



## Employer Request for Participation

The undersigned hereby requests participation in the Manufacturer & Business Association master policy(ies), which are underwritten and fully insured by The Hartford.

### Employer Information

Full Legal Name of Employer \_\_\_\_\_

Primary Street Address \_\_\_\_\_

Billing Address (if different) \_\_\_\_\_

*PO Box/Street* *City* *State* *Zip*

Executive Contact \_\_\_\_\_ Phone: ( ) - \_\_\_\_\_

*Name* *Title*

Billing Contact \_\_\_\_\_ Phone ( ) - \_\_\_\_\_ Fax: ( ) - \_\_\_\_\_

*Name*

Federal ID# (EIN) \_\_\_\_\_ SIC Code \_\_\_\_\_ Nature of Business \_\_\_\_\_

### Form of Organization *(check the appropriate box)*

<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietorship
<input type="checkbox"/> S Corporation	<input type="checkbox"/> Association
<input type="checkbox"/> Partnership	<input type="checkbox"/> Other _____

### Affiliated/Subsidiary Companies

List any affiliates or subsidiaries to be insured (include name, location, nature of business & EIN)

1. \_\_\_\_\_

2. \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_ *Please do not cancel your existing coverage until notified of approval.*

### Employee Schedule of Benefits *(please provide a class description if benefit plans vary by class of employee)*

Please provide detailed description of eligible class		Benefit Eligibility	
		Waiting Period*	# Work Hours/Week <small>(Min 20+ Life, 30+ STD)</small>
1.			
2.			
3.			
4.			

*\*New Employees are eligible for coverage as of the first day of the month coinciding with or following the Waiting Period.*

**Exclusions**

Will any subsidiaries or classes of employees be excluded?  No  Yes (if yes, please define classes to be excluded)

**Benefit Specifications** – Application for sold benefits must be supported by an Aetna proposal. Changes to proposed benefits are subject to carrier/policyholder approval. Approved rates will be based on final census and plan design.

**Basic Life/AD&D Plan Specifications**

Class #	Flat Benefit Amount	Salary Multiple		Maximum Benefit Amount
	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> 1X <input type="checkbox"/> 2X	or	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$200,000
	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> 1X <input type="checkbox"/> 2X	or	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$200,000
	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> 1X <input type="checkbox"/> 2X	or	<input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$200,000

**Short Term Disability (Weekly Income)**

Class #	Accident Benefits	Sickness Benefits	Maximum Benefit Duration	Weekly Benefit Plan Design
	<input type="checkbox"/> 1 <sup>st</sup> Day	<input type="checkbox"/> 8 <sup>th</sup> Day	<input type="checkbox"/> 13 Weeks <input type="checkbox"/> 26 Weeks	Flat Dollar <input type="checkbox"/> \$100 <input type="checkbox"/> \$300 <input type="checkbox"/> \$600 <b>- OR -</b> % of Salary (66 2/3%) Maximum Benefit <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1200
	<input type="checkbox"/> 1 <sup>st</sup> Day	<input type="checkbox"/> 8 <sup>th</sup> Day	<input type="checkbox"/> 13 Weeks <input type="checkbox"/> 26 Weeks	Flat Dollar <input type="checkbox"/> \$100 <input type="checkbox"/> \$300 <input type="checkbox"/> \$600 <b>- OR -</b> % of Salary (66 2/3%) Maximum Benefit <input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1200

**Long Term Disability**

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 4
<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 5
<input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 6

**Premium Contributions & Employee Participation**

	Life/AD&D	STD	LTD
Employer Premium %			
# of Eligible Employees			
# of Enrolled Employees			

**Broker/Consultant Information**

Broker/Consultant Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Commission payable to:  Broker  Agency

**Certification**

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this request BEFORE action is taken on this request.

I understand that the insurance coverage may be terminated by the participating employer (or me) at any time, provided The Hartford or MBA receives written notice of termination by the requested termination date. Otherwise I understand and agree that failure to pay premium when due will be considered a default of premium payment and MBA may terminate coverage following the grace period (time extension for payment of premium) 31 days from the date of non-payment of premium. The termination will be effective at midnight on the third business day after written notice has been provided to the Employer. If the coverage is terminated by MBA for non-payment of premium, MBA at the request of The Hartford, reserves the right to collect premium for the grace period.

I understand that omissions or misrepresentations could result in voiding or reformation of insurance.

Full Legal Name of Employer/Firm \_\_\_\_\_

Dated on: \_\_\_\_\_  
*(Month, Day, Year)*

By: \_\_\_\_\_  
*(Signature)*

Dated at: \_\_\_\_\_  
*(City and State)*

\_\_\_\_\_  
*(Title)*

A copy of this request will be furnished to you for your records.

**To Be Completed by Manufacturer and Business Association**

MBA, as the Policyholder, requires Participating Employers to be a MBA member in good standing. MBA hereby certifies that the Employer named in the application is a current MBA member, is eligible to participate in the Plan and the request for participation is hereby approved.

Member #: \_\_\_\_\_

By: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_