

Small Group Plans
Application For Coverage For Colorado Small Employers
 To be completed in **BLUE** or **BLACK** ink **ONLY**



EMPLOYER (CORRECT LEGAL NAME):		FEDERAL EMPLOYER ID NUMBER (EIN):
DOING BUSINESS AS (DBA):		TELEPHONE NO.: ()
MAILING ADDRESS:	CITY STATE ZIP CODE	FAX NO.: ()
STREET ADDRESS:		E-MAIL ADDRESS:
CITY:	STATE ZIP CODE	NUMBER OF YEARS AT PRESENT LOCATION:
TYPE OF BUSINESS (CHECK ONE): <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> NON-PROFIT CORP. <input type="checkbox"/> SUB-CHAPTER S CORP. <input type="checkbox"/> LLC/LLP		DATE BUSINESS ENTITY FORMED:
DESCRIBE NATURE OF BUSINESS:		SIC CODE:
AUTHORIZED COMPANY REPRESENTATIVE NAME/TITLE:		REQUESTED EFFECTIVE DATE:

A Colorado Small Employer is an employer who employed no more than "50" eligible employees, the majority of whom were employed within this state during the preceding calendar quarter. Small employer includes a Business Group of One. A small group shall be a Colorado small group if 1) the majority of the eligible employees are employed in the state or 2) if no state contains a majority of the eligible employees and the employer's primary business location is in Colorado. IF YOU DO NOT QUALIFY AS A COLORADO SMALL EMPLOYER, A DIFFERENT APPLICATION FORM WILL BE REQUIRED.

Subject to approval of this application, proposed Employer hereby requests and endorses the following selection of coverages, options and benefits as its Employee Benefit Health and Welfare Plan. The Employer understands that all employees participating in its Plan must enroll for all the coverages and options shown below as elected by the Employer. Employer also understands that plan changes requested by the Employer, once coverage becomes effective, are limited to once a year on the Employer's anniversary date.

GROUP MEDICAL PLANS

INCENTIVE CARE PPO
 PPO Deductible: \$250 \$500 \$1,000 \$2,000
 PPO Coinsurance: 70% 80% 90%

INCENTIVE SELECT 80 90 100

Colorado Standard PPO Plan

Colorado Basic PPO Plan

FOR DUAL CHOICE ONLY: Please select Plan 1 from above and Plan 2 below; and also complete the Enrollment Options section below:

INCENTIVE CARE PPO
 PPO Deductible: \$250 \$500 \$1,000 \$2,000
 PPO Coinsurance: 70% 80% 90%

INCENTIVE SELECT 80 90 100

Other: _____

Dual Choice Enrollment Options (Select One):

Employee Choice (employees may select either plan)

By Class (i.e., salaried, hourly, etc.) - list below

By Work Location (i.e., state, county, city, etc.) - list below

Plan 1: _____

Plan 2: _____

PPO NETWORK SELECTED: _____
 If network differs by work location, give details.

WAITING PERIOD All Employees **OR** Subsequent Employees Only

1 Month 2 Months 3 Months 6 Months
 Eligible first of the month following waiting period.

OPTIONAL COVERAGES

PREGNANCY (an Employer with 15 or fewer employees may elect to self-insure)

\$300 ADDITIONAL ACCIDENT

OCCUPATIONAL COVERAGE If electing, give names of Officers, Partners, or Proprietors: _____

CLASSIC DENTAL
 (Available with 5+ covered employees for stand alone)

Plan: 1 2 3

Deductible: \$25 \$50 \$100

Prior dental plan inforce: Yes* No *If Yes, are you applying for the reduced waiting period for major dentistry? Yes No

GROUP LIFE INSURANCE

If elected, \$15,000 minimum Life Benefit for A, B, C or E

A. Equal amount of \$ _____ for all employees.

B. One Times Annual Earnings (including \$15,000 minimum).

C. 25+ Covered Employees: 1x to \$100,000 2x to \$150,000

D. Dependent Life Coverage

E. Class Schedule (complete below)

SHORT TERM DISABILITY (STD) INCOME INSURANCE

If elected, choose A, B, or C. Not to exceed 66 2/3% of Weekly Earnings.

A. Equal amount for all employees: Available from \$100 to \$500 in \$50 increments (\$500 maximum). Amount: \$ _____

B. Times Earnings (minimum \$100 - maximum \$500)

C. Class Schedule (complete below)

CLASS NO.	DESCRIPTION OF EMPLOYEE CLASS (BY JOB TITLES)	LIFE BENEFIT	STD BENEFIT
1.			
2.			
3.			

NOTE: Minimum Life and AD&D benefit of \$15,000 per employee. Life and AD&D benefits are reduced to 65% at age 65; to 45% at age 70 and to 30% at age 75. Short Term Disability benefits are reduced to 65% at age 65 and terminate at age 70.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2 TO 50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING THE ANNUAL OPEN ENROLLMENT.

EMPLOYER INFORMATION

1. Is your business known by a name other than the one(s) listed on the front of this application? Yes No
 If "Yes," other name(s): _____

2. Do any employees work at a location other than the one(s) listed on the front of this application? Yes No
 Address(es) of other location(s): _____

3. What is the name of your Worker's Compensation carrier? _____

4. Does your business file an Employer's Quarterly Wage and Contribution Report? Yes No
 If "Yes," please submit the most current copy with this application.

5. NOTE: All eligible employees hired on or before the employer's requested effective date are eligible for coverage and must be included in the count of eligible employees. Evidence of Insurability is required on all employees hired on or before the employer's effective date, regardless of group size.
 - A. Please indicate the number of employees, by category, in the boxes below for the time periods indicated:

	Full-Time	Part-Time	Temporary	Seasonal	Union	Commission	Contract	TOTAL
Preceding Calendar Year	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>
Preceding Calendar Quarter	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>	<input style="width: 40px; height: 20px;" type="text"/>

 - B. Total number of employees **currently** working for your business

 - C. Total number of **eligible** employees employed 50% of the business working days during the **preceding** calendar quarter

 - D. Total number of employees applying for coverage (including Life-only applicants)
 - E. Total number of employees in Waiting Period (enrollment forms for employees in waiting periods which end in less than 3 months must be included)

6. Any employee/dependent currently hospitalized or disabled (including disability due to a work-related injury)? Yes No
 If "Yes," name of individual(s): _____

7. Is your firm subject to TEFRA legislation [i.e. 20 or more employees (both full and part-time) working for 20 or more consecutive weeks in **either** the current or prior calendar year]? Yes No

8. Is your firm subject to COBRA legislation [i.e. 20 or more employees (both full and part-time) employed at least 50% of the business days during the preceding calendar year]? Yes No
 If "Yes," please answer the following questions:
 - Any employee/dependent currently on a continuation of benefits under COBRA? Yes No
 - If "Yes," name of individual(s): _____
 - Has any employee/dependent experienced a qualifying event (i.e., employment termination, reduction in work hours due to disability, divorce, etc.) under COBRA within the last 90 days and not yet elected to continue coverage? Yes No
 - If "Yes," name of individual(s) and qualifying event dates: _____

9. Are any of your employees related by blood or marriage? Yes No
 If "Yes," please provide names and relationships: _____

10. Are any of your employees/dependents currently on a continuation of benefits under state law? Yes No
 If "Yes," name of individual(s): _____

11. Has your firm ever been insured under either this Plan or another Pacific Mutual, Pacific Life, PM Group, or Pacific Life & Annuity group health plan? Yes No
 If "Yes," policy or employer number: _____ When? _____

12. Will your present group insurance terminate prior to or on the requested effective date? Yes No
 If "Yes," provide the following and include a copy of your current premium statement(s).
 - A) Name of insurance company: _____ B) Phone Number: _____
 - C) Prior Policy / Employer Number: _____ D) Effective Date: _____
 - E) Date coverage will terminate: _____ F) Number of covered employees on termination date: _____
 - G) Reason for termination: _____

13. What percentage of the employee premium do you contribute? %

14. Is your business affiliated with any other companies (Parent companies, subsidiaries, commonly owned, related entities or partnerships)? Yes No
 If "Yes," number of full-time employees in Parent companies, subsidiaries, commonly owned, related entities or partnerships

**SUBSCRIPTION AGREEMENT
TO THE MULTI-PROTECTION TRUST-UTAH**

IMPORTANT -- READ CAREFULLY BEFORE SIGNING

The undersigned Employer, engaged primarily in the industry described in the Small Group Plans Application For Coverage, applies for enrollment in the group insurance plan established thereunder, and hereby adopts and subscribes to the terms of the Trust Agreement establishing the Multi-Protection Trust-Utah. For purposes of this Agreement, the insurance company, Pacific Life & Annuity Company, shall hereafter be referred to as the Insurance Carrier; the Administrative Representative for the Trust, Pacific Life & Annuity Company, Medical Products, Small Group Administration Department, shall hereafter be referred to as PL&A's Small Group Dept.

1. The Employer agrees to follow all terms, provisions, conditions and limitations of said Trust Agreement and all amendments thereto. The undersigned Employer, on behalf of itself and its participating employees and dependents is bound by and agrees to follow all terms, provisions, conditions and limitations contained in the Master Group Insurance Contract, established for, and issued to, the policyholder of the Multi-Protection Trust-Utah (the Trustee, Key Trust Company of the West). The Employer further agrees, on behalf of itself and its participating employees and dependents, to cooperate in the verification of compliance with the terms, provisions, conditions and limitations set forth in the Master Group Insurance Contract and the Certificate Booklet.
2. The Employer agrees to pay the required contributions monthly, said contributions being comprised of insurance premium and administrative fees. The contributions must be made in the form of a check drawn against the account of the business, payable to the Multi-Protection Trust-Utah at the address so designated by PL&A's Small Group Dept. The Employer understands that the contribution is payable on the first day of each respective month and will become delinquent if not received by PL&A's Small Group Dept. by the 15th day of the month for which the contribution is due. The Employer further understands that a delinquent status is cause for termination from the Trust, effective the last day of the calendar month for which complete contributions have been received.
3. The Employer agrees to make timely notification to PL&A's Small Group Dept. of any employee terminations, status changes or other material changes which serve to modify the statements contained in this application or render the Employer ineligible for continued participation in this Trust. Timely notification shall be defined as being no more than 31 days past the actual date of such changes.
4. The Employer understands that all new employees are eligible for participation in this plan on the first day of the month following completion of the elected waiting period and coverage will become effective on that date if the enrollment form is received by PL&A's Small Group Dept. before the employee's eligibility date. (When evidence of insurability is required, the application must be approved before coverage becomes effective.)
5. The Employer understands that under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for the plan of benefits provided by the Multi-Protection Trust-Utah on behalf of the employees of the business. These fiduciary responsibilities include, but are not limited to, remitting contributions on the employees' behalf when due and notifying employees of effective dates of coverage, effective dates of changes in coverage, termination of coverage and conversion privileges. The Insurance Carrier assumes the responsibility as claim review fiduciary for the plan.

The Employer understands that the Insurance Carrier is not responsible for complying with any state or federal laws or regulation which affect benefits that must be provided by employers to their employees.

6. The undersigned Employer understands that the Administrative Representative conducts periodic audits to assure that eligibility, participation and contribution requirements are being met by all Employers on a continuing basis. Further, the Employer agrees to cooperate with the Administrative Representative in the event of an audit with respect to said Employer's Employee Benefit Plan. Specific cooperation includes, but is not limited to, providing payroll documentation, copies of business licenses or Wage and Contribution Reports. Failure to cooperate upon request of the Administrative Representative may result in termination or cancellation of coverage at the option of the Administrative Representative.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company or other person, files a statement of claim or an application containing any materially false, incomplete, or misleading information, may be guilty of a felony and subject to criminal and civil penalties.

THE UNDERSIGNED EMPLOYER CERTIFIES to the best of its knowledge and belief that it has read all sections of this document and fully understands and agrees to abide by all requirements and conditions stated therein. **THE UNDERSIGNED EMPLOYER AGREES TO FOLLOW** all terms, provisions, conditions and limitations contained in the Master Group Insurance Contract under which coverage is provided. **THE UNDERSIGNED EMPLOYER UNDERSTANDS** that coverage shall not commence until this application has been approved by the Insurance Carrier and notice of approval has been provided to the undersigned Employer.

EMPLOYER NAME (PLEASE PRINT):	
EMPLOYER SIGNATURE: X	
NAME AND TITLE:	DATE APPLICATION COMPLETED:
CITY, STATE WHERE SIGNED:	

THE INSURANCE CARRIER RESERVES THE RIGHT TO DECLINE ANY NEW BUSINESS APPLICATION WHICH, IN THE COMPANY'S OPINION, DOES NOT MEET SOUND UNDERWRITING STANDARDS OR WHICH WOULD AFFECT THE FINANCIAL STABILITY OF THE TRUST, EXCEPT WHERE PROHIBITED BY LAW.

EMPLOYEE ELIGIBILITY REQUIREMENTS

"Eligible employee" means an employee who has a regular work week of 24 hours (the Employer may elect more minimum hours for eligibility) and includes a sole proprietor and a partner of a partnership, if the sole proprietor or partner is included as an employee under a health benefit plan of Small Employer, but does not include an employee who works on a temporary or substitute basis. If an employee's spouse or child qualifies as an employee, he or she must be covered as an employee and not as a dependent.

PARTICIPATION REQUIREMENTS

The minimum participation requirements for group enrollment and continued participation in the Plan are:

Number of Eligible Employees	Required Employee Enrollment	Required Dependent Enrollment of Employees With Eligible Dependents
Less than 6	100%	100%
6, 7, or 8	All Less 1	75%
9, 10, 11, or 12	All Less 2	75%
13, 14, or 15	All Less 3	75%
16 or More	75% of All Eligible Employees	75%

Employees and dependents who are covered under creditable coverage are considered eligible for coverage but may be excluded from the number of eligible employees and dependents before the participation requirements are calculated if they do not elect Pacific Life & Annuity coverage. However, when an employer sponsors multiple plans, employees and dependents covered under the other employer-sponsored plan are counted.

CONTRIBUTION REQUIREMENT

The employer must pay a minimum of 50 percent of the employee premium for the lowest cost plan the employer offers.

PREEXISTING CONDITIONS LIMITATION

A "Preexisting Condition" is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within 6 months immediately preceding the effective date of coverage. No medical benefits are provided for a preexisting condition until the insured has been insured for six consecutive calendar months under the Pacific Life & Annuity plan chosen by the Employer. "Qualifying previous coverage" includes Medicare, Medicaid, an employer-based or group health insurance, or an individual health insurance policy which has been held for one year. "Qualifying previous coverage" also includes coverage provided through the Colorado Uninsurable Health Insurance Plan.

PREEXISTING CONDITIONS WAITING PERIOD CREDIT

Preexisting Conditions Waiting Period Credit or "Portability" credits the time a person was covered under "qualifying previous coverage" toward the six month insured time period specified in the Preexisting Conditions Limitation above. Preexisting Conditions Waiting Period Credit is available to all employees and their covered dependents who: (a) become eligible under this plan within 90 days of termination of their "qualifying previous coverage," and; (b) apply within the applicable enrollment period.

PRODUCER'S STATEMENT

I hereby certify that I hold a valid Life, Accident and Health License issued by the state in which the employer's principal place of business is located, and that all of the information contained herein is correct, to the best of my knowledge, and I know nothing unfavorable about this firm or individuals applying for insurance that has not been disclosed. Furthermore, I certify that: (1) The firm is a bona fide business establishment and meets all eligible employer requirements as described in the sales brochure; (2) Participation and Eligibility requirements have been explained and are being met; (3) I have advised the Employer not to terminate any existing coverage until receiving notice that the coverage being applied for by the Application and Subscription Agreement is accepted; (4) Preexisting Conditions Limitation and Pre-Service Review requirements have been fully explained to, and understood by, the Employer identified in this document; (5) I will not disclose any health or financial information of the applicants to anyone other than PL&A.

<input type="checkbox"/> PRODUCER TO BE PAID, OR <input type="checkbox"/> FIRM TO BE PAID, OR <input type="checkbox"/> SPLIT*		IF SPLIT*, INDICATE COMMISSION PERCENTAGES: * First producer must receive minimum of 10% commission and first producer only will receive MVP credit and correspondence for the employer. FIRST PRODUCER _____% SECOND PRODUCER _____%		THE ADMINISTRATION KIT WILL BE SENT TO YOU TO DELIVER TO THE EMPLOYER UNLESS YOU INDICATE OTHERWISE HERE: <input type="checkbox"/> SEND ADMINISTRATION KIT DIRECTLY TO THE EMPLOYER.					
PRODUCER'S NAME: Roger Walker		SOCIAL SECURITY NO.:		INSURANCE LICENSE NO./STATE: EXPIRATION DATE:					
MAILING ADDRESS: 2010 E Sheena Phoenix, AZ 85022		CITY STATE ZIP CODE		IF PACIFIC LIFE AGENT SAID CODE: AGENCY:					
STREET ADDRESS: 2010 E Sheena Phoenix, AZ 85022		CITY STATE ZIP CODE		TELEPHONE NO.: 602-404-8633					
SIGNATURE OF WRITING PRODUCER: X Roger Walker		DATE COMPLETED:		E-MAIL ADDRESS: advisorsllc1@cox.net					
SECOND PRODUCER'S NAME OR FIRM'S NAME:		SOCIAL SECURITY NO. OR TAX ID.:		INSURANCE LICENSE NO./STATE: EXPIRATION DATE:					
MAILING ADDRESS:		CITY STATE ZIP CODE		IF PACIFIC LIFE AGENT SAID CODE: AGENCY:					
STREET ADDRESS:		CITY STATE ZIP CODE		TELEPHONE NO.: FAX NO.:					
SIGNATURE OF WRITING PRODUCER: X		DATE COMPLETED:		E-MAIL ADDRESS:					
SMA NAME:		SMA AGENCY:		SALES OFFICE USE ONLY					
SALES OFFICE:	SALES OFFICE:	REP #:	COMM SCHED:	ORIGIN CODE:	EMPLOYER NO.:	EFFECTIVE DATE:	MEDICAL <input type="checkbox"/> YES <input type="checkbox"/> NO	NO. INSURED LIVES	COPIES TO: L&C: