

# 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 (1<sup>st</sup> 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 through Guarantee Trust Life:**

Preferred Choice Plus  Basic Choice  Preferred Choice

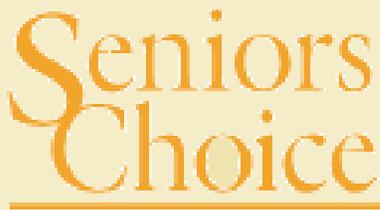
**Prescription Drug Plan Selection through Humana Insurance:** *(Select only one Plan)*

Preferred Choice Prescription Drug Plan  Premier Prescription Drug Plan



Checks payable to: Seniors Choice  
7077 E. Marilyn Road, Building 1  
Scottsdale, AZ 85254





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## 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.*

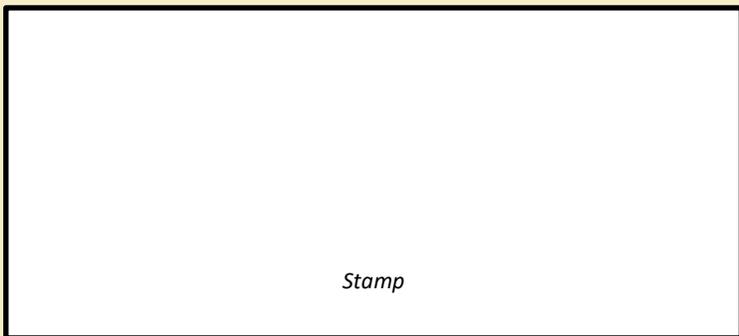
**Signature of Sponsor:** \_\_\_\_\_  
**Title of Sponsor:** \_\_\_\_\_  
**Name of Sponsor:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**Authority of Sponsor:**     Owner                       Corporate Officer             Board member  
                                          Trustee                       Legal Counsel                 Human Resources

## Agent and General Agent information:

**Agency Name:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_  
**Agency Tax ID:** \_\_\_\_\_  
**Agent SSN:** \_\_\_\_\_  
**Agent Email:** \_\_\_\_\_

**GA Name:** \_\_\_\_\_  
**GA Phone #:** \_\_\_\_\_

**Agent Status:**     New Appointment     Existing Agent  
**Commissions Paid To:**     Agent     Agency



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For more information, contact MBA, Inc. at (480) 776-5040 or visit [www.mbaadmin.com](http://www.mbaadmin.com)

# Seniors Choice Payment Authorization Form

**Return this form to: Fax (480) 776-5054 or email: [memberservices@mbaadmin.com](mailto:memberservices@mbaadmin.com)**

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

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
<b><i>Please include a copy of a voided check or savings deposit slip</i></b>	

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 (480) 776-5040**

