

Offered through the Merchants Industry Fund Group Insurance Trust

Entity - Employer Information:

Entity Name: _____
 Address: _____
 City, State, Zip: _____
 County: _____ Phone #: () _____
 Executive Contact: _____
 Email Address: _____
 Entity Type: Proprietorship (Schedule C or Occ. License) Corporation (Business License)
 Government (Letter) Partnership/LLC (Form 1065)
 Union (Letter) Non-Profit/Religious (Letter)

All applying entities must attach the requested letter or document when initially applying for coverage.

Seniors Choice Plan Selection and Coverage Information:

Requested Effective Date (1st day of the Month): _____
 Total number of full-time employees: _____ Total number of part-time employees: _____
 Total number of retirees over age 65 with Medicare parts A and B: _____
 Have you employed 20 or more full or part-time employees for 20 or more weeks in the current or previous calendar year? Yes No
 Medical Plan Selection:
 \$0 Deductible Plan \$500 Deductible Plan \$2000 Deductible Plan
 \$100 Deductible Plan \$750 Deductible Plan \$2500 Deductible Plan
 \$150 Deductible Plan \$1000 Deductible Plan \$3000 Deductible Plan
 \$250 Deductible Plan \$1500 Deductible Plan \$4000 Deductible Plan

Optional Benefit Plan Selection: *(If selected, all members must participate)*
 Private Duty Nursing Comprehensive Wellness
 At Home Recovery Skilled Nursing Coverage (101 to 365 days per Calendar Year)

Prescription Drug Plan Selection: *(Select one or more plans)*
 Coverage can also be offered on a stand-alone basis.
 Check the Stand-Alone box if applicable. Stand-Alone?
 Choice Prescription Drug Plan Preferred Prescription Drug Plan Premier Prescription Drug Plan

Remittance:

The execution of this agreement does not imply financial responsibility to the Entity/Employer unless elected by same.
 Who should be billed for this coverage? The Entity/Employer The Enrollee/Member

Premium Contribution:

If the Enrollee/Member contributes to the premium, enter the amount or percentage of the premium contribution.

Medical Plan % _____ or \$ _____ Rx Plan % _____ or \$ _____

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Current Group Medical Coverage:

List any group medical coverage you are currently offering your employees, retirees or members.

Insurer Name: _____
 Policy Number: _____
 Type of Coverage: _____
 Effective Date: _____

Entity - Employer Endorsement:

Please note: This application is subject to approval by MBA, Inc. Do not cancel existing coverage until approved in writing by MBA, Inc.

Signature of Sponsor: _____
 Title of Sponsor: _____
 Name of Sponsor: _____
 Date: _____
 Authority of Sponsor: Owner Corporate Officer Board Member
 Trustee Legal Counsel Human Resources

Agent and General Agent Information:

Agency Name: _____ GA Name: _____
 Street Address: _____ GA Phone #: _____
 City, State, Zip: _____ GA Fax #: _____
 Phone Number: _____
 Fax Number: _____
 Agency Tax ID: _____
 Agent Name: _____
 Agent SSN: _____
 Agent Email: _____
 Agent Status: New Appointment Existing Agent
 Commissions Paid To: Agent Agency

Stamp

Administrative Purposes Only:

CMA: Yes No % _____
 DRP: Yes No Member Deductible: _____ Plan Deductible: _____
 CPR: Yes No
 Date Received: _____ Account Number: _____
 Approved Date: _____ Rating Area: _____
 Approved By: _____ Premium Received: _____
 Approved Effective Date: _____ Payment Method: _____

For more information, contact Seniors Choice at (800) 800-6543 or visit www.seniorschoiceplan.com

Pre-Authorized Check (PAC) Draft Authorization

Return this form and a voided check in the enclosed envelope OR FAX to: (480) 776-5055

As a convenience to me, I authorize **MBA, Inc.** administrator of **Seniors Choice**, to debit premiums and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below. I also authorize said Bank to debit and, if applicable, credit the amount of those entries to my account made payable to the order of **MBA, Inc.**, Scottsdale, Arizona.

I understand and agree that:

- 1) My premium will be drafted on or about the 5th day of each month;
- 2) The Bank's rights with respect to each charge will be the same as if personally executed by me;
- 3) This authorization will remain in effect until I provide written notification to MBA, Inc. that I wish to revoke it;
- 4) MBA, Inc. and my Bank may discontinue this service;
- 5) The presentation of any such debit or draft shall constitute due notice of premiums being due for a policy of insurance on my behalf. I understand that should my Bank dishonor any such debit or draft for any reason, it will be my responsibility to make arrangements with MBA, Inc. for premium payments within the grace period to prevent lapse or possible termination due to non-payment in accordance with the terms of the policy. It is also understood that MBA, Inc. assumes no responsibility for bank charges on these draws; and
- 6) I further agree that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such debit, other than my monthly banking statement.

INSURED INFORMATION premium payer

BANK ACCOUNT INFORMATION

Name of Insured/Employer

Name of Bank or Financial Institution

Account or PID Number

Branch City State Zip

Month to begin my PAC Service

Name(s) as appears on Bank Account

Email Address

Checking Account # Bank Transit/Routing #

Under the bank draft arrangement, we present a draft to your bank each month for the amount of your premium. The bank pays us, and then lists the draft on your statement, just as it lists your other cancelled checks.

Signature of Premium Payer
(Must be identical to bank records)

Please take a few minutes to complete the information requested on this form, and return it along with a voided check or a copy of a check on which is printed your account number and bank transit number.

**Seniors Choice Questions?
Please call (888) 538-9333**

