



Complete this form to apply for group insurance coverage available to Participating Clients of ERMC which sponsors these programs. Check each section below before you sign. Your signature applies to all sections.

Send the completed form to:

Benefits Department
Employers Resource
1305 South Vista Avenue, Suite 250
Boise, ID 83705
Phone: 866-214-9506; Fax: 888-201-6365

Retain a photocopy of this form for your records.

SECTION I: GENERAL INFORMATION

Participating Client's Full Legal Name:				
Business Address:	City:	State:	Zip Code:	Phone No.: ()
Billing Address:	City:	State:	Zip Code:	Phone No.: ()
Participating Client Tax ID No.:	Client Type: <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Other: _____			
Requested Effective Date:				
This application must be submitted prior to the requested effective date. The actual effective date will be determined by Standard Insurance Company (The Standard).				
Does this disability insurance replace a Prior Plan of disability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes: <input type="checkbox"/> Replace: Type of Coverage: _____				
Policy No.: _____ Carrier: _____				
<input type="checkbox"/> Replace: Type of Coverage: _____				
Policy No.: _____ Carrier: _____				
Effective date of Prior Plan: _____ Termination date of Prior Plan: _____				
Prior Plan means the Participating Client's group insurance plan(s) in effect on the day before the effective date its participation under the Group Policy and which is replaced by the ERMC Group Disability Policy.				
The following persons may be eligible for the coverages selected: Active full-time employees regularly working at least the minimum number of hours each week required by the Participating Client, but in no event less than 30 hours.				
<input type="checkbox"/> Short Term Disability Insurance (Participating Client paid):				
Total – Employees: _____				
<input type="checkbox"/> Long Term Disability Insurance (Participating Client paid):				
Total – Employees: _____				
Required Participating Client Contribution: All coverages must be 100% Participating Client paid.				
Enrollment Requirement: Participating client must have a minimum of five (5) full-time employees.				
Eligibility Waiting Period: There is no waiting period on the effective date of participation, except new hires.				
For New Hires: After effective date, the waiting period is the first day of the month coinciding with or next following:				
<input type="checkbox"/> Date of Hire <input type="checkbox"/> One month <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days				
Active Work Requirement: An active employee must meet an active work requirement to become insured. Employees who have not met the active work requirement are not insured until returning to work for at least one full day of active work and meeting all other requirements for coverage. Client Initial: _____				

SECTION II: BENEFITS

Check Plans and Options Desired

A. SHORT TERM DISABILITY *(Minimum STD benefit is \$15.00. W-2 preparation is the responsibility of participating Client/ERMC)*

Option 1 .29/\$10.00 of benefit

50% of weekly earnings²
\$500 maximum
15-15-180¹

Cost example 12 employees each make \$550 wkly
\$6,600 x .50 = \$3,300 / \$10 = \$330 x .29
= \$95.70 monthly cost to employer

Option 2 .38/\$10.00 of benefit

66²/₃% of weekly earnings²
\$1,000 maximum
15-15-180¹

Cost example 12 employees each make \$550 wkly
\$6,600 x .667 = \$4,402 / \$10 = \$440 x .38
= \$167.28 monthly cost to employer

Option 3 .304/\$10.00 of benefit

50% of weekly earnings²
\$1,000 maximum
15-15-90¹

Cost example 12 employees each make \$550 wkly
\$6,600 x .50 = \$3,300 / \$10 = \$330 x .304
= \$100.32 monthly cost to employer

B. LONG TERM DISABILITY *(Minimum LTD benefit is \$100.00. Definition of Disability: Two year own-occupation, any occupation thereafter.)*

Option 1 .46% of monthly payroll

60% of monthly earnings²
\$5,000 maximum
180 Day BWP³
to age 65, or SSNRA⁴

Cost example 12 employees each make \$2,000 per month
\$24,000 mthly payroll / \$100 = \$240 x .46
= \$110.40 monthly cost to employer

Option 4 .552% of monthly payroll

60% of monthly earnings²
\$5,000 maximum
90 Day BWP³
to age 65, or SSNRA⁴

Cost example 12 employees each make \$2,000 per month
\$24,000 mthly payroll / \$100 = \$240 x .552
= \$132.48 monthly cost to employer

Option 2 .31% of monthly payroll

50% of monthly earnings²
\$5,000 maximum
180 Day BWP³
to age 65, or SSNRA⁴

Cost example 12 employees each make \$2,000 per month
\$24,000 mthly payroll / \$100 = \$240 x .31
= \$74.40 monthly cost to employer

Option 5 .36% of monthly payroll

50% of monthly earnings²
\$5,000 maximum
90 Day BWP³
to age 65, or SSNRA⁴

Cost example 12 employees each make \$2,000 per month
\$24,000 mthly payroll / \$100 = \$240 x .36
= \$86.40 monthly cost to employer

Option 3 .17% of monthly payroll

50% of monthly earnings²
\$5,000 maximum
180 Day BWP³
2 Year Maximum Benefit Period

Cost example 12 employees each make \$2,000 per month
\$24,000 mthly payroll / \$100 = \$240 x .17
= \$40.80 monthly cost to employer

Option 6 .21% of monthly payroll

50% of monthly earnings²
\$5,000 maximum
90 Day BWP³
2 Year Maximum Benefit Period

Cost example 12 employees each make \$2,000 per month
\$24,000 mthly payroll / \$100 = \$240 x .21
= \$50.40 monthly cost to employer

¹ 15 day wait for disability caused by accidental injury - 15 day wait for disability caused by physical disease, pregnancy or mental disorder – 180 days is the Maximum Benefit Period.

² Earnings do not include bonuses or overtime pay. Please refer to your Benefits at a Glance documents or Certificate of Insurance for the complete definition of earnings.

³ Benefit Waiting Period (BWP) is the period of time to wait until eligible benefits first become payable.

⁴ Social Security Normal Retirement Age (SSNRA) means your normal retirement age under the Federal Social Security Act, as amended.

SECTION II continued on page 3

SECTION II: BENEFITS (continued)

C. Premium and Renewal Information

Premium Due Dates:	Effective date and the first day of each calendar month ERMC collects and remits premium on behalf of the participating client
Initial Rate Guarantee Period:	Effective date to 1/01/2010

SECTION III: AGREEMENTS

We request participation under the Group Insurance Policies issued to ERMC as policyholder for the coverage we have elected in **Section II: Benefits**. We agree that we are bound by all the terms of the group policies and any amendments thereto.

We agree that, if this application is not accepted, any premium advanced by us shall be refunded.

We agree to make coverage available to all present and future eligible employees. We agree that each employee must meet all requirements before insurance will become effective.

We agree to:

- (1) Promptly provide ERMC with the names of each employee and dependent to be insured, as well as all information necessary to determine (a) the amount of benefit (including changes), (b) the effective date of insurance, and (c) the premium to be charged,
- (2) Distribute certificates to each insured employee,
- (3) Not distribute material describing coverage without Standard's prior written consent,
- (4) Allow The Standard to inspect all records relating to the provisions of the policies, and
- (5) Pay the cost of insurance on or before each premium due date.

We understand that The Standard may change premium rates when:

- (1) A change in law or governmental regulation affects the amount payable under the group policies.
- (2) Our participation changes by 25% or more.

We understand our coverage under the Group Policy will terminate automatically on the date we cease to be a Participating Client under ERMC.

We understand the Group Policy may be terminated, changed or amended in whole or in part by ERMC and The Standard according to the terms of the Group Policy. Any such change or amendment may apply to current or future Participating Clients and employees covered under the Group Policy. We understand The Standard may terminate our participation on any premium due date in accordance with the terms of the Group Policy. We understand our participation will terminate automatically at the end of the grace period during which the required premium has not been paid. We understand ERMC is responsible for premium billing and collection.

We agree it is our responsibility to comply with federal, state and local laws and regulations which govern employment relationships and the provision of fringe benefits to employees. We agree to indemnify and hold The Standard, ERMC, any related or affiliated business or entity thereof and the employees, agents and representatives thereof, harmless from any and all liability which may arise because of our failure to comply with such laws.

We understand that insurance under the group policies is not a substitute for coverage under a workers' compensation law and does not relieve us of any obligation to provide such coverage.

Please fill out SECTION IV on the next page to complete this application.

SECTION IV: SIGNATURE

I hereby certify that all statements on this document are complete and true to the best of my knowledge and belief. I understand Standard Insurance Company will rely on these statements as the basis for approving this Participating Client Application. I have read and understand the information herein.

I understand the group policies and certificates contain exclusions and limitations that are not stated in this Participating Client Application.

By: _____

Signature of Authorized Company Officer: _____

Title: _____ Date: _____

Authorized Representative of ERMC: _____

Title: _____ Date: _____

Retain a photocopy of this application for your records.