N·A·W
National Association of Wholesaler-Distributors

Underwritten by
Trustmark
LIFE INSURANCE COMPANY

EMPLOYER INFORMATION FORM

The information below is necessary for evaluation of your request for proposal. Please complete each question for your employees and their covered dependents.

COMPANY INFORMATION		
Company Legal Name	Employer Tax ID Number	
Name of Subsidiary or Affiliated Companies		
Main Address		
City	State	Zip
Phone	Fax	Web Address
Contact Person	Title	E-Mail Address
Branch Locations (City/State/Zip):		
Years of Operation	Ever filed for bankruptcy or in the process of filing? ☐ Yes ☐ No	
Number of Employees	Number of employees eligible for National Association of Wholesalers (NAW) coverage*	Number of employees applying for NAW health coverage
Is this firm currently a member of NAW**? ☐ Yes ☐ No		
Are 30% or more of your company's employees members of one family either by blood or marriage? ☐ Yes ☐ No		
During the last 12 months, has there been an increase or decrease in the number of employees? ☐ Yes ☐ No If YES, please explain:		

* An eligible employee is any person who performs services for the firm with a normal work week of 30 or more hours, earning W-2 wages of at least the federal minimum wage.

** As a condition to participate in the NAW, the employer must be a member in good standing with NAW. NAW membership must begin prior to the employer's effective date of coverage.

CURRENT CARRIER INFORMATION

Medical carriers in past five years *(including current carrier):*

CARRIER NAME (S)	START DATE (MTH/YR)	END DATE (MTH/YR)	REASON FOR MOVING

Current and renewal medical rates (not required if copy of renewal letter is provided):

	CURRENT RATES	RENEWAL RATES
Employee		
Employee + Spouse /Domestic Partner		
Employee + Child(ren)		
Employee + Family		

Are there any full-time employees not covered by your current medical plan? ☐ Yes ☐ No
If YES, please explain:

Are any non-employees currently covered by your medical plan *(1099s, Board members, or other non-employees)*?
☐ Yes ☐ No
If YES, please complete the following:

TOTAL NUMBER OF:	TOTAL NUMBER OF:
1099s working at company?	1099s enrolling for this coverage?
Board members of company?	Board members enrolling for coverage?
Other non-employees working at company?	Other non-employees enrolling for coverage?

Number of former employees covered under _____ COBRA _____ Retiree Medical Coverage

Please indicate employer's insurance contribution toward the monthly premium:

COVERAGE	EMPLOYEE	CHILD(REN) ONLY	SPOUSE /DOMESTIC PARTNER ONLY	CHILD(REN) & SPOUSE /DOMESTIC PARTNER
Life/AD&D	% OR $	% OR $	% OR $	% OR $
Medical	% OR $	% OR $	% OR $	% OR $
Dental	% OR $	% OR $	% OR $	% OR $
STD	% OR $	% OR $	% OR $	% OR $
LTD	% OR $	% OR $	% OR $	% OR $
Other	% OR $	% OR $	% OR $	% OR $

Are there any other group health plans that would be in force concurrently with the NAW plan?
☐ Yes ☐ No

If yes, please provide the following information:

CARRIER	TYPE OF BENEFITS HMO, PPO, ETC.	NUMBER ENROLLED	% EMPLOYER CONTRIBUTION

Please attach a copy of the following to complete the Employer Information Form:

- Current medical/Rx/vision schedule of benefits or detailed benefit summary.
- Current employee census showing age, dependent status, eligible waivers, and location breakdown.

HEALTH INFORMATION

1. Are there covered employees who are not actively at work and/or dependents who are disabled or hospitalized and who are applying for coverage? ☐ Yes ☐ No

If yes, please provide details below. (Please attach additional sheets if necessary.)

Employee or Dependent	Age	Sex	Diagnosis and Prognosis	Treatment and Medications	Date of Onset and Recovery	Paid Claim Total for Last 12 Months

When applying for or receiving multiple coverages through the NAW under the same application or enrollment form, personal information will be used and disclosed internally between those products for the purpose of administering all benefits. All information is held to the same Privacy standards and is not used or disclosed unless required or permitted by law.

EMPLOYER CERTIFICATION

I understand and do hereby certify that information contained in the Employer Information Form is complete (including attachments) and accurate. It is further understood that any misrepresentation or false statements will subject any issued coverage to immediate termination by Trustmark Life Insurance Company.

Signature

Date

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PARTICIPATING EMPLOYER APPLICATION AND AGREEMENT

Comprehensive Medical

Eligibility Waiting Period:

☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 days

(State restrictions may apply. Please ask your sales consultant.)

The effective date of coverage for those who fulfill the eligibility requirements will be:

☐ First of month coinciding with or following date of eligibility

☐ On date of eligibility

☐ **Comprehensive Medical Plan**

Plan Name: _____

☐ **Long-Term Disability Income**
- ☐ Standard Plan ☐ Enhanced Standard Plan
- ☐ Mid Cost Plan ☐ Cost Saver Plan

Elimination Period:
- ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 months ☐ 1 year
- ☐ 2 years (Standard Plan *only*)

Cost of Living Adjustment (COLA) ☐

Employer Sponsored Pension Plan Contribution ☐

Definition of Income:
- ☐ Base Salary Only (excludes commissions, bonuses, overtime pay or any extra compensation) (Std)
- ☐ Other - Commissions ☐ No ☐ Yes
  - Bonuses ☐ No ☐ Yes

Averaged over _____ Months

Benefit Duration:
- ☐ Standard
- ☐ Social Security Normal Retirement Age
- ☐ Two Year up to age 70

Please indicate all coverages for which application is made.

☐ **Basic Life**
- ☐ Flat $10,000 ☐ Flat $ _____
- ☐ 2x salary; $50,000 maximum
- ☐ 2x salary; $100,000 maximum *(Firm must have 10+ employees enrolled)*

☐ **Weekly Disability Income**
Elimination Period: ☐ 1/8 ☐ 8/8 ☐ 15/15 ☐ 30/30

☐ **Dental**

Plan Name: _____

Date of NAW membership approval	The proposed effective date of this group insurance is

Insurance will be effective at 12:01 a.m. Standard Time on the date shown above, provided this application has been accepted by Trustmark Life Insurance Company, and the deposit premium has been paid.

If any information on the Employer Information Form attached to this application has changed since the date the Employer Information Form was completed, please complete an updated Employer Information Form in its entirety and submit it with this application. Be it further understood that the attached Employer Information Form dated _____ , and any updated Employer Information Forms, are attached to and considered part of this application, and will be relied on by Trustmark Life Insurance Company for purposes related to underwriting the coverage.

AGREEMENTS

I understand that the insurance applied for shall not take effect until approved by Trustmark Life Insurance Company at its Home Office and that coverage provided by any prior carrier should not be terminated until written approval for this coverage is received from Trustmark Life Insurance Company. I understand that the actual terms and conditions of coverage will be contained in the Policy and Certificate(s) issued by Trustmark Life Insurance Company. The undersigned is authorized by the Applicant to make representations on its behalf and has done so in each of the preceding questions, based on a thorough investigation and a complete review of all legally available sources, including, but not limited to, attendance and payroll records, personnel files, and information provided by the Applicant's prior carrier. All answers and statements made on the Application are true and complete. I have read the completed Application, and I agree that any false statements or misrepresentation in the Application may result in loss of coverage. Subscription to Trust: Employer hereby applies for participation in the National Association of Wholesalers Trust and for enrollment in the Group Insurance Contract established thereunder.

Any person who knowingly presents a false or fraudulent claim for payment of loss 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.

Signature of Company's Authorized Officer/Purchaser

Date

Signature of Licensed Resident Agent (where required by law)