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
☐ $100 Deductible Plan
☐ $150 Deductible Plan
☐ $250 Deductible Plan
☐ $500 Deductible Plan
☐ $750 Deductible Plan
☐ $1000 Deductible Plan
☐ $1500 Deductible Plan
☐ $2000 Deductible Plan
☐ $2500 Deductible Plan
☐ $3000 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)*

Participants must be retired or part-time to enroll

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

mba merchants benefit admin

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

Humana

Seniors Choice

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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 www.mbaadmin.com

Medical Coverage Underwritten By:
Guarantee Trust Life Insurance Company

Administered By:
MBA, Inc

Prescription Coverage Provided by:
Humana Insurance Company

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:	☐ SAVINGS ☐ CHECKING
Please include a copy of a voided check or savings deposit slip	

AUTHORIZATION FOR CREDIT CARD PAYMENT	
CHARGE MY CREDIT CARD:	☐ Visa ☐ MasterCard ☐ Discover ☐ 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

mba merchants benefit admin

MBA, Inc. 15974 N 77th St Suite 102, Scottsdale, AZ 85260 Fax: (480) 776-5050