

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 through Guarantee Trust Life:

Preferred Choice Plus Basic Choice Preferred Choice

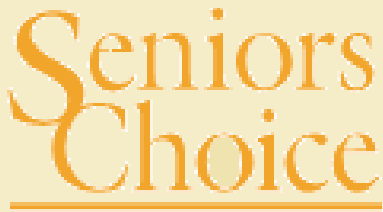
Prescription Drug Plan Selection through Humana Insurance: *(Select only one Plan)*

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: _____

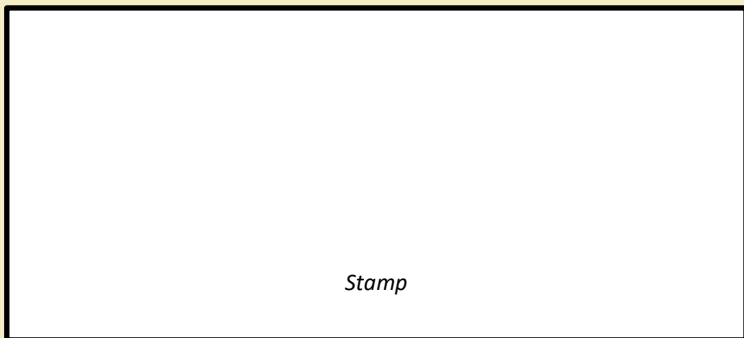
Entity - Employer

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: _____ **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 www.mbaadmin.com

Seniors Choice Payment Authorization Form

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

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

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

| 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

