

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
 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 than 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.

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):
 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 John Alden Life Insurance Company.

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 Forms 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 John Alden Life Insurance Company (i.e. Wage & Tax Form, Payroll Records, Business License, etc.).

I understand that providing incomplete, inaccurate or untimely information 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

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 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: _____ 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: _____

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

Office Name: _____ Office #: _____ DA #: _____

Representative Name: _____ Representative #: _____

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

E-mail 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: _____
