

# Employer Trust Participation Agreement



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 (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:**

<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)*

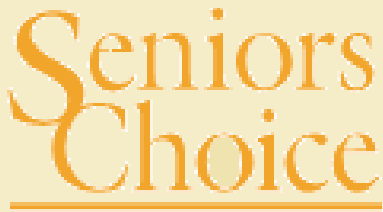
**Prescription Drug Plan Selection:** *(Select only one Plan)*

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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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

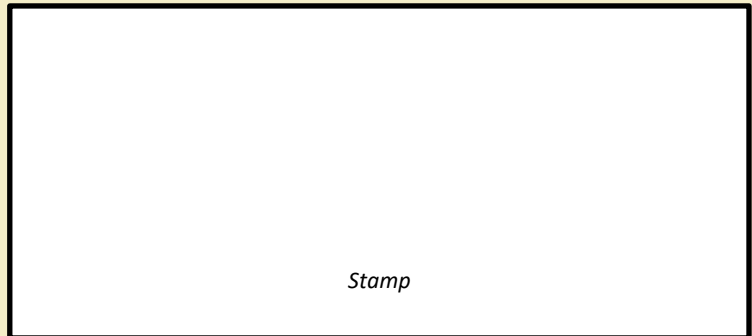
*Please Note: This application is subject to approval by MBA, Inc. Do not cancel existing coverage until approved in writing by MBA, Inc.*

**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:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_  
**Phone Number:** \_\_\_\_\_  
**Agency Tax ID:** \_\_\_\_\_  
**Agent SSN:** \_\_\_\_\_  
**Agent Email:** \_\_\_\_\_  
**Agent Status:**     New Appointment     Existing Agent  
**Commissions Paid To:**     Agent     Agency

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



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