



Texas Agricultural Cooperative Trust

Group Application

The following form should be filled out completely and accurately. Please type or print neatly using black ink.

GROUP INFORMATION

Group Name: *(Note: Enter the legal of the group, including any punctuation and abbreviations.)*

Street Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____ Website Address: _____
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Type of entity: Proprietorship Partnership Corporation Association
 Government Non-Profit Other _____

Description of Business: _____ Standard Industry Code (SIC): _____ Years in Business: _____

Member of: Texas Cooperative Marketing Exchange (TCMX) Triangle Cooperative Service Company (TCSC)
 Texas Grain and Feed Association (TGFA) Texas Cotton Ginners' Association (TCGA)

(Note: Group must be a member of one of the above organizations in order to be eligible for coverage.)

Location of corporate/parent headquarters: Same as above Other _____

Are other divisions, subsidiaries or affiliates covered under this plan? No Yes

If yes, please list below:

Name	Location	Relationship
_____	_____	_____
_____	_____	_____

Primary Contact Person: _____ Title: _____

Telephone Number: _____ Fax Number: _____ Email Address: _____
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EMPLOYEE INFORMATION

Are there any employees located in other states or countries? No Yes
(If yes, list employees by state and country on census.)

Are any foreign nationals covered under this plan? No Yes
(If yes, list employees by state and country on census.)

Does this company participate in workers' compensation, PERA or PERS program? No Yes

Description of eligible employees: All full time employees Other _____

Are any employees excluded from eligibility? No Yes If yes, describe: _____

Note: Employees must work a minimum of 30 hours per week in order to be eligible for coverage. The waiting period for all employees is 30 days, with coverage to be effective the first of the month following completion of the waiting period.

Total number of full-time employees: _____
Total number of part-time employees: _____
Total number of eligible employees: _____
Total number of employees enrolling in this plan:
(Minimum participation is 75% of eligible employees.) _____
Total number of COBRA eligible members enrolling:
(Prior carrier COBRA election forms must be submitted.) _____
Total number of employees waiving coverage: _____
Total number of employees in the waiting period: _____

Employer Contributions: *(Note: Minimum employer contribution is 75% of the employee cost.)*

<i>Line of Coverage</i>			<i>Medical/Rx</i>	<i>Life/AD&D</i>
For employee coverage	<input type="checkbox"/> %	<input type="checkbox"/> \$	_____	_____
For dependent coverage	<input type="checkbox"/> %	<input type="checkbox"/> \$	_____	_____

COVERAGE HISTORY

Number of carriers in the past five (5) years: _____
Provide explanation if more than three (3) carriers:

Has the group ever been denied or cancelled by another group carrier? No Yes
If yes, please explain.



RISK INFORMATION

Number of...

- _____ Employees or dependents in this group who are pregnant (*Indicate date due below*)
- _____ Employees or dependents in this group who are disabled
- _____ Employees or dependents in this group who have been hospitalized during the past twenty-four (24) months
- _____ Employees or dependents in this group who are anticipating surgery
- _____ Employees or dependents in this group who incurred \$5,000 or more in claims during the past twenty-four (24) months
- _____ Employees or dependents in this group who have knowledge of or, during the past twenty-four (24) months, received treatment for disease, disorder or ailment of: blood, immune system, cancer, diabetes, heart, kidney, skeletal system, respiratory system, psychological, alcohol or drug abuse.

Provide details to questions above in the area below. For past claims, provide diagnosis, prognosis, course of treatment (if applicable) and the approximate claim amount for all individuals. Please use another sheet if necessary.

PLAN INFORMATION

Requested effective date of plan: ___ / ___ / ___ Requested anniversary date of plan: ___ / ___ / ___
 Initial open enrollment period: ___ / ___ / ___ to ___ / ___ / ___
 Standard open enrollment period: 31 days prior to anniversary date Other _____

Plan Selection(s):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Plan A (500-2085) | <input type="checkbox"/> Plan B (750-2585) | <input type="checkbox"/> Plan C (1000-3085) |
| | <input type="checkbox"/> Plan D (2000-3585) | <input type="checkbox"/> Plan E (5000-3515) | |
| <input type="checkbox"/> Rx | <input type="checkbox"/> Plan B (10-20-50) | <input type="checkbox"/> Plan C (15-25-60) | |
| | <input type="checkbox"/> Plan D (20-35-75) | <input type="checkbox"/> Plan E (150-90-75-50) | |
| <input type="checkbox"/> Life/AD&D | <input type="checkbox"/> Flat amount \$ _____ per employee | <input type="checkbox"/> Salary based _____ times annual salary | |
| <input type="checkbox"/> Dependent Life | <input type="checkbox"/> Low (\$5k-\$2.5k-\$1k) | <input type="checkbox"/> High (\$10k-\$5k-\$2.5k) | |

Does this plan replace other coverage? No Yes

If yes, list coverage(s) and carrier name(s): *Coverage(s)* *Carrier*



EMPLOYER DECLARATION AND REQUEST FOR PARTICIPATION

I, the undersigned, understand and agree to the following...

- 1) This application is for the health care coverage offered by Texas Agricultural Cooperative Trust (TACT). It will form a part of any agreement issued in reliance upon it.
- 2) Acceptance of this group for coverage and the final rates are based upon the information contained herein and the census of actual enrollees. Any material misrepresentation, whether intentional or unintentional, will permit TACT to terminate such coverage and to pursue all other legal remedies available.
- 3) By signing this application, I hereby adopt the Trust Agreement of TACT (the Trust) and I hereby agree to be bound by all the terms, provisions, conditions and limitations of the Trust, including any amendments thereto. A copy of the Trust Agreement will be provided to me upon written request. Further, I hereby accept the Contract Administrator as designated by the Trust.
- 4) Any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received.
- 5) Only those employees who meet the eligibility requirements (including the Statement of Health, if required) are to be included. It is my responsibility to offer coverage to all eligible employees and their eligible family members. I will provide to TACT an enrollment form or a waiver of coverage form signed by each employee within 30 days of his/her hire date and collect any employee contribution(s) toward any payment/premium due. My group must maintain minimum participation and contribution levels for the coverage to continue under this agreement.
- 6) Contributions will include costs of benefits, administration and expenses of the Trust and any additional assessment determined by the Trustees as necessary to maintain the financial integrity of the Trust or its benefit plan(s), as provided in the Trust agreement.
- 7) A one-month deposit is being submitted with this application, to be held without obligation, until this application is approved. If the application is approved, the deposit will be applied to the first month's premium/fees under this agreement. If coverage does not become effective, the deposit will be refunded.
- 8) The obligation to participate in the Trust is on a plan year basis. If I withdraw from participating in the Trust or if my participation is terminated for failure to pay the required contribution for participation, the Trust will have no further obligation or liability to me or my covered participants for plan benefits or any claim on the Trust funds as of the date of withdrawal or termination. If claims have been incurred by my covered participants prior to that date, I will be solely liable for those claims and the Trust will have no liability for such claims, either to me, my covered participants or any third party claimant.
- 9) My representative has explained the coverages, limitations, exclusions and other details of the coverage for which I applied.

Name:

Title:

Company:

Signature:

Date:

____ / ____ / ____