

BANKERS INSURANCE COMPANY

P. O. Box 15707., ST. PETERSBURG, FLORIDA 33733

TELEPHONE: (866) 987-9844 FAX: (727) 803-2094

WEBSITE: www.BankersHealthPlans.com



Bankers
Health
Plans

A subsidiary of Bankers Financial Corporation

Application Submission Checklist

Agents Name: _____ Phone Number: _____

Agent's Email Address: _____ Fax: _____

Applicant Name: _____ Effective Date: _____

County: _____ PEO Client: Yes / No If yes-Client Name: _____
(If YES, use PEO section below)

*** Please include the proposal with your submission***

LIMITED BENEFIT HEALTH

- Application for Coverage
- Replacement and Disclosure Form
- 1st Month Premium Check or Credit Card Auth
- Authorization for Payment by Credit Card or Bank Withdrawal (if applicable)
- Application for Network Access Card (Optional)

ERISA STOP LOSS APPLICATION

Note: The ERISA Stop Loss application is a two-step process. You will be contacted by underwriting for additional information, as needed.

- Request for Proposal
- Census
- Current and Renewal Rates
- Schedule of Current Plan Benefits

INDIVIDUAL MAJOR MEDICAL

- Application for Coverage
- 1st Month Premium Check or Credit Card Auth
- Authorization for Payment by Credit Card or Bank Withdrawal (if applicable)

PEO Clients

Note: Do not send in the Payroll Deduction form to Bankers Employer Services. Bankers Health Plans will forward once application for coverage has been approved.

- Application for Coverage
- Replacement and Disclosure Form
- Application for Network Access Card (Optional)
- Employee Authorization for Health Plan Payroll Deduction
- Pre or Post Tax Deductions? (If Pretax, Client must have Section 125 or elect BES Section 125)

Quotes for Individual Major Medical, and Limited Benefit Health Plans - log on to www.BankersHealthPlans.com and sign on with your name. Your Bankers Health Plans agent number is your password.

If you are not a Bankers appointed agent or need your agent number, please call us, 866-987-9844 prompt #1 to obtain your password.

Submit Applications to Bankers Health Plans - Attn: Underwriting by Fax (727) 803-2094, send original documents and check to Bankers Health Plans - Attn: Underwriting, P. O. Box 15707, St. Petersburg, FL 33733.

Confirmation of application receipt will be sent via email within one business day. Underwriting decisions will be sent within five business days after *all* requirements are received.

Questions on our plans, please contact Bankers Health Plans, 866-987-9844
*Vice-President of Health Plan Sales – David Harting (x4224) or
Underwriting Manager – Pete Collins (x4157)*

Bankers Insurance Company

Home Office: 11101 Roosevelt Boulevard N.
St. Petersburg, FL 33716

Group Limited Benefit Health Indemnity Insurance Employer Application and Participation Agreement

A. Employer

Name and Street Mailing Address _____

Tax ID# _____

Street _____

Contact Name _____

City _____ State _____ Zip _____

Address _____

Industry _____

Telephone _____

Fax Number _____

Email Address _____

B. Eligibility Information

- Total Number of Eligible Employees at ALL locations (including those not insured under this plan): _____
- Requested Effective Date: _____
- Employer Contribution: _____
- Waiting Period for Salaried Employees: None 30 60 90days of continuous employment]
- Waiting Period for Hourly Employees: None 30 60 90 days of continuous employment
- Participation Requirements: The employer must employ a minimum of 51 employees, _____% of which must participate in the Plan, but no fewer than _____ must be enrolled for this coverage to be issued and kept in force.
- Please indicate the number of hours per week an employee must work to be eligible for coverage: _____
- Coverage is to be provided for: Employees Only Employees and Dependents

C. Group Health Insurance Coverage

		Benefits	
		In-Hospital Indemnity Benefit	<input type="checkbox"/> \$300 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 per day
		Surgery & Anesthesia Benefit	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 per surgery
		Outpatient Physician Office Visit Benefit (6 visits)	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100per visit
		Outpatient Diagnostic X-ray and Laboratory Benefit (3 tests)	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 per day
		Off-the-Job Accidental Injury Benefit (5 occurrences) (includes \$150 ambulance benefit) (3 occurrences)	<input type="checkbox"/> \$300 <input type="checkbox"/> \$500 per accidental injury
		Outpatient Prescription Drug Benefit	<input type="checkbox"/> \$10 <input type="checkbox"/> \$20 per prescription <input type="checkbox"/> 1 Prescription per month <input type="checkbox"/> 12 Prescriptions per year
Yes	No	Optional Additional Benefits	
		Critical Illness Benefit	<input type="checkbox"/> \$2,500
		Subsequent Critical Illness	<input type="checkbox"/> \$2,500
		In Hospital & Surgical Additional Indemnity Benefit Number of Confinements per year	<input type="checkbox"/> \$1,000 per confinement <input type="checkbox"/> 2 confinements
		Wellness Benefit Waiting Period	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50 <input type="checkbox"/> \$75 <input type="checkbox"/> \$100 per year <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months
		Daily Intensive Care In-Hospital (30 days per confinement)	<input type="checkbox"/> \$600 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 per day

The Employer agrees to: (1) maintain the records necessary to the administration of the Coverage; (2) to report additions, changes, terminations and other information necessary to the administration of the Coverage to the Insurer within 30 days after the Effective Date of such additions, changes or terminations; (3) that if the Employer does not notify the Insurer of any insured ineligibility or termination within 30 days, the [Employer] shall forfeit any premium refund or credit that would otherwise have been due; (4) to make all such records, including payroll records, tax returns, and personnel files and other documentation as determined by the Insurer available upon request to the Insurer or its authorized administrator; (5) to pay all premiums in accordance with the terms of this Policy; (6) for purposes of the Employee Retirement Security Act (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Employer is deemed the Plan Administrator; and (7) to notify all Employees, Contract Staff and retirees of any termination or rescission of coverage which affects them and refund any appropriate premium.

By signature below of its duly authorized representative, the proposed Employer hereby applies for the Bankers Insurance Company Group Limited Benefit Health Indemnity Insurance Policy; and the proposed Employer understands and agrees that it shall be subject to the provisions set forth herein.

The Employer also agrees no liability is created for, or assumed by the Insurer until this application and participation agreement has been approved in writing; acceptance of the check submitted with the application does not constitute approval or guarantee coverage; and if for any reason this application is not so approved in writing, the sole obligation of the Insurer will be, and the Employer shall be entitled to a refund of any premiums paid.

In the event of any misappropriation by the Employer, its employees or agents, of funds owed to the Insurer, the Employer shall reimburse the Insurer for the Insurer's entire loss including attorney fees and expenses incurred in collection, and any benefits the Insurer would not have had to pay but for such misappropriations.

It is understood that all of the answers of the Employer has provided herein are representations and not warranties.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Dated at _____ this _____ day of _____

Agent _____

Employer [Plan Sponsor] Name: _____

Signed By: _____

Title: _____

Date: _____

Agent's Statement

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge; (b) I have complied fully with any required underwriting rules; (c) I have explained the proposed insurance Policy in detail; and (d) to the best of my knowledge the proposed Employer [Plan Sponsor] is financially sound.

I further certify that all agents involved in presentation of this Policy: (a) are licensed as required by applicable state law and appointed by Bankers Insurance Company.

Servicing Agent:

Name _____

Tax ID No. _____

Agency Name: _____

Telephone No. _____

Address: _____

Fax No. _____

Florida Agent License No _____

Email Address _____

City _____ State _____ Zip _____

Florida Agent Signature _____

Please complete, sign and date this document. Return this document to the Insurer indicated on prior page.
Make a photocopy for your records.

Bankers Insurance Company

Home Office: 11101 N. Roosevelt Boulevard
St. Petersburg, FL 33716

Group Limited Benefit Health Indemnity Insurance Employee Application

First Application Add Dependents-Certificate# _____ Increase Coverage-Certificate # _____
Group Name: _____ Group Number: _____ Location: _____

Employee (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of Birth	Date of Marriage
Spouse (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of Birth	Date of Marriage
Date of Hire	Avg hours worked per week	Annual Salary	Occupation		Employee ID
Home Address				Work Phone/ext	
City		State	Zip Code	Home phone	
Child(ren) name		Date of birth	Gender	Full Time Student	
_____		_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____		_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____		_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
_____		_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Beneficiary*: (Last, First, M.I.)				Relationship:	
Contingent Beneficiary: (Last, First, M.I.)				Relationship:	
*Employee will be the beneficiary for any spouse and/or child(ren) coverage					

Payroll Mode: Weekly Bi-Weekly Semi-Monthly Monthly Other _____.

I Am Employee Employee Plus Spouse Employee Plus Children Employee Plus Family

<input type="checkbox"/> Yes, I want to following Plan offered by the Employer ___ Plan 1 ___ Plan 2 ___ Plan 3	Premium per pay period* \$ _____
--	-------------------------------------

*If increasing coverage, enter the **TOTAL** Monthly Benefit, Coverage Amount, and Premium. Total Premium \$ _____.

APPLICANT'S STATEMENTS AND AGREEMENTS:

Is the insurance being applied for intended to replace any existing health, accident and sickness, or disability insurance coverage? Yes No If "Yes," list name of company _____, Policy/certificate # _____, complete the replacement form(s) provided by your agent and return with this application.

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein, which materially affect the acceptance of the risk or the hazard assumed, may result in loss coverage under the policy/certificate to which this application is attached. **I understand that any person who knowingly and with intent to injure, defraud , or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all the questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled (unless included by special endorsement), on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administrative office. **Lastly, I understand** that completion of this application in no way implies that I will be accepted for insurance coverage.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution, or person, that has any records knowledge of me or my health, to give to Banker's Life Insurance Company, or its reinsurers, any such information.

I understand the information obtained by use of this Authorization will be used by Bankers Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Bankers Insurance Company to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I authorize. **I know** that I may request to receive a copy of this Authorization. **I agree** that a photographic copy of the Authorization shall be as valid as the original. **I agree** that this Authorization shall be valid for two years from the date shown below.

Signed in (City/State) _____ this _____ day of (Month/Year) _____.
Employees Signature _____ Spouse's Signature (if applicable) _____.

AGENT'S STATEMENTS AND AGREEMENTS

I hereby certify that I have accurately recorded in this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application. **I also certify** that this insurance [does does not] replace any existing health, accident and sickness, or disability insurance coverage.

FL. Licensed Agent's Name _____ FL. Licensed Agent's Signature _____ Agent # _____.

BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD. ST. PETERSBURG, FLORIDA 33716

Telephone (866) 987-9844 Fax: (727) 803-2094

Replacement and Disclosure Form – Group Limited Benefit Medical Plan



Bankers
Health
Plans

A subsidiary of Bankers Financial Corporation

This is an Indemnity Plan that pays benefits based on a set dollar amount. This plan is not a major medical plan, and therefore the benefits are limited.

Please review all materials you have been provided in making your decision to purchase this plan.

If you are replacing your existing medical insurance, this insurance plan does not provide protection under HIPAA for portability of coverage or credit for prior coverage. This may affect coverage for any pre-existing conditions you may have.

It has been explained to me, and I understand that this is a Group Limited Benefit Medical plan and is not comprehensive major medical coverage. I understand the terms of coverage, benefits, and exclusions of the Group Limited Benefit Medical Plan. I also understand that if I purchase a health plan that excludes or reduces coverage for certain services, treatment or conditions, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes.

Signature of Applicant

Name of Applicant

Address

City

State

Zip Code

Date

Note: This form must be retained by the carrier issuing the policy and a copy given to the applicant upon application.

BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD N., ST. PETERSBURG, FLORIDA 33716

Authorization for Payment by Credit Card
or Automatic Bank Withdrawal



A subsidiary of Bankers Financial Corporation

Applicant's Full Name				
Street Address		City	State	Zip Code
Coverage Period: _____ Months		Payment Method: <input type="checkbox"/> Credit <input type="checkbox"/> Automatic Bank Withdrawal		
Monthly Premium \$ _____ +	Credit Card Transaction Fee \$ _____ <small>* (Add 2% for payments by CC) (Auth must be received by the 20th of the month)</small>	Total Monthly Withdrawal \$ _____		

<p>CREDIT CARD PAYMENT REQUEST: I authorize Bankers Insurance Company to bill my:</p> <p><input type="checkbox"/> Visa <input type="checkbox"/> MC account(s) for <u>12</u> months of monthly premiums/fees.</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"><p><small>* A 2% transaction fee applies when payment is made by Credit Card. Information must be received by the 20th of the month to set up credit card payment for the first of the next month.</small></p></div> <p>Name on Card: _____</p> <p>List Digits of account: _____</p> <p>_____</p> <p>Expiration Date: _____</p> <p>Signature of Cardholder _____ Date _____</p>	<p>AUTOMATIC BANK WITHDRAWAL REQUEST: By selecting automatic bank withdrawal, your monthly premium will automatically be withdrawn from your account. Complete the form below and include a voided check, with the Application Form and the initial premium.</p> <p>Name of bank: _____</p> <p>Address of bank/branch: _____</p> <p>Bank routing number: _____ Account number: _____</p> <p>Account type: <input type="checkbox"/> Checking (please attach a voided check) <input type="checkbox"/> Savings</p> <p>Name of bank depositor/account holder: _____</p> <p>I request that you pay and charge my account debits drawn from the account by Bankers Insurance Company to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advance written notice to me and to Bankers Insurance Company. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.</p> <p>Signature of Premium Payer: _____</p> <p>Date: _____</p>
---	--