Manufacturer & Business ASSOCIATION
www.mbausa.org
2171 West 38th Street • Erie, Pa. 16508
814/833-3200 • 800/815-2660 • Fax: 814/833-4844

Employer Request for Participation

The undersigned hereby requests participation in the Manufacturer & Business Association master policy(ies), which are underwritten and fully insured by The Hartford.

Employer Information

Full Legal Name of Employer _____

Primary Street Address _____

Billing Address (if different) _____
PO Box/Street *City* *State* *Zip*

Executive Contact _____ Phone: ( ) -
Name *Title*

Billing Contact _____ Phone ( ) - Fax: ( ) -
Name

Federal ID# (EIN) _____ SIC Code _____ Nature of Business _____

Form of Organization *(check the appropriate box)*

☐ Corporation ☐ Sole Proprietorship
☐ S Corporation ☐ Association
☐ Partnership ☐ Other _____

Affiliated/Subsidiary Companies

List any affiliates or subsidiaries to be insured (include name, location, nature of business & EIN)

1. _____
2. _____

Requested Effective Date: _____ ***Please do not cancel your existing coverage until notified of approval.***

Employee Schedule of Benefits *(please provide a class description if benefit plans vary by class of employee)*

		Benefit Eligibility	
	Please provide detailed description of eligible class	**Waiting Period***	**# Work Hours/Week** *(Min 20+ Life, 30+ STD)*
1.			
2.			
3.			
4.			

**New Employees are eligible for coverage as of the first day of the month coinciding with or following the Waiting Period.*

Exclusions

Will any subsidiaries or classes of employees be excluded? ☐ No ☐ Yes (if yes, please define classes to be excluded)

Benefit Specifications – Application for sold benefits must be supported by an Aetna proposal. Changes to proposed benefits are subject to carrier/policyholder approval. Approved rates will be based on final census and plan design.

Basic Life/AD&D Plan Specifications

Class #	Flat Benefit Amount	Salary Multiple		Maximum Benefit Amount
	☐ $10,000 ☐ $20,000	☐ 1X ☐ 2X	**or**	☐ $50,000 ☐ $100,000 ☐ $200,000
	☐ $10,000 ☐ $20,000	☐ 1X ☐ 2X	**or**	☐ $50,000 ☐ $100,000 ☐ $200,000
	☐ $10,000 ☐ $20,000	☐ 1X ☐ 2X	**or**	☐ $50,000 ☐ $100,000 ☐ $200,000

Short Term Disability (Weekly Income)

Class #	Accident Benefits	Sickness Benefits	Maximum Benefit Duration	Weekly Benefit Plan Design
	☐ 1st Day	☐ 8th Day	☐ 13 Weeks ☐ 26 Weeks	Flat Dollar ☐ $100 ☐ $300 ☐ $600 **- OR-** % of Salary (66 2/3%) Maximum Benefit ☐ $400 ☐ $800 ☐ $1200
	☐ 1st Day	☐ 8th Day	☐ 13 Weeks ☐ 26 Weeks	Flat Dollar ☐ $100 ☐ $300 ☐ $600 **- OR-** % of Salary (66 2/3%) Maximum Benefit ☐ $400 ☐ $800 ☐ $1200

Long Term Disability

☐	Plan I	☐	Plan 4
☐	Plan 2	☐	Plan 5
☐	Plan 3	☐	Plan 6

Premium Contributions & Employee Participation

	Life/AD&D	STD	LTD
Employer Premium %			
# of Eligible Employees			
# of Enrolled Employees			

Broker/Consultant Information

Broker/Consultant Name: _____

Agency Name: _____

Address: _____

City, State, Zip Code: _____

Email Address: _____ Phone: _____

Fax: _____ Commission payable to: ☐ Broker ☐ Agency

Certification

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this request BEFORE action is taken on this request.

I understand that the insurance coverage may be terminated by the participating employer (or me) at any time, provided The Hartford or MBA receives written notice of termination by the requested termination date. Otherwise I understand and agree that failure to pay premium when due will be considered a default of premium payment and MBA may terminate coverage following the grace period (time extension for payment of premium) 31 days from the date of non-payment of premium. The termination will be effective at midnight on the third business day after written notice has been provided to the Employer. If the coverage is terminated by MBA for non-payment of premium, MBA at the request of The Hartford, reserves the right to collect premium for the grace period.

I understand that omissions or misrepresentations could result in voiding or reformation of insurance.

Full Legal Name of Employer/Firm _____

Dated on: _____ By: _____
(Month, Day, Year) *(Signature)*

Dated at: _____ _____
(City and State) *(Title)*

A copy of this request will be furnished to you for your records.

To Be Completed by Manufacturer and Business Association

MBA, as the Policyholder, requires Participating Employers to be a MBA member in good standing. MBA hereby certifies that the Employer named in the application is a current MBA member, is eligible to participate in the Plan and the request for participation is hereby approved.

Member #: _____ By: _____

Date: _____ Title: _____