ACEC LIFE/HEALTH TRUST

MEMBER FIRM GROUP APPLICATION FOR HEALTH CARE BENEFITS

EMPLOYER INFORMATION

Employer Name _____ Requested Effective Date _____

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other Years in Business _____

Employer Tax ID# _____ Email _____

Address _____

Mailing Address (if different) _____

Contact _____ Title _____ Phone Number _____

Nature of Business Engineering Company – SIC 8711 Fax Number _____

Current Group Medical Insurance ☐ Yes ☐ No Current Health Plan Carrier _____

Please indicate the carrier(s) you have had the past five (5) years

Carrier _____ List Coverage Dates (From-To) _____

Carrier _____ List Coverage Dates (From-To) _____

ADDITIONAL INFORMATION

Total number of employees (including active Partners, Proprietors and Corporate Officers: _____

Number of eligible full time employees working 30 or more hours per week _____

Define your company policy relative to employee eligibility

Eligible DOH ☐ Eligible First of Mo DOH ☐ Eligible First of Mo 30 days DOH ☐ Eligible First of Mo 60 days DOH ☐

Number of former employees / dependents on COBRA _____

Are you interested in obtaining a quote on the ACEC Life Health Trust Ancillary Products?

Short Term Disability ☐ **Term Life** ☐ **Dental** ☐ **Vision** ☐ **Cancer** ☐ **Critical Illness** ☐ **Accident** ☐ **Long Term Disability** ☐

QUOTE REQUIREMENTS

Depending upon Firm group size, there are three levels of underwriting requirements in order to obtain a quote on your health insurance:

Firms with <25 employees + dependents

- Employee and Dependent census to include name, age, date of birth resident zip code and gender
- Employee level health statements
- Current and renewal plan rates
- Current and renewal plan summaries
- Employer level disclosure

Firms with 25> employees + dependents but <100 employees

- Employee and Dependent census to include name, age, date of birth resident zip code and gender
- Current and renewal plan rates
- Current and renewal plan summaries
- Employer level disclosure

Firms with >100 employees

- Employee Level Census
- 24 months of claims experience (premium vs claims report)
- Large claims report
- Current and renewal plan rates
- Current and renewal plan summaries
- Employer level disclosure

I, the undersigned employer, wish to become a participating employer. I am acquainted with the rules of eligibility and understand that the effective date of the insurance for which I am applying shall be subject to the written approval of the ACEC Life/Health Trust. I understand that the benefits provided shall be subject to the terms of the group insurance policy(ies) as amended from time to time, and that those group insurance policies may be terminated by the ACEC Life/Health Trust following due notice. I agree to remit to the Administrator regularly, in advance, the required monthly premium contributions for insurance, and I understand that failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the 31-day grace period. I agree to offer the insurance to all present and future employees who work for remuneration on a full-time basis. I also agree to maintain the participation requirements of the plan with respect to eligible employees and their eligible dependents in order to procure and continue the requested insurance and agree that any insurance issued as a result of this request may be cancelled as of any monthly premium due date if participation requirements are not maintained.

Dated: _____ Firm's Legal Business Name: _____

Printed Name: _____ Title: _____

Employer's Signature: _____

WRITING AGENT (if applicable)

To the best of my knowledge all statements in the Member Firm Group Application and representations are complete and true. My client has been advised by me not to terminate any existing coverage until receiving notice that the coverage being applied for is accepted. I agree that I have not the right to bind this coverage, alter terms of the insurance contract or Member Firm Group Application, or adjust any claim for benefits under the insurance contract.

Dated: _____

Writing Agent's Name (Printed): _____

Writing Agent's Signature: _____

Submit this completed application to: sales@aceclifehealthtrust.com. Additional instructions will be forwarded to you

Edited: August 2017