The plan of insurance is subject, in every respect, to the group policy which alone constitutes the AGREEMENT under which benefits will be paid.

It is understood that the Employer intends to establish an employee benefit plan through this Trust participation and neither the Administrator, the Trustee nor the insurance carrier will act as "sponsor" or "fiduciary" of any such plan as defined in the Employee Retirement Income Security Act of 1974 (ERISA).

Employer Representation

I hereby certify that all statements are complete and true to the best of my knowledge

✕ ____

SIGNED (Employer) TITLE

____

SIGNED AT (City & State) DATE SIGNED

H. AGENT DATA

The agent named below is hereby recognized as the Agent of Record to receive credit for this submission according to company rules and regulations on coverage issued in accordance with this request for benefits, provided he or she is duly licensed as required by law.

I hereby certify that to the best of my knowledge and belief, all of the foregoing statements and answers are true.

SIGNED (Agent) ✕ ______________________ DATE SIGNED ______________________

FULL NAME (Please Print) ______________________ SOCIAL SECURITY NUMBER ______________________

NAME OF AGENCY/ INSURANCE COMPANY ______________________ BUSINESS PHONE (   ) ______________________

ADDRESS ______________________ Are you currently appointed with us? ❑ Yes ❑ No

Indicate to whom commission should be paid and any commissions splits if applicable % of Split

____ __________

____ __________