

SMALL BUSINESS EMPLOYER PARTICIPATION AGREEMENT

By completing this Small Business Employer Participation Agreement (*the Agreement*), the Proposed Participating Employer (*the Employer, You or Your*) named below requests participation in the National Employers' Specialty Trust (*the Trust*) for insurance coverage under one or more of the insurance policies (*the Policies*) issued by the CNA Group Life Insurance Company, the Continental Assurance Company, or the Continental Casualty Company (*We, Our, or Us*) to Lexis Document Services, 801 Adlai Stevenson Drive, Springfield, Illinois 62703; Illinois agent for SentryCorp, Ltd., located at 99 North Main Street, Mullica Hill, New Jersey 08062, as Trustee.

CUSTOMER NUMBER(S): _____

EMPLOYER INFORMATION: Enter information exactly as it should appear in the certificate.

Full legal name of employer: _____	Address: _____ <div style="text-align: center; font-size: small;"><i>Street and number</i></div> <hr/> <div style="display: flex; justify-content: space-between; font-size: x-small;"> <i>City</i> <i>State</i> <i>Zip</i> <i>County</i> </div>
Contact: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. _____ <div style="text-align: center; font-size: x-small;"><i>First Last</i></div> Title _____	Phone: () _____ Fax: () _____ E-mail: _____
Federal Tax ID Number: _____	

Check the box next to the coverage you are selecting.

ELIGIBILITY: Enter exactly as it should appear in the policy for each coverage (example: *all active full-time employees*).

Basic Life:

Short-Term Disability Income:

Long-Term Disability Income:

DEFINITION OF FULL-TIME EMPLOYMENT: Minimum number of hours for full-time eligibility: _____ hours/week

EARNINGS DEFINITION

Salary only
 W-2
 K-1
 Salary & commissions*
 Salary & bonuses*
 Salary, commissions & bonuses*

*Earnings definition contains a 12-month average of commissions and/or bonus.

FMLA (Family Medical Leave Act): Do you wish to have coverage extended during this leave? **Yes** **No**

PROVIDE SPD (Summary Plan Description)? **Yes** (Complete items below, if yes.) **No**

Plan Name: _____	Plan Sponsor: _____
Plan Administrator (if different from Plan Sponsor): _____	Plan Number: _____
How are fiscal records for the plan maintained? <input type="checkbox"/> calendar year <input type="checkbox"/> coverage year <input type="checkbox"/> fiscal year	If other than calendar year, what is the last day of the coverage or fiscal year? _____

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BILLING INFORMATION: Send bill to: **Employer** **Other** (If other, please complete the information below.)

Company Name:	Contact:
Billing Address:	Phone: () _____ Fax: () _____

RISK QUESTIONNAIRE

Have any eligible employees or dependents been treated for a serious medical condition during the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are any eligible employees or dependents presently disabled and not actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are 50% or more of eligible employees, who have been with the firm for less than 2 years, related by blood or marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNATURES

The proposed insurance coverages are those You elected in the *Summary of Group Insurance* to which this Agreement is attached. You understand that: 1) this Agreement is subject to the terms of the Trust; 2) insurance coverage is subject in every respect to the terms of the Policies, which alone constitute the contracts under which benefits are paid; and 3) We will not put any insurance coverages into force under any of the Policies if You do not satisfy the requirements of the Trust for becoming a Participating Employer or if You answered *yes* to any of the questions in the *Risk Questionnaire* above.

If You satisfy the requirements of the Trust for becoming a Participating Employer and if We agree to put coverage into force for You under the Policies, We will issue certificates of insurance, based on this *Summary*, as evidence of coverage under each of the applicable Policies. The premium rates will be as proposed in this *Summary*.

In no event will any insurance coverage take effect until the latest of the following: 1) the date the first premium is received; 2) the *Requested Effective Date of Coverage* stated below; or 3) the date We agree to put coverage into force pursuant to this Agreement, the Policies and Our underwriting rules. We will return any premium We have accepted if coverage cannot be put into force for any reason.

Once your coverage under a Policy is in force, We may terminate Your coverage only if:

- There is less than 100% participation of Your eligible employees for an employer paid plan;
- You fail to perform any of Your obligations that relate to the Policy;
- There are fewer than 2 of Your eligible employees (fewer than 10 employees for life insurance in Washington) insured under the Policy;
- You fail to pay any premium within the grace period; or
- The Policy terminates.

If We terminate Your coverage under a Policy for reasons other than Your failure to pay premium, a written notice will be delivered to You at least 31 days prior to the termination date.

A grace period of 31 days from the premium due date is allowed for the payment of any unpaid premium. Coverage under the Policy will remain in force during the grace period. If the premium is not paid by the end of the grace period, coverage under the Policy will terminate on that date. You will continue to be liable to Us for any unpaid premium.

Requested Effective Date of Coverage: _____

Dated at _____ **this** _____ **day of** _____, 20 _____.

Witness: _____ <i>Licensed Resident Agent</i>	Employer: _____
California Only: _____ <i>Agent's License/Identification Number</i>	By: _____ <i>Signature</i> <i>Title</i>

STATE NOTICES

All states except AZ, CA, CO, FL, NJ, and VA: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement 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.

AZ: For your protection Arizona law requires the following statement to appear on this form: *Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.*

CA: Notice for California Residents: For your protection California law requires the following to appear on this form: *Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.*

CO: 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, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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 of regulatory agencies.

FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer file a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

VA: 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.

Additional notice for NC: Under North Carolina General Statute section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance, or health care plan premiums, will: (1) cause the cancellation or nonrenewal of group health or life insurance, hospital, medical, or dental service plan, multiple employer welfare arrangement, or health care plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay such premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days prior to the termination of such coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

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