ASA
Agri-Services Agency
Leaders in Agricultural Insurance

P.O. Box 4910, Syracuse, New York 13221-4910 1-800-654-8840 Fax: 315-431-1310 www.Agri-ServicesAgency.com

Please check one:

☐ New Group
☐ Renewing Group/change

Employer Group Application

You, the Employer and Policyholder, wish to establish and sponsor an Employee Benefit Plan, the terms of which are set forth in the applicable ASA policy. You understand and agree that the Policyholder is not an insurer with respect to paying claims for benefits under the policy. ASA has the discretion to interpret policy terms, make decisions regarding eligibility and resolve factual questions.

Participation:

For you to be eligible under the policy the following participation requirements must be maintained. If you fail to maintain participation requirements, ASA will terminate your coverage under the policy.

A minimum of 75% of your eligible employees must participate in the health program. An eligible employee is someone who is working 30 or more hours per week. When considering participation levels, we do not count as "eligible employees" those employees who have other coverage that is qualifying coverage. Qualifying coverage includes Medicare, Medicaid or other group spousal coverage with benefits similar to those being applied for.

An employee census must accompany this application.

ASA reserves the right to change the above stated participation requirements in the event that the employer offers multiple options for health insurance coverage.

Income:

A minimum of 66% of your primary source of income must result from your involvement with or direct support of production agriculture.

Appropriate items from the following list are required to verify status as an eligible employer group, and must accompany this application.

a) IRS form 1065K (for a partnership)
b) IRS form 1120SK-1 or 1120E (for a corporation)
c) DBA Certificate (for new business, which have not filed tax returns)

We may require an employee or dependent to complete a Health Questionnaire based on our standard underwriting practice. UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP COVERAGE, WITHOUT A FINAL RATE BEING SUPPLIED BY ASA'S UNDERWRITING DEPARTMENT AND YOUR WRITTEN AGREEMENT THAT YOU ACCEPT THAT RATE.

If an existing group changes any information contained within this document, for example: legal name, probationary period, benefits, etc. the Group must complete Sections A, B, D, E of a new Employer Group Application and send it to ASA. Benefit changes must be submitted to ASA within 30 days of our group open enrollment which falls on January 1st every year, changes will be effective on January 1st.

Section A- Group Employer Information

1. Exact Legal Name of Employer
   (Policyholder/Sponsor):_____
   Name of d/b/a (doing business as):_____
2. Street Address: _____
   City:_____State:_____ Zip Code:_____
3. Mailing Address:_____
   City:_____State:_____Zip Code:_____
4. County: _____Phone Number: (_____) _____Fax Number: (_____) _____
5. Is this group associated or affiliated with any other group? ☐Yes ☐No If so, is the other group insured by ASA. If yes, Name of Group:_____
6. Nature of Business:_____
7. How long has your company been in business? _____
8. Employer Management Contact Person: : _____Title_____
9. Employer Administrative Contact Person: _____ Title_____

Section B – Plan Information

1. Employees working at least 30 hours per week are eligible for coverage. **Census required**
   Total number of employees:_____ Total number seasonal or part time employees:_____
   Total number of employees on payroll eligible for coverage:_____
   Total number of employees enrolling:_____
2. Do you currently have any former employees who have elected coverage and are covered under COBRA or state continuation? ☐Yes ☐ No If yes, indicate names of individuals and their expiration dates:
   _____
3. Do you carry workers' compensation coverage? ☐Yes ☐ No If no, please explain why not:_____
4. Name of workers' compensation carrier:_____
5. Probationary period for new employees: ☐0 days ☐30 days ☐60 days ☐90 days☐ other_____
   - The first possible effective date for new employees will be the first of the month following the above identified probationary period, if any.
   - The employee termination date will be the first of the month following the date of termination.
6. Requested effective date (1st of the month)_____
   (Coverage is not effective until rates are accepted in writing)

Section C – Employees with Medicare coverage

Groups with 20 or more employees :

- Active employee MUST maintain standard group coverage, with Medicare as secondary payer.
- Retired employee can maintain standard group coverage with Medicare as primary payer.

Groups with less than 20 employees:

- Active employee MUST maintain standard group coverage with Medicare as primary payer.
- Retired employee can maintain standard coverage with Medicare as primary payer.

Section D – Benefits

1. The rate proposal sheet must be attached with approval signature
2. Benefit Plan chosen:

☐ $300 POS ☐ $500 POS ☐ $1000 POS ☐ $2500 POS ☐$2500 HSA ☐ $5000 HSA

Section E – Employer Agreement

You, the employer and policyholder/sponsor, understand the following is required:

☐ Fully completed Employer Group Application
☐ Employee Census
☐ Appropriate tax documentation
☐ Fully completed enrollment applications for all eligible persons requesting insurance coverage
☐ Fully completed health questionnaires for all eligible persons requesting insurance coverage
☐ Check to ASA for first month's premium
☐ Rate proposal sheet with signature

As an authorized representative of this Employer, I do hereby agree to the terms and conditions stated herein and in the policy forms. I further attest and certify that all the statements included herein are true and correct to the best of my knowledge.

Dated on: _____ By: _____
(mo/day/year) (Print Employer Name)

By:_____
(Authorized Signature)

Title:_____

Section F – Agent/Agency Information

You, the agent, certify that you have met with the Employer submitting this application and that you have fully explained its contents. You have discussed coverage, rates, eligibility, the effect of misrepresentations and termination provisions.

Date:_____ Agent's name_____

Agent's Signature_____

You, the agent, understand the following is required:

☐ All information documented on the ASA Underwriting Quote checklist pre-sale and ASA Underwriting Checklist post sale

Comments:_____
_____
_____
_____
_____

Section G – For use by ASA

Date Received_____ Effective Date:_____

Approved by: _____Date:_____