ASSURANT Health®

TEXAS
EMPLOYER PARTICIPATION AGREEMENT/APPLICATION

HOME OFFICE USE ONLY Group Number: ________________________

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 Assurant Health *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. Phone Number: (_______)______________________ Fax Number: (_______)______________________
5. Contact Person and Title:____
6. E-mail Address: ____
7. Owner(s) Name(s): ____
8. Nature of business/articles sold, manufactured, or service rendered: ______________________________
9. Type of Ownership/Filing Status: ☐ Proprietorship ☐ Partnership ☐ C-Corporation ☐ S-Corporation
   ☐ For Profit ☐ Non-Profit ☐ Government Agency/Entity
   ☐ Texas Small Health Employer Coalition ☐ Other (specify) ________________________
10. Federal Tax Identification Number: ____________________ How long has this company been in business? _______________
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 then one physical location?... ☐ Yes ☐ No
    If "Yes," to either of the above, complete the following. Write the number of Full-time and Part-time employees whether they are enrolling or not.

	Address	Nature of Business	Business Relationship	Tax ID #	# PT	# FT
Location #1						
Location #2						
Location #3						

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)*:
    ☐ 0 days ☐ 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.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

SECTION B – 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 **provide 12 months of information below and attach a copy of the most recent billing for both medical and dental.**

Prior Medical Carrier(s)	Policy Number	Effective Date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)

Major Medical Plan? ☐ Yes ☐ No

Orthodontics? ☐ Yes ☐ No

Prior Dental Carrier	Policy Number	Effective Date (MM/DD/YYYY)	Termination Date (MM/DD/YYYY)

Major Services? ☐ Yes ☐ 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.

Name	Title *(Owner, Partner, Officer, etc.)*	Reason Not Covered

SECTION D – 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 have read the group plans brochure, any applicable Supplements, and the dental plans brochure, and understand the coverages they describe.

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 Time 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 Time 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 Time 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 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 agree to meet all participation guidelines of Time Insurance now and in the future and acknowledge that insurance may be terminated if the percentage falls below the participation requirements for six consecutive months;** (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, 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 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.

SECTION E – ELIGIBILITY

All eligible full-time employees, including those in the new employee waiting/affiliation period, must submit an Enrollment Form or a Waiver of Coverage Form. If additional employees are hired between the date this application is completed and the date coverage is issued, completed Enrollment Forms or Waiver of Coverage Form must be submitted within 5 days of date of hire.

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, family medical leave, or receiving disability benefits? ..... ☐ Yes ☐ No

If "Yes," give names and details. ____

ELIGIBLE EMPLOYEES

An eligible employee is any person who performs services on a full-time basis (defined as at least 30 hours per week) and is considered an employee for federal employment tax purposes, at any of the employer's business establishments.

A partner, proprietor or corporate officer of the employer is eligible if he/she performs services for the employer on a full-time basis (defined as at least 30 hours per week), at any of the employer's business establishments.

The term "Employee" does not include: a) retirees or employees who are not expected to perform any duties, responsibilities or services for the employer; or b) "part-time" employees; or c) any "seasonal" or "temporary" employees who work only part of the calendar year on the basis of natural or suitable times or circumstances.

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 Time 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 further agree to either (1) deliver the original signed waiver form to Time 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/Application, 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 Assurant Health
- ☐ Copy of the prior carrier's most recent list billing statement, if replacing coverage

Time 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 Time Insurance Company to support that eligibility and participation requirements are met.

SECTION G – 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: ______________________

Print Agent's Name: ____________________________ Agent #: ____________________

Agent's Address: _______________________________ Agent's Phone #: (_______) ______________

Agent's City, State, Zip:__________________________ Agent's Fax #: (_______) ________________

E-mail Address: ______________________________

SECTION H – DISTRIBUTION PARTNER'S INFORMATION (Complete all applicable fields)

Office Name: ______________________________ Office #: ______________ DA #: ______________

Representative Name:_________________________ Representative #: ______________________

Representative Phone #: (______)_________________ Representative Fax #: (______)_______________

Email Address: ______________________________

SECTION I – SPECIAL MAILING INSTRUCTION

If no address is indicated below, the group kit will be mailed according to the distribution partner's policy.

Mail New Business Kits to: ____

At Address Specified: ____

____

____

Mail future certificates to: ____

At Address Specified: ____

____

ASSURANT
Health

Name of Group: ____

Group Number: ___________________

Employer contribution

________ % Current percent the employer pays for the employee's medical premium

________ % Current percent the employer pays for the dependent's medical premium

Group Size

______ Total Group Size

How to determine group size:

The average number of total employees working for the employer on business days during preceding calendar year. This must include **each full-time, part-time or seasonal employee**. Please note, if your business has any affiliated companies as defined by the federal tax code, employees of the affiliated companies must be included in your total count. If you believe that your business may have affiliated companies, please consult your tax advisor on how to complete this form.

NOTE: If the business was not in existence during the preceding calendar year, determine group size using the following:

In the case of an employer that was not in existence throughout the preceding calendar year, the Total Group Size shall be the average number of employees that the employer reasonably expects to employ on business days in the current calendar year.

The undersigned has the authority to make decisions on behalf of the employer and agrees that all the information shown above is correct and complete.

Signature and Title: ____

Print Name: ____Date: ________________