

AMERICAN MEDICAL ACCESS PLAN

**Life & Health
Indemnity Plan**

PARTICIPATION AGREEMENT

AMERICAN MEDICAL ACCESS PLAN

Subscription to the ABAS Plans Trust
Bank of Newport, Trustee

APPLICATION FOR PARTICIPATION IN THE PLAN OF INSURANCE TO BE UNDERWRITTEN BY
COMPANION LIFE INSURANCE COMPANY

Administered by
American Benefit Administrative Services, Inc.

SECTION I – Subscription Agreement to Trust and Application for Participation

The undersigned Employer hereby adopts the Agreement and Declaration of Trust, in which the Bank of Newport, Newport, Rhode Island is Trustee, known as the ABAS Plans Trust, agrees to be bound by all the terms, provisions, conditions and limitations of said Agreement and Declaration of Trust and all lawful amendments thereto; and applies to the Insurer for group indemnity insurance under a policy or policies issued to the Trustee for the plan(s) of insurance shown in Section II, subject to the following conditions. Effective as of the date the Employer is approved as an eligible employer, it (1) agrees to be bound by all the terms and provisions of the policy or policies insuring such plan issued to the Trustee including riders or amendments to such policy or policies applying to the Employer's plan (herein called the "policy"); and (2) understand that the Employer's application for insurance is subject to the approval of the Insurer (or designated representative), that nothing contained herein shall be binding upon the Insurer until the application is approved and accepted in writing by the Insurer.

SECTION II – Specifications for Group Insurance

1. Legal Name of Applicant Firm _____

Street Address _____

Mailing Address _____

City, State, Zip _____

Telephone Number (____) _____ Fax Number (____) _____

Subsidiary and/or Branch Locations _____

How long in Business? _____ Tax I.D. No. _____

Firm is: Corporation Partnership Sole Proprietorship Non-Profit Other _____

Nature of Business _____ SIC Code _____

2. List any associated firm(s) whose employees will be included, complete address, nature of business and nature of affiliation; otherwise indicate NONE:

3. Is any class of employees to be excluded? (circle) YES NO
Explain _____

4. Total Number of Employees (Also include those **NOT** applying for this Plan): _____
(An Eligible Employee works an average of 18 hours per week.)

Subtract:

Employees not Eligible (works less than 18 hours average)	Less -	_____
Employees (class to be excluded)	Less -	_____
Employees in Probationary Period	Less -	_____
Other (explain) _____	Less -	_____
Total Number of Eligible Employees	Equals =	_____

5. Employer Contribution: _____ % Employee _____ % Dependent

20% OF ELIGIBLE EMPLOYEES MUST BE COVERED,
UNLESS THE EMPLOYER CONTRIBUTES A MINIMUM OF 25% TOWARDS THE SINGLE EMPLOYEE COST.

6. Probationary Period – The effective date for new employees shall be the first of the month following:
 One Month Two Months Three Months Other _____

SECTION III – Indemnity Health and Life Insurance

Select a Benefit Plan:	<input type="checkbox"/> <u>OPTION 1</u>	<input type="checkbox"/> <u>OPTION 2</u>	<input type="checkbox"/> <u>OPTION 3</u>
Employee Class Designation:			
Daily In-Hospital Indemnity Benefit	\$250	\$500	\$1,000
Maximum Number of Days of Confinement	30	30	30
Surgical Indemnity Benefit Maximum	\$1,200	\$1,800	\$2,400
(per RBRVS Schedule)			
Accident Benefit (per Accident)	100% to \$500	100% to \$1,000	100% to \$1,000
Anesthesia Indemnity Benefit:	20% of Surgical Indemnity Benefit	20% of Surgical Indemnity Benefit	20% of Surgical Indemnity Benefit
Outpatient Physician Office Visit (per Visit)	\$50	\$50	\$75
Calendar Year Max. Office Visits / Person	5	5	7
Outpatient Diagnostic X-Ray & Lab Benefit (per Day)	N/A	\$100	\$100
Calendar Year Max. Testing Days / Person	N/A	3	5
Outpatient Prescription Drug Indemnity Benefit (per Prescription)	N/A	\$20	\$20
Calendar Year Max. Prescriptions / Person	N/A	10	15
Life Insurance* (Employee)	\$10,000	\$10,000	\$10,000
(Spouse)	\$2,500	\$2,500	\$2,500
(Each Child – over 14 days)	\$1,000	\$1,000	\$1,000

**(For persons ages 65 or older, the Principal Sum will be 65% of the amount shown.)*

NO BENEFITS WILL BE PAYABLE FOR EXPENSES INCURRED AS A RESULT OF A PRE-EXISTING CONDITION UNTIL THE COVERED PERSON HAS BEEN INSURED UNDER THE POLICY FOR 12 MONTHS FROM THE EFFECTIVE DATE

SECTION IV – Employer’s Statement

1. Requested Effective Date _____ (First of the Month Only)
2. First Month’s Premium Deposit of \$ _____
(Make Check Payable to: American Benefit Administrative Services, Inc.)

DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED IN WRITING BY THE INSURANCE COMPANY OF ACCEPTANCE OF THIS APPLICATION

The undersigned represents that all answers contained herein are true and complete. The Applicant Firm further understands that the Insurer may institute such inspection reports with regard to questions answered herein. The Applicant Firm also understands the Insurance Company may decline acceptance of the Application or where permitted by law, any person for whom coverage is requested. The Applicant Firm also understands that no coverage will become effective under this plan of insurance until written approval is received from the Insurance Company. The Applicant Firm also understands that either the Insurance Company or the Trustee may terminate the policy(ies) or any class of participating employers by giving advance written notice as required in the policy; that the Insurance Company and the Trustee may agree to amend the policy at anytime; and that consent of any employer, employee or other person is not required.

The Applicant Firm has read any Fraud Notice (on the last page of this application) applicable to the Firm’s situs state.

Signature and Title of Applicant Firm Officer _____
Date

SECTION V – Agent’s Statement

Witnessed by Agent: I, the undersigned, duly licensed insurance agent, hereby witness said Applicant Firm signature. I represent that the information contained herein is correct to the best of my knowledge and state that I have reviewed the Employee enrollment forms and that I know nothing unfavorable about this risk or any individual proposed for insurance. I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application is approved in writing. I understand that I have no right to bind this coverage, to alter the terms of the insurance contract in any manner, or to adjust any claim for benefits under the insurance contract.

Signature of Agent _____
Date

Address _____
City/State/Zip _____
Home Telephone #

Work Telephone # _____
Fax # _____
E-Mail Address

FRAUD WARNING NOTICES: (If the Applicant firm is located in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Arkansas/Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.
DC	It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and /or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky/Ohio	I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.
Maine	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico/ Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.