

Employer Trust Participation Agreement



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.)*

Private Duty Nursing Comprehensive Wellness
 At Home Recovery Skilled Nursing Coverage
(101 through 365 days per Calendar Year)

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

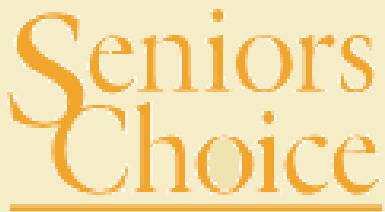
Participants must be retired or part-time to enroll

Choice Prescription Drug Plan Preferred Prescription Drug Plan Premier Prescription Drug Plan



Checks payable to: Seniors Choice
15974 N. 77th St Suite 102
Scottsdale, AZ 85260





Employer Trust Participation Agreement

Underwritten by:



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: _____

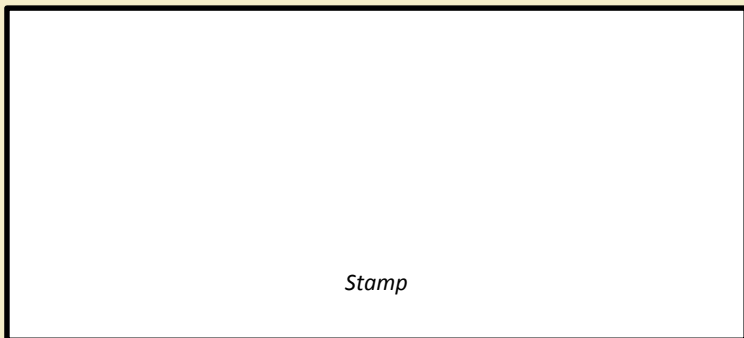
Agency Tax ID: _____

Agent SSN: _____

Agent Email: _____

Agent Status: New Appointment Existing Agent

Commissions Paid To: Agent Agency



Stamp

For more information, contact MBA, Inc. at (800) 800-6543 or visit www.mbaadmin.com

Seniors Choice Payment Authorization Form

Return this form with enrollment or fax to: (480)776-5050

INSURED INFORMATION	
TODAY'S DATE:	
NAME OF INSURED:	
EMAIL ADDRESS:	
POLICY ID NUMBER:	
DATE TO BEGIN*:	
*Payment will be taken on the 1st of every month	

I would like to pay by: EFT CREDIT CARD

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUND TRANSFER	
NAME ON BANK ACCOUNT:	
NAME OF BANK:	
BANK ACCOUNT NUMBER:	
BANK ROUTING NUMBER:	
TYPE OF ACCOUNT:	<input type="checkbox"/> SAVINGS <input type="checkbox"/> CHECKING
Please include a copy of a voided check or savings deposit slip	

AUTHORIZATION FOR CREDIT CARD PAYMENT	
CHARGE MY CREDIT CARD:	<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express
CREDIT CARD NUMBER:	
CREDIT CARD EXP DATE:	
NAME ON CREDIT CARD:	
CARD BILLING ADDRESS:	

DEDUCTION AUTHORIZATION: I hereby authorize the insurance premiums to be deducted and remitted to Merchants Benefit Administration. This authority is to remain in effect until I cancel it by written notification to Merchants Benefit Administration at least 30 days in advance of the intended termination date of my coverage. (Any excess premiums which may accrue after termination of my coverage will be refunded to me.) There will be a \$15.00 fee associated with an insufficient funds notification.

ACCOUNT HOLDER SIGNATURE

DATE (MM/DD/YYYY)

Questions?
Please call (888) 538-9333

