CENTRAL RESERVE LIFE INSURANCE COMPANY
17800 Royalton Road • Cleveland, OH 44136-5197 • 440-572-2400
www.centralreserve.com

PARTICIPATION REQUEST AND AGREEMENT

The undersigned hereby requests approval from Central Reserve Life Insurance Company (CRL) for participation in the group insurance trust (designated as the International Professional Trust [Trust]) and agrees to comply with, satisfy and be bound by all terms and conditions of the Trust and the group policies.

Certification of Employer:

EMPLOYER (EXACT LEGAL NAME INCLUDING ANY DBA)	TELEPHONE NUMBER ( )			FAX NUMBER (OPTIONAL) ( )	
BUSINESS STREET ADDRESS	CITY	STATE	COUNTY	COUNTY CODE	ZIP
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	COUNTY	COUNTY CODE	ZIP
CORPORATE ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	COUNTY	COUNTY CODE	ZIP
NATURE OF BUSINESS (BE SPECIFIC)	MONTH / YEAR STARTED	EMPLOYER'S FEDERAL I.D. NUMBER			

Employer-Sponsored Group Major Medical Plan:

1. **Arizona Employers only:** Complete Form AEF-0571.

   All other Employers: Are all employees, including owners, who are applying for coverage under this plan, full-time, permanent employees Actively Working a minimum of 30 hours per week (as defined by state law) and receiving Earnings? ☐ Yes ☐ No

   All Employers, including Arizona Employers: Check which of the following apply: ☐ Corporation ☐ Partnership ☐ Sole-proprietor (If Sole-proprietor, number of full-time employees to be insured, including the sole-proprietor/ owner:_____) ☐ Other ____________________

2. Subsequently added full-time employees are eligible for coverage on the first day of the month following completion of one month's continuous full-time service. A waiting period longer than 1 month may be elected (varies by state law). Indicate waiting period here: ________________

3. Total number of employees: _____
   Total number of full-time employees: _____ (Include owners and any employees in their waiting period.)
   Total number of part-time employees (to determine HIPAA/COBRA eligibility): _____
   Total number to be insured: _____ Total number of Non-participating Employee Waivers: _____

4. Do you offer multiple health benefit plans to your employees and have an open enrollment period during which employees may select from any of the plans made available? ☐ Yes ☐ No

   If so, when is your open enrollment period?_________ How many days is open enrollment available? _________

   (In Kansas, the open enrollment period is on the employer's annual renewal date.)

5. Is this group a non-profit organization? ☐ Yes ☐ No If "Yes", complete a Non-Profit Organization Questionnaire.

6. Does this application include employees of any subsidiary companies or any other business enterprise? ☐ Yes ☐ No

   If "yes," provide details: ____________________

7. Is any person currently, or will soon be, covered under a continuation of coverage benefit, such as COBRA or an extended benefit provision? ☐ Yes ☐ No If "Yes", an Enrollment Application must also be included for that person. Provide name(s) and expected termination date of coverage: ____________________

8. Did you employ 20 or more employees 50% of the preceding year? ☐ Yes ☐ No

9. Is coverage being replaced? ☐ Yes ☐ No If "Yes", include a copy of the prior carrier(s) billing statement and a copy of the Certification of Creditable Coverage for each employee and dependent. Provide a copy of the Schedule of Benefits for groups in NV (25+ lives).

10. Are your employees responsible for paying any portion of their insurance premium? ☐ Yes ☐ No
    If "Yes," provide the percentage of premium being paid by each employee (must be no more than 75%): _________

11. **Plan Desired:**

☐ PROFESSIONAL MULTI-OPTION

☐ Non-Composite Rate ☐ Composite Rate (10+ health lives only)

Deductible: ______________________

PPO Network: ______________________

Coinsurance Limit: ______________________

Coinsurance Percentage: ______________________

Optional Benefits:

☐ $300 Accident Expense Benefit
☐ $500 Accident Expense Benefit
☐ Vision Service Plan (VSP)
☐ Short-Term Disability: $__________
Waiting Periods: ☐ 1-8-13 ☐ 1-8-26
(If Short-Term Disability is selected, complete #12)
☐ Supplemental Life Insurance
☐ Optional Employee Deductible
☐ Progressive Dental B
☐ Drug Card Program Upgrade

☐ PARTNERSHIP OPTION

Employer Deductible: ______________________

PPO Plan ______________________

PPO Network: ______________________

Employee Deductible: ______________________

Employee Co-insurance Limit: ______________________

Optional Benefits:

☐ Vision Service Plan (VSP)
☐ Short-Term Disability: $ _____ **(If Short-Term Disability is selected, complete #12.)**
Waiting Periods: ☐ 1-8-13 ☐ 1-8-26
☐ $300 Accident Expense Benefit
☐ $500 Accident Expense Benefit
☐ Prescription Drug Card Benefit: ☐ 1 ☐ 2 ☐ 3
☐ Organ Transplant/Lifetime Maximum Upgrade
☐ Supplemental Life Insurance

☐ HSADVANTAGE

Deductible:
_______ single coverage
_______ family coverage
PPO Plan __________ PPO Network: __________
Coinsurance: ☐ (75%/25%) ☐ (100%)
☐ Managed Indemnity Plan Coinsurance: ☐ (75%/25%) ☐ (100%)

Optional Benefits:

☐ Vision Service Plan (VSP)
☐ Organ Transplant/Lifetime Maximum Upgrade

12. **EMPLOYEE CLASSES (Required for Professional Multi-Option and HSAdvantage groups of 10 or more and for all Partnership Plans.)**

CLASS	DESCRIPTION	NO. IN CLASS	TOTAL LIFE	AD&D	TOTAL SHORT-TERM DISABILITY

Requested Effective Date: ______________________ If insurance is approved, the actual effective date will be determined by CRL's Home Office.

DO NOT CANCEL EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN APPROVAL FROM CRL'S HOME OFFICE

NOTICE: For OHIO residents only: We are required by Ohio law to inform you of the following: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

NOTICE: For PENNSYLVANIA residents only: We are required by Pennsylvania law to inform you of the following: Any person who knowingly and with intent to defraud any insurance company or other person files an application of insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE: For TENNESSEE residents only: We are required by Tennessee law to inform you of the following: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE: For VIRGINIA residents only: We are required by Virginia law to inform you of the following: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

I understand, acknowledge and certify that I have read the Participation Request and Agreement, and understand that it will become part of my contract of coverage.

______________________ PRINT EXACT LEGAL NAME OF EMPLOYER

______________________ PRINT NAME AND TITLE OF EMPLOYER/AUTHORIZED REPRESENTATIVE

______________________ SIGNATURE OF EMPLOYER/AUTHORIZED REPRESENTATIVE

______________________ DATE

CERTIFICATION OF SOLICITING INSURANCE AGENT TO CRL:

As the soliciting insurance agent, I certify that I have fully explained to the above Employer all provisions of the Participation Request and Agreement, a specimen of the enrollment application, the group insurance plan selected by the Employer, and all insurance benefits, limitations, exclusions and conditions of the selected group insurance plan as described by CRL in its brochure.

I have advised the above-named Employer: (1) not to cancel any existing coverage until the Employer has received a written notice of approval from CRL's Home Office; and (2) if the Employer is approved for coverage by CRL, the notice of approval will indicate the effective date of coverage.

I further certify that I have reviewed all documents completed by the Employer for participation in the Trust and all enrollment applications completed by the eligible employees and their dependents requesting insurance coverage, and that all such documents are properly completed for submission to CRL. I further certify that in soliciting this business, I have fully complied with and signed the CRL Agent Code of Ethics and Procedures, form S911, and I have not exceeded my limited authority as an agent.

Signed at ____________________, on this __________ day of ______________, 20 __________

____

Signature of Soliciting Insurance Agent   Agent SS. # (Required)   Agent Code

____

Print or Type Name of Agent   Agent Address

TO BE COMPLETED BY GA/MGA	GA/MGA	GA/MGA Code

The Employer understands, acknowledges and certifies the following:

1. The Trustee of the Trust is the Policyholder of the group insurance policies which will insure Employer's eligible Employees and their eligible Dependents, if approved by CRL.
2. Insurance premiums constitute a part of the funds of the Trust and will be paid directly by the Employer to CRL as payments for and on behalf of the Trustee of the Trust.
3. The group insurance plan will be made available to all of Employer's eligible Employees in accordance with the terms of the group insurance policies issued to the Trustee of the Trust.
4. Upon acceptance for participation in the Trust, the Employer will become a party and will be subject to the written Agreement and Declaration of Trust (Agreement) between the Trustee and the participating Employers therein, as amended, and which may be amended from time to time in the future, the terms and conditions of which are incorporated into this Participation Agreement by reference. The Agreement is on file in the Home Office of CRL and is available for inspection by the Employer.
5. The terms of the coverage, including premiums and benefits, are subject to change under the terms of the Policy. A written notice of such change will be provided.
6. Insurance coverage for the eligible Employees of Employer will become effective only on the date specified by the Home Office by written notice to Employer.
7. Each insurance premium is due, in full, in advance of each period of insurance coverage. Failure to pay insurance premiums as provided by the terms of the group insurance policies will result in automatic termination of all insurance coverage for all Employees and Dependents.
8. Payment by check shall not constitute payment of insurance premiums until the check has been received by CRL's Home Office and honored by the drawee bank when presented.
9. CRL does not have nor does it assume any responsibility for the Employer's obligations or compliance under ERISA, COBRA or any other federal or state employer law.
10. Eligibility for both the initial and for continuing participation in the Trust and for coverage under CRL's group insurance plan are conditioned upon the Employer being engaged in a legitimate business enterprise as described in this Participation Request and Agreement.
11. Each Employee who does not complete an application for coverage under CRL's plan will complete and submit to CRL a Non-participating Employee Waiver. If any Employee fails to complete the Waiver, CRL may, in its discretion, decline coverage for the entire group due to inadequate information regarding participation.
12. Subsequently added individuals are accounted for by either enrollment application or a Non-participating Employee Waiver.
13. All insurance coverage on each eligible Employee and each eligible Dependent of such Employee is conditioned upon and subject to all applicants meeting all requirements for coverage. No insurance will go into effect for an eligible Employee and the eligible dependents of such Employee unless full disclosure of any requested health information has been made on the applicable enrollment forms and during verification.

14. The Employer is solely responsible for distributing any riders, certificate booklets, notices or other information received from CRL to the Employees.
15. If the prescription drug card option is selected, the Employer must notify CRL immediately if an Employee's insurance coverage is no longer in force (for example, the Employee is terminated from employment). If the Employer fails to notify CRL immediately and the Employee continues to use the drug card, the Employer will be liable for all unauthorized charges.
16. If an Employee/dependent is no longer eligible for insurance coverage, notice must be provided to CRL within 30 days after the date of ineligibility.
17. Changes to the Waiting Period may be made at the written request of the Employer.
18. Optional benefits may be added or deleted by written request. Any change in benefits will be subject to underwriting for rating purposes by CRL's Home Office.
19. Federal laws and certain state laws may require an employer to provide the same coverage for pregnancy as is provided for an illness. If you are required to provide full pregnancy benefits, and decline to elect full pregnancy benefits as an option (or, if it is not already included in the plan), you must self-insure full pregnancy benefits. If you are uncertain of the requirements, please consult your own legal advisor.
20. 24-Hour Coverage is included, but *only* for an individual who works for himself or herself, such as a sole proprietor, partner, farmer or independent contractor and who is exempt from state or federal workers' compensation statutes
21. The Participation Request and Agreement is subject to the approval of CRL at its Home Office, and nothing contained herein shall be binding upon the Policyholder (Trustee), or CRL, until so approved in writing. The agent has limited authority to represent CRL. For example, the agent has no authority to vary or change any of the terms or conditions of this agreement nor any other form or agreement required by CRL. Furthermore, the agent has no authority to promise that coverage will be approved by CRL or that coverage will be effective on a particular date. If the insurance does not become effective, the amount paid will be refunded.
22. Any disputes arising under the Policy are subject to an appeals procedure and arbitration, which may be binding, depending on state law.
23. An Employee and or any eligible Dependent(s) will be effective on the date specified in writing by CRL's Home Office. An Employee who does not meet the definition of Actively at Work will not have coverage become effective until he/she has returned to Active Work and has been notified in writing by CRL's Home Office of the effective date.
24. An Employee shall be considered Actively at Work if the Employee is working not less than thirty (30) hours per week (varies by state) in the performance of regular duties in the Employer's business. An Employee shall also be considered Actively at Work if the Employee is, on the date that the coverage would otherwise be effective, on a regular paid vacation, Family Medical Leave, or absent from work due to a health-related factor (e.g., absent from work due to Illness). The Employer certifies that all Employees are Actively at Work. CRL may request any documents necessary to verify an employer/employee relationship.
25. Employer shall notify CRL's Home Office by contacting a Customer Service Representative or by sending written notification to CRL's Home Office within thirty (30) days:
    a. after an Employee/Dependent is no longer eligible for coverage and is to be terminated from the plan;
    b. if an Employee is no longer actively working due to a disability; or
    c. after Employee is laid off or goes on an approved leave of absence.
26. Employer agrees to pay, upon demand, the amount of premium owed CRL due to the failure of Employer, Employee, or Dependent to provide, regardless of the reason, the information necessary for CRL to properly underwrite the group for rating purposes in accordance with state law. If Employer fails to make the required premium payment, CRL may terminate the employer group for nonpayment. Such termination shall be as effective as of the last date for which premium was paid before the amount owing was added to the billing.
27. Small Employer Certification: If I am applying for guarantee issue, I certify that I currently meet the definition of a small employer as defined by the Health Insurance Portability and Accountability Act of 1996 or the laws of the state where this company is located. In general, a small employer is defined as "An employer who employed an average of at least 2 but not more that 50 Employees on business days during the preceding calendar year and who employs at least 2 Employees on the first day of the plan year." Unless otherwise provided by state law, a minimum of two Employees must be enrolling, subject to all other eligibility and participation requirements.
28. Certification of Creditable Coverage: The Group Health Plan and health insurance issuer is responsible for providing Certification of Creditable Coverage upon termination of the Insured Person's coverage or, upon request, within 24 months of such termination. CRL will assume the responsibility of providing the certification for the period of time during which the individual was insured by CRL using the standard method. If the Employer provides an option of more than one carrier's plan to his and/or her Employees, the Employer is responsible for obtaining Certification(s) of Creditable Coverage from all such carriers and providing such certification to all Employees and dependents. CRL will accept and/or provide information regarding Creditable Coverage to another carrier through means other than a written certification (e.g., by telephone).
29. This Participation Request and Agreement will become part of my contract of coverage.

PLEASE MAKE AND RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.