

**TEXAS  
EMPLOYER PARTICIPATION AGREEMENT/APPLICATION**

**JOHN ALDEN LIFE INSURANCE COMPANY**

<b>HOME OFFICE USE ONLY</b> Group Number: _____
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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) The first month's premium made payable to John Alden G.T. must accompany this submission.

Requested Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (**Must be 1st or 15th**)      Requested Billing Mode:     Monthly     Quarterly

**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  
 Texas Small Employer Health Coalition  
 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 organizations (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 (*must be a minimum of 50% of employee's 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
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.**
16. A Serious Mental Illness Benefit is available only at enrollment to groups of 2 to 50 employees and is automatically included for groups of 51+ employees.  
 If you wish to include the Serious Mental Illness benefit as part of your plan, check this box:

**SECTION B – PRIOR COVERAGE INFORMATION**

1. Will this plan replace another 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
<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
				<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 John Alden Life 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 John Alden Life 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 until eligibility is verified by John Alden Life Insurance Company and that any fraud or intentional misrepresentation of material fact not related to health status 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 John Alden Life Insurance Company by making any promise or representation.

I have been offered and hereby decline coverage under an alternative Consumer Choice of Benefits Health Insurance Plan that in whole or in part does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. I acknowledge that the coverage agreed to hereby is a health plan containing all applicable state-mandated benefits.

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) coverage will not become effective until evidence of eligibility has been received by John Alden Life Insurance Company; (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 John Alden Life 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 agree to meet all participation guidelines of John Alden Life Insurance Company now and in the future and acknowledge that insurance may be terminated if the percentage falls below the participation requirements for 6 consecutive months.** (10) John Alden Life 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 John Alden Life Insurance Company; (b) notice of effective date has been furnished by John Alden Life 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 John Alden Life 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.

John Alden Life Insurance Company relies on group and individual information as disclosed on the enrollment materials to set premium rates for the entire group. Any incomplete, untruthful or inaccurate information may result in an adjustment to the premium rates, while fraud or intentional misrepresentation of material fact not related to health status may result in insurance coverage being voided.

Any person who, with intent to defraud or knowing that they are facilitating against John Alden Life 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.

**SECTION E – ELIGIBILITY**

All eligible full-time employees, including those in the new employee waiting period, must submit an Enrollment Form or a Waiver of Coverage Form.

Total number of employees (including owners, partners, etc.) working in your business? \_\_\_\_\_

How many are full-time employees? \_\_\_\_\_ How many are 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**

An employee must be regularly scheduled to work at least 30 hours per week at any of the Employer's business establishments within the United States or Canada to be considered eligible for coverage. A partner, proprietor or corporate officer of the Employer must be currently working in connection with conducting the Employer's business.

The term "Employee" does not include any "seasonal" or "temporary" employees.

**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.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

*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 are met at all times while coverage is provided by John Alden Life Insurance Company (i.e. Wage & Tax Form, Payroll Records, Business License, etc.). In the event an Eligible Employee chooses to waive coverage of any type, I agree to either (1) deliver the original signed waiver form to John Alden Life Insurance Company or (2) if a copy of such waiver form is delivered, I agree to maintain the original signed waiver form as part of the Employer's records for no less than six years.

I understand that providing incomplete, inaccurate or untimely information not related to health status 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.

Signature of Employer \_\_\_\_\_ Title \_\_\_\_\_

Print Name of Employer \_\_\_\_\_ Date \_\_\_\_\_

## 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
- A business check, made payable to John Alden G.T.
- Copy of the prior carrier's most recent list billing statement, if replacing coverage

John Alden Life 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 John Alden Life Insurance Company to support that eligibility and participation is being met.

## SECTION G – NORTH STAR INFORMATION

Sales Office: \_\_\_\_\_

Sales Representative Name: \_\_\_\_\_ Representative #: \_\_\_\_\_

## 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 have complied with all of the underwriting rules and have explained the coverage fully.

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Commission Split: \_\_\_\_\_%

Print Agent's Name: \_\_\_\_\_ Agent #: \_\_\_\_\_

Agent's Address: \_\_\_\_\_ Agent's Phone #: (\_\_\_\_\_) \_\_\_\_\_

Agent's City, State, Zip: \_\_\_\_\_ Agent's Fax #: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### SECONDARY AGENT INFORMATION

Secondary Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Commission Split: \_\_\_\_\_%

Print Agent's Name: \_\_\_\_\_ Agent #: \_\_\_\_\_

Agent's Address: \_\_\_\_\_ Agent's Phone #: (\_\_\_\_\_) \_\_\_\_\_

Agent's City, State, Zip: \_\_\_\_\_ Agent's Fax #: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_