

**Western Mutual Insurance Company**  
**P.O. Box 572450**  
**Murray, UT 84157-2450**  
**Phone (801) 263-8000 – Fax (801) 263-1247**

**Employer Application:** Please complete this form to make application for group insurance, including any optional plan benefits, provided by Western Mutual Insurance Company. Before signing in the appropriate space, check each section listed. Signature applies to all sections.

Section I: General Information

Company Name \_\_\_\_\_ Federal EIN \_\_\_\_\_ Contact Person \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ E-mail address \_\_\_\_\_

Waiting Period for New Employees: 30 days \_\_\_\_\_ 60 days \_\_\_\_\_ 90 days \_\_\_\_\_ 120 days \_\_\_\_\_ Other \_\_\_\_\_

Number of Eligible Employees Who Work More Than 80 Hours Per Month \_\_\_\_\_ With Eligible Dependents \_\_\_\_\_

Employer Contribution toward: Employee Premium \_\_\_\_\_ Dependents Premium \_\_\_\_\_

Will the Employer reimburse employees and/or their dependents for amounts paid toward the satisfaction of the policy deductible?  
 Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much and at what percentage? \_\_\_\_\_

Will the employer treat the health benefit plan as part of a plan or program for the purposes of sections 106, 125 or 162 of the Internal Revenue Code? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, is any part of the plan or program funded by the employer? Yes \_\_\_\_\_ No \_\_\_\_\_

Does employer currently carry workers' compensation insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ If owners and partners are not covered under workers' compensation, do they wish normal plan coverage while on the job for additional premiums? Yes \_\_\_\_\_ No \_\_\_\_\_

Does the company currently have group health insurance with another company? Yes \_\_\_\_\_ No \_\_\_\_\_

Present Insurer \_\_\_\_\_ Date Coverage to Terminate \_\_\_\_\_

Is anyone currently on COBRA? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many and details \_\_\_\_\_

CURRENT COPY OF PAYROLL REPORT (FICA OR WORKERS' COMPENSATION) MUST ACCOMPANY APPLICATION.

Section II: Benefits

Medical:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Plan Selected: _____
Dental:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
Vision:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Requested effective date: _____
Life ("VGL"):	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
Disability:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
Other	_____		

Section III: Medical Questions

Of those applying for coverage, are there any who have the following conditions?

AIDS	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Heart Problems	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Cancer	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	High Blood Pressure	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Diabetes	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	Pregnancy	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>

Please Provide Details: \_\_\_\_\_

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Of those mentioned above, is anyone currently on COBRA?

Name:

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Please list information on any claims over \$10,000 in the past 12 months.

Details:

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### Section IV: Terms and Conditions

The undersigned employer hereby requests group insurance with the Western Mutual Insurance Company. By signing this agreement, the employer agrees to adopt and subscribe to all terms and conditions of this document as well as those set forth in the insurance policy booklet. The employer understands and agrees that all insurance underwriting and participation requirements must be maintained during the insurance period. Insurance applied for hereunder will not be effective until this application has been approved in writing by Western Mutual Insurance Company. The employer agrees to notify Western Mutual Insurance Company within ten (10) days of any material change affecting the employer or which may render the employer ineligible for insurance with the company. The employer agrees that it is the administrator of the plan as that term is contemplated under the Employee Retirement Income Securities Act ("ERISA") and that Western Mutual Insurance Company does not assume any obligations imposed by that law or any amendments thereto, including, but not limited to, the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and the Health Insurance Portability and Accountability Act ("HIPAA"). The employer also agrees that Western Mutual Insurance Company may conduct periodic audits to ensure that eligibility, participation, and contribution requirements are being satisfied and that the employer will provide each insured employee and qualified beneficiary with not less than thirty (30) days prior written notification of that termination.

### Section V: Signature

I hereby certify that the information provided herein is true and complete to the best of my knowledge. I have also read and understand the group enrollment requirements\* as explained in the benefit description booklet and the terms and conditions set forth herein.

By: \_\_\_\_\_  
(Signature of Company Officer)

Title: \_\_\_\_\_ Date \_\_\_\_\_

\*WMI requires that companies with 2-5 employees must enroll 100% of employees; companies with 6-10 employees must enroll at least 90% of all eligible employees; and companies with 11 or more employees must enroll at least 80% of all eligible employees. An eligible employee is one who works a minimum of 80 hours per month and does not carry other major medical insurance coverage.