

JOHN ALDEN REWARDSSM EMPLOYER 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 current copy of the employer's quarterly state wage and tax must accompany this submission.
 - 3) Note on your state quarterly each employee's current status (full-time, part-time, etc.) and hours worked/week.
 - 4) A signed copy of the proposal/quote must accompany this submission.
 - 5) The first month's premium made payable to Key Benefit Administrators, Inc. must accompany this submission.

Requested effective date ____ / ____ / ____

SECTION A – Employer Information

Company Name: _____
(Full Legal Name of Company)

Contact Person and Title: _____ Phone Number (____) _____

E-mail Address: _____ Fax Number (____) _____

Owner(s) Name(s): _____

Street Address: _____ Mailing Address: _____
(If Different)

City, State, Zip _____

Nature of Business/articles sold, manufactured, or services rendered _____

Type of Ownership/Filing Status: Proprietorship Partnership C Corporation S Corporation
 For Profit Non-Profit Government Agency/Entity
 Other (specify): _____

Federal Tax Identification Number: _____

How long has this company been in business? _____

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
 Does your business have more than one physical location?..... Yes No
 If Yes to either of the above, complete the following:

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

Employer contribution to premium (must be a minimum of 50% of employee's premium): Medical _____%

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

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 – Plan Information

Eligible Employees

The Employer has the right to establish eligibility requirements for the group. If the employer does not request different requirements, eligibility will be administered based on the following: 30 hours per week, 48 weeks per year standard. A partner, proprietor or corporate officer of the employer must be working the specified hours and weeks for eligibility in connection with conducting the employer's business.

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 less than 48 weeks a year.

total # of employees

1. How many people, including owners are employed by your business? _____
- a) How many are full-time employees, including owners on your payroll? _____
- b) How many are full-time employees not on your payroll (contractors/1099/leased)? _____
- c) How many are part-time employees? _____
- d) Number of employees not identified above (explain): _____

2. Is there a class of employees that you are not including? (explain): _____ 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.

4. List all employees in your company not shown on your most current quarterly wage and tax statement, including:
 - a) **Employees still in their waiting 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.**
 - d) **If group is not required to file a state quarterly wage and tax statement, this census must be completed**

Please indicate current status using the following status codes:

F - Full-time (as defined above)

P - Part-time

R - Retired

C - Continuation (State/Federal)

A - Active Partner

T - Temporary or Seasonal

I - Independent Contractor

D - Totally Disabled Employee

W - Within Waiting Period

O -Other (Please Explain): _____

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 required)

5. Are any former employees or dependents currently on, have already elected or are eligible to elect COBRA/state continuation? Yes No
If Yes, provide the following information:

Name	Start Date	End Date	Type of Continuation	Reason
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6. Are there any employees who are not actively working due to injury or disability? Yes No
If Yes, please complete the following:

Name	Reason	Not Working Since (date of injury or disability)	Expected Date of Return
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SECTION C – Benefit Information

A SIGNED COPY OF THE PROPOSAL/QUOTE MUST BE ATTACHED TO THIS APPLICATION.

Will this plan replace other group coverage? Yes No
If Yes, complete the following and attach a copy of the most recent billing for both medical and dental:

Prior Medical Carrier(s)	Policy Number	Phone Number	Effective Date	Termination Date	Major Medical Plan?
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Select a provider network: _____

Employee Benefit selection: 100% / 70% 90% / 70% 80% / 60% 70% / 50% 50% / 50%

Optional HSA: Owner(s) only All Employees Specified class Describe: _____
HRA: Owner(s) only All Employees Specified class Describe: _____

SECTION D – Worker's Compensation Information

Name of Workers' Compensation Carrier _____

Policy/Certificate # _____ 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 E – 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 without the approval of John Alden Life 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 John Alden Life 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: benefits under the Group Policy and the cost of providing those benefits may change; 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; those subject to evidence of insurability must receive prior approval by John Alden Life Insurance Company at its home office before coverage becomes effective; (1) no insurance will become effective until the first full premium has been paid; (2) the cancelled check tendered as the first premium will be a receipt for deposit; (3) the Group Policy may be discontinued by John Alden Life Insurance Company under certain circumstances identified in the Group Policy and Certificates of Coverage; (4) a minimum of 50% contribution toward the employee cost of insurance is required; (5) only full-time employees and their dependents are eligible; and (6) **I must enroll all eligible employees now and in the future according to the participation rules of John Alden Life Insurance Company and that insurance may be terminated if the percentage falls below the participation requirements.** (10) 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. (11) 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.

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.

Signature and Title _____ Date _____

Print Name _____ Signed at (city/state) _____

SECTION F – Agent Checklist

1. **Complete sections A, B and C.**
Healthy Rewards is for employers with 5 or more employees
2. **Include the following documents with your application:**
 - Signed and dated proposal indicating stoploss and plan design options
 - Administrative Services agreement
 - Risk Management Services agreement
 - HSA Enrollment Form, if applicable
 - HRA Enrollment Form, if applicable
 - All eligible employee enrollment forms
 - Your state quarterly unemployment withholding form
 - Your renewal premium notice and last billing notice from your current carrier
 - Any state-specific forms, as indicated by your agent
3. **Include a check for the first month's cost**
Make check payable to Key Benefit Administrators, Inc.
4. **Send your completed application, attached documents and check to:**
Key Benefit Administrators, Inc.
P.O. Box 1239
Fort Mill, SC 29716-1239

SECTION G – Agency Information

Office Name: _____ Office # _____
Representative Name: _____ Representative # _____
Representative Phone # (_____) _____ Representative Fax # (_____) _____

SECTION H – Agent's Statement

I certify that all of the information contained in the Employer Agreement 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 Phone # (_____) _____
Agent's City, State, Zip: _____ Agent Fax # (_____) _____

SECTION I – Special Mailing Instructions

Mail New Business Kit to: Writing Agent at Address Specified: _____
 Other (please specify): _____
