



# VOLUNTARY "WORKPLACE" Dental & Vision

## Employer Application

<b>APPLYING FOR:</b>	<input type="checkbox"/> <b>DENTAL COVERAGE</b>	<input type="checkbox"/> <b>VISION COVERAGE</b>
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## Enrollment Acknowledgement

Firm Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Exact Nature of Business: \_\_\_\_\_ SIC Code: \_\_\_\_\_ In Business Since: \_\_\_\_\_ Whom do we contact at the firm for information? \_\_\_\_\_

I certify that I have read the Program provisions and highlight sections, understand them, and have enrolled all eligible employees and their dependents in accordance with the program's requirements. I have discussed coverages, eligibility, and expenses not covered with my broker and understand them fully.

I certify that this is a bona fide business with a legitimate business purpose and that a true employer-employee relationship exists with the individuals designated as employees. I understand that any false statements made in this application constitute the legal basis for termination or cancellation of coverage retroactive to the effective date, and denial of all claims incurred.

**EMPLOYER CONTRIBUTIONS** – All eligible employees working 24 or more hours per week may enroll for coverage (or as mirrors the eligibility under your medical plan), unless they have other group dental/vision coverage in effect. To encourage continuing employee participation, the Employer may pay some amount of the employee cost if desired.

Employer agrees through payroll deduction to collect and remit the contributions selected from each eligible Employee enrolling in Multi Benefit Plans Trust. The Administrative Office will send a monthly contribution statement to assist the Employer with reporting of these monies.

Employee coverage and dependent coverage will terminate on the earliest of the following dates: (1) the date the employee ceases to be an eligible employee or the date the dependent is no longer eligible as a dependent under the Program; (2) the date the Master Group Dental Service and/or Master Group Vision Contract is terminated; (3) the date the employer terminates the coverage by failing to pay the required premium. The benefits are subject to all conditions and limitations of the Program.

Classes of Employees Not Eligible \_\_\_\_\_

Total No. Of Employees on Payroll _____	Total No. Of Full-Time Employees on Payroll _____	Employer's Federal Taxpayer ID Number _____	Requested Effective Date (Must be 1 <sup>st</sup> of the month subject to approval) _____
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Dated \_\_\_\_\_  
Month Day Year

By: \_\_\_\_\_  
Signature of Company Officer

\_\_\_\_\_  
Print Name

Administered By:  
**PacFed Benefit Administrators, Inc.**  
 1000 N. Central Avenue, Suite 400  
 Glendale, California 91202  
 (800) 308-5443

# Employer Trust Acceptance

Legal Name of Firm: \_\_\_\_\_

Street Address

City

State

Zip

County

## TRUST DISCLOSURE STATEMENT

The undersigned Employer understands that by adopting one or more plans in the **Multi Benefit Plans Trust** that it is establishing an employee welfare plan for its employees. The Employer's plan is funded through the **Multi Benefit Plans Trust**, which the Employer joins. The service providers, issue a Master Group Service Contract to the Trustees of the **Multi Benefit Plans Trust**. These service contracts define and provide the employee benefits selected by the Employer.

The Multi Benefit Plans Trust receives payments from the Employer and remits these dues to the Service Providers. A portion of each contribution is retained by the Administrative and Marketing Contractors for the Multi Benefit Plans Trust.

By signing this Association and Trust Membership Sub-Agreement, and if approved by the Trustees, the Employer becomes a Trustor of the Trust. The Employer thereby subscribes to and agrees to be bound by all the terms and conditions of the Trust Agreement and Service Contract(s). The Employer further agrees that the Trustees shall not be liable to any Participating Employers, to any person covered, or to anyone else in connection with the operation of the Multi Benefit Plans Trust.

The Employer additionally agrees to pass on all communications from the Multi Benefit Plans Trust to covered employees. The Employer further agrees that any and all disputes shall be resolved through arbitration that will be binding on all parties. The Employer further agrees that the initial term of this Agreement shall be one year and will automatically renew each year thereafter provided dues are paid when due.

Dated \_\_\_\_\_  
Month Day Year

By: \_\_\_\_\_  
Signature of Company Officer

\_\_\_\_\_  
Print Name

## Producer's Statement

I hereby certify that I hold a valid Life, Accident & Health Insurance License issued by the State in which this document is executed. I also certify that I understand the information contained herein and affirm that it is correct. Furthermore, I certify that:

- 1) This is a bona fide firm eligible to participate in the Multi Benefit Plans Trust
- 2) Employee and dependent participation requirements have been met and were explained to the Employer
- 3) Coverages, eligibility, and exclusions have been explained to the Employer.

I also certify that I have made no warranties, alterations or modifications to this Program.

Is this Employer currently covered under an existing dental or vision plan?  Yes  No

If yes, please indicate the current carrier \_\_\_\_\_

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Date: Month Day Year

\_\_\_\_\_  
Producer's Name (Print)

\_\_\_\_\_  
Social Security Number

(\_\_\_\_\_) \_\_\_\_\_  
Phone No.

(\_\_\_\_\_) \_\_\_\_\_  
Fax No

\_\_\_\_\_  
E-mail address:

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Tax Payer ID No.

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Insurance License No.

Indicate who should receive commissions  
 Producer  Company

\_\_\_\_\_  
Name of General Agent if Applicable