Seniors Choice

Employer Trust Participation Agreement

Underwritten by:

G·T·L

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:

- ☐ Co-pay
- ☐ No Co-pay

☐ $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 through 365 days per Calendar Year)*

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

☐ Preferred Choice Prescription Drug Plan ☐ Premier Prescription Drug Plan

mba merchants benefit admin

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

Humana

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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

Stamp

For more information, contact MBA, Inc. at (800) 800-6543 or visit https://main.mbaadmin.com/

Medical Coverage Underwritten By:
Guarantee Trust Life Insurance Company
Glenview, IL

Administered By:
Merchants Benefit Administration, Inc
Scottsdale, AZ

Prescription Coverage Provided by:
Humana Insurance Company