MMA 2080

APPLICATION FOR PARTICIPATION IN THE PLAN OF INSURANCE TO BE UNDERWRITTEN BY COMPANION LIFE INSURANCE COMPANY

Administered by
Self Insured Service Company (SISCO)

SECTION I – Subscription Agreement to Trust and Application for Participation

The undersigned Employer hereby adopts the Agreement and Declaration of Trust, in which the Bank of Newport, Newport, Rhode Island is Trustee, known as The Companion Limited Benefit Medical Trust, agrees to be bound by all the terms, provisions, conditions, and limitations of said Agreement and Declaration of Trust and all lawful amendments thereto; and applies to the Insurer for group indemnity insurance under a policy or policies issued to the Trustee for the plan(s) of insurance shown in Section II, subject to the following conditions. Effective as of the date the Employer is approved as an eligible employer, it (1) agrees to be bound by all the terms and provisions of the policy or policies insuring such plan issued to the Trustee including riders or amendments to such policy or policies applying to the Employer's plan (herein called the "policy"); and (2) understand that the Employer's application for insurance is subject to the approval of the Insurer (or designated representative), that nothing contained herein shall be binding upon the Insurer until the application is approved and accepted in writing by the Insurer.

SECTION II – Specifications for Group Insurance

1. Legal Name of Applicant Firm

____

Company Address

____
(Street) (City) (State) (Zip Code)

Mailing Address- if different than above

____
(Street) (City) (State) (Zip Code)

Telephone Number (_____)____________________Fax Number (_____)____________________

Billing Address – If different from above

____
(Street) (City) (State) (Zip Code)

Billing Contact Name ______________________________ Phone (_____)____________________

Billing Contact Fax (_____)__________________________ Email___________________________

Nature of Business ______________________SIC Code _________________________

Tax ID # ______________________

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2. Do your Employees, or any classification of Employees, have Group Coverage under another carrier?
   ❒ Yes ❒ No
   If "Yes", will this insurance replace it? ❒ Yes ❒ No

   Current Insurer's Name and Telephone Number:
   ____

3. Is there any class of employees to be excluded? ❒ Yes ❒ No
   Explain
   ____

4. Waiting Period – The effective date for new employees:
   ❒ The first day of the month following date of employment
   ❒ The ______________ day of the month following ________ month(s) or ________ days of employment
   ❒ Other ____
   Waive waiting period for current employees: ❒ Yes ❒ No

5. Open Enrollment Period: ____ / ____ / _______ to ____ / ____ / _______

6. Enrollment Method: ❒ Paper (face-to-face) ❒ Call Center

7. Total Number of Employees: _______

Subtract:	Employees not Eligible (works less than ___ hours per week)	Less -	_______
	Employees (class to be excluded)	Less -	_______
	Employees in Waiting Period	Less -	_______
	Other (explain) ________________________________	Less -	_______
	Total Number of Eligible Employees	Equals =	_______

Note:

- *Eleven to 25 employees require 50% participation. Groups with 26-99 employees require a 25% participation level. 100-250 eligible lives require 25 enrolled employees. 251+ eligible employees require 10% participation.*
- *To qualify as an Employer Sponsored plan the minimum employer contribution must be 50% of the cost of the lowest single plan offered or $25.00, whichever is the greater amount.*

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SECTION III – Limited Medical and Life Insurance

PLAN SELECTION: ***REQUIRED BENEFITS***

Benefit Description	❒ **Plan Name** ____________	❒ **Plan Name** ____________	❒ **Plan Name** ____________
Doctor Office Visits & Outpatient Clinic Benefit Per Visit	❒ $30 ❒ $40 ❒ $50 ❒ $60 ❒ $70 ❒ $80 ❒ $90 ❒ $100	❒ $30 ❒ $40 ❒ $50 ❒ $60 ❒ $70 ❒ $80 ❒ $90 ❒ $100	❒ $30 ❒ $40 ❒ $50 ❒ $60 ❒ $70 ❒ $80 ❒ $90 ❒ $100
Calendar Year Maximum *(No Family Maximum)*	❒ 6 Visits per Person per Year ❒ 8 Visits per Person per Year	❒ 6 Visits per Person per Year ❒ 8 Visits per Person per Year	❒ 6 Visits per Person per Year ❒ 8 Visits per Person per Year
Surgery and Anesthesia Indemnity Benefit (Paid according to a surgical schedule.)	❒ $500 ❒ $1,000 ❒ $1,500 ❒ $2,000 ❒ $2,500 ❒ $3,000 ❒ $3,500 ❒ $4,000 ❒ $4,500 ❒ $5,000 **Anesthesia Benefit** – Paid at 20% of the surgical schedule reimbursement.	❒ $500 ❒ $1,000 ❒ $1,500 ❒ $2,000 ❒ $2,500 ❒ $3,000 ❒ $3,500 ❒ $4,000 ❒ $4,500 ❒ $5,000 **Anesthesia Benefit** – Paid at 20% of the surgical schedule reimbursement.	❒ $500 ❒ $1,000 ❒ $1,500 ❒ $2,000 ❒ $2,500 ❒ $3,000 ❒ $3,500 ❒ $4,000 ❒ $4,500 ❒ $5,000 **Anesthesia Benefit** – Paid at 20% of the surgical schedule reimbursement.
Hospital Indemnity - Daily Inpatient Benefits:	❒ $100 ❒ $200 ❒ $300 ❒$400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1,000	❒ $100 ❒ $200 ❒ $300 ❒$400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1,000	❒ $100 ❒ $200 ❒ $300 ❒$400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1,000
Group Size 5 – 499 eligible:	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1,000 ❒ $1,100	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1,000 ❒ $1,100	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1,000 ❒ $1,100
Group Size 500 eligible or larger:	❒ $1,200 ❒$1,300 ❒ $1,400 ❒ $1,500	❒ $1,200 ❒$1,300 ❒ $1,400 ❒ $1,500	❒ $1,200 ❒$1,300 ❒ $1,400 ❒ $1,500
Mandatory Term Life & AD&D	**$10,000 minimum per Employee**	**$5,000 minimum per Spouse**	**$2,000 minimum per Dependent**

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PLAN SELECTION: ***OPTIONAL BENEFITS***			
Outpatient Diagnostic Tests, X-Rays, & Lab Benefit Per Visit **Calendar Year Maximum**	❒ $30 ❒ $40 ❒ $50 ❒ $60 ❒ $70 ❒ $80 ❒ $90 ❒ $100 ❒ $150 ❒ $200 ❒ $250 ❒ $300 --------------------------------------- ❒ 3 Visits per Person per Year ❒ 6 Visits per Person per Year	❒ $30 ❒ $40 ❒ $50 ❒ $60 ❒ $70 ❒ $80 ❒ $90 ❒ $100 ❒ $150 ❒ $200 ❒ $250 ❒ $300 --------------------------------------- ❒ 3 Visits per Person per Year ❒ 6 Visits per Person per Year	❒ $30 ❒ $40 ❒ $50 ❒ $60 ❒ $70 ❒ $80 ❒ $90 ❒ $100 ❒ $150 ❒ $200 ❒ $250 ❒ $300 --------------------------------------- ❒ 3 Visits per Person per Year ❒ 6 Visits per Person per Year
Outpatient Surgical Facility Indemnity Benefit	❒ cover --------------------------------------- (Paid according to a surgical schedule.)	❒ cover --------------------------------------- (Paid according to a surgical schedule.)	❒ cover --------------------------------------- (Paid according to a surgical schedule.)
Outpatient Chemotherapy & Radiation Therapy Indemnity Benefit	❒ cover	❒ cover	❒ cover
Supplemental Accident Benefit: (Benefit pays up to the amount selected or any remaining charges per accident, whichever is less.)	❒ $500 ❒ $1,000 --------------------------------------- ❒ 1 Occurrence ❒ 2 Occurrences ❒ 3 Occurrences	❒ $500 ❒ $1,000 --------------------------------------- ❒ 1 Occurrence ❒ 2 Occurrences ❒ 3 Occurrences	❒ $500 ❒ $1,000 --------------------------------------- ❒ 1 Occurrence ❒ 2 Occurrences ❒ 3 Occurrences
Preventive Care Benefit **Calendar Year Maximum:**	❒ $100 ❒ $200 ❒ $300 --------------------------------------- 1 Visit per Person per Year	❒ $100 ❒ $200 ❒ $300 --------------------------------------- 1 Visit per Person per Year	❒ $100 ❒ $200 ❒ $300 --------------------------------------- 1 Visit per Person per Year
Mammography Screening Benefit	❒$50 --------------------------------------- Paid according to Mammography Age Schedule.	❒$50 --------------------------------------- Paid according to Mammography Age Schedule.	❒$50 --------------------------------------- Paid according to Mammography Age Schedule.
Outpatient Emergency Room Sickness Benefit	❒ $75 per Visit (4 Visit Max) ❒ $100 per Visit (2 Visit Max) ❒ $150 per Visit (2 Visit Max) ❒ $200 per Visit (2 Visit Max)	❒ $75 per Visit (4 Visit Max) ❒ $100 per Visit (2 Visit Max) ❒ $150 per Visit (2 Visit Max) ❒ $200 per Visit (2 Visit Max)	❒ $75 per Visit (4 Visit Max) ❒ $100 per Visit (2 Visit Max) ❒ $150 per Visit (2 Visit Max) ❒ $200 per Visit (2 Visit Max)

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Ground Ambulance Benefit Calendar Year Maximum	❒ $100 ❒ $200 ❒ $300 --------------------------------------- 2 Trips per Person 6 Trips per Family	❒ $100 ❒ $200 ❒ $300 --------------------------------------- 2 Trips per Person 6 Trips per Family	❒ $100 ❒ $200 ❒ $300 --------------------------------------- 2 Trips per Person 6 Trips per Family
Initial Hospital Admission Benefit **Calendar Year Maximum:**	❒ $500 ❒ $1000 ❒ $1500 ❒ $2000 ❒ $2500 ❒ $3000 ❒ $3500 ❒ $4000 ❒ $4500 ❒ $5000 --------------------------------------- ❒ 1 Visit per Person per Year ❒ 2 Visits per Person per Year	❒ $500 ❒ $1000 ❒ $1500 ❒ $2000 ❒ $2500 ❒ $3000 ❒ $3500 ❒ $4000 ❒ $4500 ❒ $5000 --------------------------------------- ❒ 1 Visit per Person per Year ❒ 2 Visits per Person per Year	❒ $500 ❒ $1000 ❒ $1500 ❒ $2000 ❒ $2500 ❒ $3000 ❒ $3500 ❒ $4000 ❒ $4500 ❒ $5000 --------------------------------------- ❒ 1 Visit per Person per Year ❒ 2 Visits per Person per Year
Hospital Intensive Care Daily Inpatient Benefit **Calendar Year Maximum:**	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1000 --------------------------------------- ❒ 10 Day ❒ 20 Day ❒ 30 Day	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1000 --------------------------------------- ❒ 10 Day ❒ 20 Day ❒ 30 Day	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 ❒ $600 ❒ $700 ❒ $800 ❒ $900 ❒ $1000 --------------------------------------- ❒ 10 Day ❒ 20 Day ❒ 30 Day
Substance Abuse Daily Inpatient Hospital Benefit **Calendar Year Maximum:**	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year
Alcoholism Benefit **Lifetime Maximum**	❒ 31 Days of Inpatient/60 Days of Outpatient --------------------------------------- 2 Inpatient per Lifetime 2 Outpatient per Lifetime	❒ 31 Days of Inpatient/60 Days of Outpatient --------------------------------------- 2 Inpatient per Lifetime 2 Outpatient per Lifetime	❒ 31 Days of Inpatient/60 Days of Outpatient --------------------------------------- 2 Inpatient per Lifetime 2 Outpatient per Lifetime
Chemical Dependency Benefit	❒ cover	❒ cover	❒ cover
Mental Illness Daily Inpatient Hospital Benefit **Calendar Year Maximum:**	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year
Skilled Nursing Daily Inpatient Benefit **Calendar Year Maximum:**	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year	❒ $100 ❒ $200 ❒ $300 ❒ $400 ❒ $500 --------------------------------------- 30 Days per Person per Year

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<table>
<tr><td>Heart Attack – Stroke -Cancer Daily Hospital Benefit</td><td>❒ 30 Days per Calendar Year</td><td>❒ 30 Days per Calendar Year</td><td>❒ 30 Days per Calendar Year</td></tr>
<tr><td>Neighborhood Clinic Visit Benefit</td><td>❒ 50%</td><td>❒ 50%</td><td>❒ 50%</td></tr>
<tr><td>Speech and Hearing Benefit</td><td>❒ cover</td><td>❒ cover</td><td>❒ cover</td></tr>
<tr><td>Treatment of Bones or Joints of Face, Neck, or Head Benefit

Calendar Year Maximum:</td><td>❒ $2500

Per Person per Year</td><td>❒ $2500

Per Person per Year</td><td>❒ $2500

Per Person per Year</td></tr>
<tr><td>AmeriDoc</td><td>❒ Yes ❒ No</td><td>❒ Yes ❒ No</td><td>❒ Yes ❒ No</td></tr>
<tr><td>PPO Network</td><td></td><td></td><td></td></tr>
<tr><td>Optional Supplemental Term Life Policy with AD&D Benefit :

Optional Spouse Term Life Coverage

Optional Dependent Term Life Coverage</td><td>❒ Yes ❒ No
(Increases Life Insurance by the amount selected up to $50,000.)
❒ $5,000 ❒ $10,000 ❒ $15,000
❒ $20,000❒ $25,000 ❒ $30,000
❒ $35,000❒ $40,000

❒ Yes ❒ No
(Equals 50% of Employee Supplemental Life Coverage.)

❒ Yes ❒ No
(Equals 20% of Employee Supplemental Life Coverage.)</td><td>❒ Yes ❒ No
(Increases Life Insurance by the amount selected up to $50,000.)
❒ $5,000 ❒ $10,000 ❒ $15,000
❒ $20,000❒ $25,000 ❒ $30,000
❒ $35,000❒ $40,000

❒ Yes ❒ No
(Equals 50% of Employee Supplemental Life Coverage.)

❒ Yes ❒ No
(Equals 20% of Employee Supplemental Life Coverage.)</td><td>❒ Yes ❒ No
(Increases Life Insurance by the amount selected up to $50,000.)
❒ $5,000 ❒ $10,000 ❒ $15,000
❒ $20,000❒ $25,000 ❒ $30,000
❒ $35,000❒ $40,000

❒ Yes ❒ No
(Equals 50% of Employee Supplemental Life Coverage.)

❒ Yes ❒ No
(Equals 20% of Employee Supplemental Life Coverage.)</td></tr>
<tr><td>Pharmacy Program
• Envision Rx (Discount Rx Program)
• PRAM Rx (Fully Insured Rx Program)</td><td colspan="3">(Choose Only One)
❒ Yes ❒ No (This is not an insurance benefit.)

❒ Yes ❒ No (If “Yes” Requires a separate Employer Application be completed.)</td></tr>
<tr><td>Dental Benefit:
(Not a Companion product)</td><td colspan="3">❒ Yes ❒ No (If “Yes” Requires a separate Employer Application be completed.)</td></tr>
<tr><td>Vision Benefit:
(Not a Companion product)</td><td colspan="3">❒ Yes ❒ No (If “Yes” Requires a separate Employer Application be completed.)</td></tr>
</table>

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SECTION IV – Billing / Remittance

Employer Contribution: **$ __________ per Employee** **or** __________ **% of Lowest Cost Single Limited Medical Plan**

Rate Tier Available: ❒ 3 Tier ❒ 4 Tier

Will this plan be offered as part of a Section 125 Plan (Cafeteria Plan)? ❒ Yes ❒ No

Billing Information

Select Method: ❒ Advance
❒ Self Bill (Proceed to Payroll Deduction Information if selecting Self Bill); or
❒ List Bill (Complete all remaining billing questions if selecting List Bill)

**Note: Arrears only available upon prior approval*

Billing Frequency - ***How often would you like to receive your invoice?:***
❒ Monthly – For accounts with 12, 24 or 48 deduction pay periods per year indicated above (12 invoices)
❒ 28-Day Biweekly – For accounts with 13, 26 or 52 deduction pay periods per year indicated above (13 invoices)
❒ 10 Month (10 invoices) ❒ 9 Month (9 invoices) ❒ 8 Month (8 invoices)
For 8, 9, or 10 month, indicate months when no deductions will be made:
❒Jan ❒Feb ❒Mar ❒Apr ❒May ❒Jun ❒Jul ❒Aug ❒Sep ❒Oct ❒Nov ❒Dec
Are Billings required for multiple locations: ❒ YES ❒ NO
If there is more than 1 Billing Location please attach a list with the Location Name and full Billing Address:
(Please note: if benefit plans differ between billing locations a separate group enrollment form is mandatory per location. Individual application must have the correct Location listed in order to display on the appropriate List Bill.)

Payroll Deduction Information:
Initial Deduction - ***When will premium deductions begin?***
Date of first deduction: ____ / ____ / ______ Date of second deduction: ____ / ____ / ______
Number of annual deduction pay periods:
❒ 8 ❒ 9 ❒ 10 ❒ 12 ❒ 13 ❒ 24 ❒ 26 ❒ 48 ❒ 52

For Self Bill Clients Only:
Benefit Begin Date: ________ / ________ / ___________(Initial Effective Date)
Initial Payroll Deduction File Mailed: ________ / ________ / ___________ (From Administrator)
Initial Payment and Remittance File Mailed: ________ / ________ / ___________ (From Employer)
Claims Administration Type: ❒Standard Paid-to-date or ❒ Gap in Coverage

Premium Payment Method:
❒ Wire/ACH
❒ Check

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SECTION V – Mailing Instructions (check only one box for each item)

Master policy and administrative kit: ❒ Employer ❒ Agent ❒ TPA
Employee Certificate packets: ❒ Employer ❒ Agent ❒ TPA ❒ Employee

SECTION VI – Employer's Statement

1. Requested Effective Date ____
(Month) (Year)

2. First Month's Premium Deposit of $_______________________________________ Required for all List Bill Employers
(Make Checks Payable to: Companion Limited Benefit Medical Trust)

DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED IN WRITING BY THE INSURANCE COMPANY OF ACCEPTANCE OF THIS APPLICATION

The undersigned represents that all answers contained herein are true and complete. The Applicant Firm further understands that the Insurer may institute such inspection reports with regard to questions answered herein. The Applicant Firm also understands the Insurance Company may decline acceptance of the Application or where permitted by law, any person for whom coverage is requested. The Applicant Firm also understands that no coverage will become effective under this plan of insurance until written approval is received from the Insurance Company. The Applicant Firm also understands that either the Insurance Company or the Trustee may terminate the policy(ies) or any class of participating employers by giving advance written notice as required in the policy; that the Insurance Company and the Trustee may agree to amend the policy at anytime; and that consent of any employer, employee or other person is not required.

The Applicant Firm has read any Fraud notice (on the last page of this application) applicable to the Firm's situs state.

Dated this _______________________day of ____________________________year of_________________

____
Signature and Title of Applicant Firm Officer

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SECTION VII – Agent's Statement

Witnessed by Agent: I, the undersigned, duly licensed insurance agent, hereby witness said Applicant Firm Signature. I certify that the information contained herein is correct to the best of my knowledge and state that I have reviewed the Employee enrollment forms and that I know nothing unfavorable about this risk or any individual proposed for insurance. I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application is approved in writing. I understand that I have no right to bind this coverage, to alter the terms of the insurance contract in any manner, or to adjust any claim for benefits under the insurance contract.

- ☐ I am currently licensed as a Life and Accident & Health Agency in my Resident State.
- ☐ I am currently appointed to represent Companion Life Insurance Company.

____
Agent Name (Please Print) Agent #

____ ________________
Signature of Agent Date

____ ________________
Street Address City/State/Zip

____
Telephone # Fax # E-Mail Address

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FRAUD WARNING NOTICES: ***(If the Applicant firm is located in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)***

State	Fraud Warning Notices
Arkansas/Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.
DC	It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky/Ohio	I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico/ Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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.
Tennessee	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.

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