MedAmerica Simply Business℠
Application for Employer Program Offering

1. Employer Information

Company Name	Employer Contact Name and Title
Address, City, State, Zip Code	Company Web site

	( )	( )
Contact E-mail Address	Telephone	Fax

Type of Company (Check one box) ❑ Government ❑ Non-Profit Organization ❑ Privately Held ❑ Publicly Traded

Type of Industry (i.e. Hospital, Manufacturing, Engineering)

# of W-2 Employees working 30 hours or more per week		# of W-2 Employees working LESS than 30 hours per week		Enter # of Eligible Board Members		Enter # of new employees in last year	

Do you have employees in more than one state? ❑ Yes* ❑ No

* If Yes, list all states where you have employees ❑ All 50 States OR Please List:

2. Employer Funding: NOTE - When Only Select Eligibles Are Paid: We default all other Employees to a Voluntary Offering. If choosing more than one option, be sure the Census correctly indicates who falls into the various choices.

1. ❑ Employer pays 100% of ALL BENEFITS CHOSEN for: ❑ All Employees ❑ All Care Partners
   Must identify individuals on the Census supplied with this form. ❑ Select Employees Only ❑ Care Partners of Select Employees
   Billing Frequency (Choose One) ❑ Monthly ❑ Annual | Pay By (Choose One) ❑ Check ❑ Wire
2. ❑ Employer pays 100% of DEFINED BENEFIT for: ❑ All Employees ❑ All Care Partners
   Must identify individuals on the Census supplied and Illustration of proposed plan. BOTH must accompany this form. ❑ Select Employees Only ❑ Care Partners of Select Employees
   Billing Frequency (Choose One) ❑ Monthly ❑ Annual | Pay By (Choose One) ❑ Check ❑ Wire
3. ❑ Employer pays DOLLAR CONTRIBUTION of $________ per month: ❑ All Employees ❑ All Care Partners
   Must identify individuals on the Census supplied with this form. ❑ Select Employees Only ❑ Care Partners of Select Employees
   Billing Frequency is ALWAYS Monthly | Pay By (Choose One) ❑ Check ❑ Wire
4. ❑ Voluntary Offer Only — The employer is NOT contributing for any employee

3. Payroll Deduction (Only available if 10 or more issued lives)

Is Payroll Deduction an available payment option? ❑ Yes — Must Complete and Sign Payroll Deduction Questionnaire
❑ No

4. New Hire Eligibility: When are your New Hires Eligible to Apply? (Check One)

❑ First Day of Hire ❑ After _____ days from Hire Date (Enter #) ❑ Annual Offering to begin the month of __________________ (Enter Month)

5. Requested Open Enrollment Dates — Subject to Approval of MedAmerica* (Maximum Initial Enrollment Period is 60 Days)

Enter Enrollment Start Date (mm/dd/yyyy)	Enter Enrollment End Date (mm/dd/yyyy)

* Must submit Census and Completed Forms at least 10 days prior to Open Enrollment Dates.

6. Signatures

Your signature below attests to the accuracy of the information provided and confirms your request to offer MedAmerica's Simply Business℠ LTC Program to your employees. You acknowledge an accurate census has been provided. You acknowledge you have read and understand the following: The Employer Offering is subject to pre-approval by MedAmerica. The product and rates may vary by state. Upon approval, MedAmerica will provide written confirmation to you detailing the agreed upon offering.

Print Full Name of Authorized Employer Representative	Print Title
Signature of Authorized Employer Representative	Date Signed
Signature of Agent	Date Signed

MedAmerica Approval Section

Approved By: ______________________ Date: ______________________ MedAmerica Assigned Group #: ______________________

COMPLETE AND RETURN

Simplicity℠