

NEW HAMPSHIRE MOTOR TRANSPORT ASSOCIATION  
EMPLOYEE BENEFIT TRUST  
APPLICATION AGREEMENT

The applicant signing below request participation in the New Hampshire Motor Transport Association – Employee Benefit Trust (“Trust”) to provide group insurance for the employees named below:

**EMPLOYER DATA** (Type or print all information):

1. Full Name and Address of Participating Employer:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Telephone Number: \_\_\_\_\_

3. Fax Number: \_\_\_\_\_

4. Participating Employer is a  Proprietorship;  Corporation;  Association;  Other (please explain): \_\_\_\_\_

5. Nature of Business: \_\_\_\_\_

6. How many vehicles over 10,000 lbs. \_\_\_\_\_

7. Are the employees of any affiliated or subsidiary companies to be covered?  Yes  No If  
yes, state nature of business (if different from participating employer) and give details below:

\_\_\_\_\_

\_\_\_\_\_

**COVERAGE DATA:**

8. If the Employer and Employee share in the cost of this coverage, please indicate below which portion of the premium is paid by the employer:

Health	_____
Life	_____
Dental	_____
Vision	_____
Short term Disability	_____

9. Census Data (Attach a copy of previous insurance listing – Employee – DOB – Sex – Type of Coverage (Single, two-person, Family) or type list containing this information or you may fill out the enclosed census form.

10. Requested Effective Date: \_\_\_\_\_

11. Average Number of Employees covered under the Employer’s plan during each of the last three years:

Year _____	# of Employees _____
Year _____	# of Employees _____
Year _____	# of Employees _____

12. Description of current plans (please attached booklet or summary of benefits sheet of your current plan):

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13. Retirees – Are they covered under current plan? [ ] Yes [ ] No If yes, what is covered?

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14. Current rates for present programs (please attach a copy of your current invoice).

15. Reason for requesting coverage under the Trust program: \_\_\_\_\_

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16. Please list the states in which your employees reside other than NH, MA, VT or ME: \_\_\_\_\_

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**COVERAGE REQUESTED:**

17. Please check the boxes for coverage requested. You must either select Life or Life and AD&D coverage with a health benefit plan. If no box is check under Life, you will automatically be charged for Life only at \$7,500 level.

Health Plans [ ] OAP 601 [ ] OAP 602 [ ] OAP 603 [ ] HD1 [ ] HD2 [ ] HD3 (Not HSA Compatible)  
[ ] HD 4 (Not HSA Compatible) [ ] HRA 750 [ ] HRA 500

Life Only [ ] \$7,500 level [ ] 1x salary [ ] 2x salary  
 Life and AD & D [ ] \$7,500 level [ ] 1x salary [ ] 2x salary

**Optional Coverages:**

Life and AD & D only\*\*  \$7,500 level  1x salary  2x salary  
 Short Term Disability  Yes  No  
 Vision Plan  Yes  No  
 Dental Plan  409-2  409-3  495-8  495-9  496-0

\*\* Applies to those not covered under Health plan

**DEFINITIONS AND REQUIREMENTS:**

Eligible Employees: A full time employee is one who:

- ...qualifies as a full time employee as determined by the participating employer (but works not less than 20 hours per week; and
- ...performs his/her job for full pay; and
- ...works at or from the participating employer's place of business.

18. How many hours per week must an employee work to be considered by your to be a full time employee? \_\_\_\_\_

19. Waiting periods for insurance: Each new full time employee will be eligible:

- on the first of the month following the date of hire.
- on the first of the month following the date he/she completes \_\_\_ days/months of full time work.

20. Participation Requirements: 80% of eligible employees must participate

Number of part time employees \_\_\_\_\_  
 Number of full time employees \_\_\_\_\_  
 Total number of employees \_\_\_\_\_

(Must equal census report or provide a copy of your C41 statement from your State quarterly unemployment reports)

Number of employees waiving coverage  
 Because of Spousal coverage \_\_\_\_\_  
 Refusing no coverage at all \_\_\_\_\_  
 Military or Medicare coverage \_\_\_\_\_  
 Total number of employees waiving coverage \_\_\_\_\_

Number of employees still in waiting period \_\_\_\_\_

Total number of employees requesting coverage at this time \_\_\_\_\_

(Total number of full time employees Less number of employees waiving coverage Less number of employees still in waiting period)

**APPLICANT’S DECLARATION**

1. I agree to be bound by the terms of the Agreement and Declaration of Trust under which this Trust operates, and the Plan Documents and Summary Plan Descriptions and agree to be bound by all terms and conditions of them and any amendments thereto.
2. To the best of my knowledge and belief, all the statements and answers in the Application are true and complete.
3. I understand that:
  - a) No agent may change or waive any provision of this Application or of any Trust policy, underwriting rule or regulation;
  - b) This Application will be accepted or declined on the basis of the statements and answers given above;
  - c) Only full time employees and their dependents are eligible for coverage;
  - d) I agree to pay the required contribution for my employees and their dependents; regardless of any co-sharing agreement or contribution arrangement that may be in effect between me and my employees; failure to pay contributions when due may result in claims for my employees being held until such payment is made;
  - e) I may withdraw from participation in the Trust on the last day of the calendar month as long as at least 30 days prior written notice is given to the Trust;
  - f) Failure to pay contributions when due will constitute such withdrawal.

\_\_\_\_\_

Date

Print Name

\_\_\_\_\_

Signature

ACCEPTED:

NEW HAMPSHIRE MOTOR TRANSPORT ASSOCIATION – EMPLOYEE BENEFIT TRUST

BY: \_\_\_\_\_  
Signature

\_\_\_\_\_ Date

