

## 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 _____ ADDRESS _____ NATURE OF BUSINESS/ TELEPHONE _____ SIC CODE _____ NUMBER (____) _____ EMPLOYER _____ CONTACT (Please Print) _____ TITLE _____	DATE FIRM ESTABLISHED _____ TYPE OF BUSINESS <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other _____
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### 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 <input type="checkbox"/> None <input type="checkbox"/> Details _____	Effective Date ____ / ____ / ____
Are all Eligible Employees participating in: Workers' Comp <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No If no to either question, provide details: _____	Employees on Payroll Total _____
Are all employees currently actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, complete form on the reverse side.	Eligible _____
When are employees eligible for coverage? New Employees: <input type="checkbox"/> One Month <input type="checkbox"/> Two Months <input type="checkbox"/> Three Months <input type="checkbox"/> Other _____ Current Employees: <input type="checkbox"/> Effective Immediately <input type="checkbox"/> Same as New Employees	Part-Time _____

### C. PLANS SELECTED

	% Paid by Employer																														
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\*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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Other _____
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**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

**X**

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) <b>X</b> _____	DATE SIGNED _____
FULL NAME (Please Print) _____	SOCIAL SECURITY NUMBER _____
NAME OF AGENCY/ INSURANCE COMPANY _____	BUSINESS PHONE (      ) _____
ADDRESS _____	Are you currently appointed with us? <input type="checkbox"/> Yes <input type="checkbox"/> No

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