

Employer Trust Participation Agreement

Underwritten by:



Guarantee Trust Life Insurance Company

Offered through the Merchants Industry Fund Group Insurance Trust

Entity - Employer Information:

Entity Name: _____
Street Address: _____
City, State, Zip: _____
County: _____ Telephone#: (____) _____
Executive Contact: _____
Email Address: _____
Entity Type: ☐ Proprietorship (Schedule C or Occ. Lic.) ☐ 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 Coverage Information:

Requested Effective Date (1st day of the month): _____
Total number of full-time and part-time employees: _____
Total number of retirees 65 or over with Medicare Parts A and B: _____
Have you employed 20 or more full-time or part-time employees,
20 or more weeks in the current or previous calendar year? ☐ Yes ☐ No
(If yes, active employees eligible for the employer sponsored group health plan are not eligible for Seniors Choice)

Seniors Choice Plan Selection:

☐ Medical & Prescription ☐ Medical Only ☐ Prescription Only

Medical Plan Selection:

<input type="checkbox"/> Co-pay	<input type="checkbox"/> \$0 Deductible Plan	<input type="checkbox"/> \$500 Deductible Plan	<input type="checkbox"/> \$2000 Deductible Plan
<input type="checkbox"/> No Co-pay	<input type="checkbox"/> \$100 Deductible Plan	<input type="checkbox"/> \$750 Deductible Plan	<input type="checkbox"/> \$2500 Deductible Plan
	<input type="checkbox"/> \$150 Deductible Plan	<input type="checkbox"/> \$1000 Deductible Plan	<input type="checkbox"/> \$3000 Deductible Plan
	<input type="checkbox"/> \$250 Deductible Plan	<input type="checkbox"/> \$1500 Deductible Plan	<input type="checkbox"/> \$4000 Deductible Plan

Optional Benefit Plan Selection: *(If selected, all members must participate.)*

<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/> Comprehensive Wellness
<input type="checkbox"/> At Home Recovery	<input type="checkbox"/> Skilled Nursing Coverage

(101 through 365 days per Calendar Year)

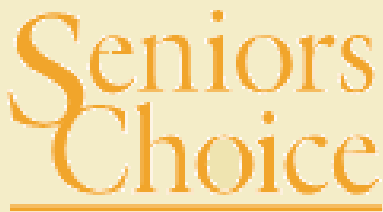
Prescription Drug Plan Selection: *(Select only one Plan)*

☐ Preferred Choice Prescription Drug Plan ☐ Premier Prescription Drug Plan



Checks payable to: Seniors Choice
18700 N Hayden Rd, Suite 390,
Scottsdale, AZ 85255





Employer Trust Participation Agreement



Offered through the Merchants Industry Fund Group Insurance Trust

Remittance:

The execution of this agreement does not imply financial responsibility to the entity/employer unless selected by same.

Who should be billed for this coverage? ☐ The Entity/Employer ☐ The Enrollee

Premium Contribution: *(If the employer contributes to premium, employer is responsible for paying as invoiced.)*

If the enrollee contributes to the premium, enter the amount or percentage of the premium contribution.

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

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: _____

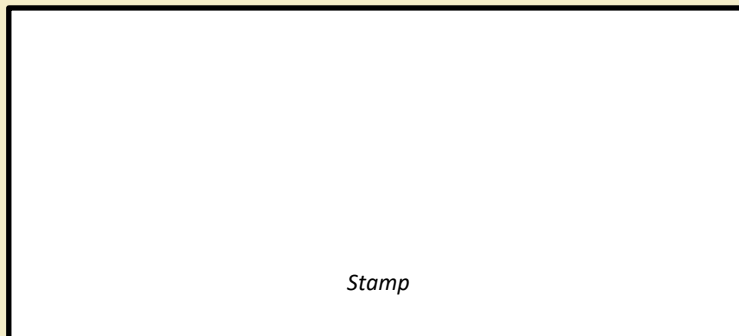
Entity - Employer

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: _____
Phone Number: _____
Agency Tax ID: _____
Agent SSN: _____
Agent Email: _____
Agent Status: ☐ New Appointment ☐ Existing Agent
Commissions Paid To: ☐ Agent ☐ Agency



For more information, contact MBA, Inc. at (480) 776-5040 or visit <https://main.mbaadmin.com/>