REQUEST FOR PARTICIPATION

INSTRUMENT OF ADOPTION AND REQUEST FOR PARTICPATION IN THE EMPLOYERS GROUP TRUST

THE UNDERSIGNED Employer (hereafter "the Employer") hereby requests that it be approved as a Participating Employer under the above referenced Trust and accepts and agrees to be bound by all the terms and conditions of the restated and amended Trust Agreement dated December 1, 2008 and as amended thereafter.

The Employer hereby agrees to the appointments of First County Bank, a Connecticut chartered banking corporation with offices at 100 Prospect Street, North Tower, 3rd Floor, Stamford, CT. 06901, as Trustee and National Employee Benefit Companies, Inc. of 16 International Way, Warwick, RI 02886 as the Administrator. The Administrator will be paid a billing administration fee by the Employer. Such fee is presently eighteen ($18) dollars per month and may change in the future at the discretion of the Administrator with prior written notice to the Employer.

The Employer requests that insurance be made available to all of its eligible employees pursuant to the Group Insurance Policy or Policies issued to the Trust and in accordance with the Group Insurance application which is attached hereto. The Employer agrees to be bound by all the terms and conditions of such Group Insurance Policy or Policies issued by The Lincoln National Life Insurance Company of Omaha, Nebraska. It is understood that, if the request for insurance coverage is approved, any insurance or amount or duration of insurance for which evidence of insurability is required will become effective only after approval by The Lincoln National Life Insurance Company and, further, that in no event will any employee be insured who has not completed and signed an enrollment card or other required documentation.

The Employer represents that it has offered the opportunity to enroll to all of its eligible employees and agrees to promptly make this opportunity available to newly eligible employees. The Employer agrees to remit the required premiums as they become due to The Lincoln National Life Insurance Company. Enclosed is a check for the initial required amount together with (1) completed individual application for eligible employees who have enrolled and (2) the required initial evidence of insurability.

The Employer hereby acknowledges that neither the Administrator nor the Trustee shall be liable for the payment of claims under the plan, nor shall they be held liable for any obligations of the Employer to pay the required premiums or to provide any benefits under the plan. The Employer further acknowledges that National Employee Benefit Companies, Inc. and/or its affiliate receives compensation, ranging from 5 – 20% of premiums depending on the applicable Group Policy or Policies, from The Lincoln National Life Insurance Company for certain administrative services which it performs regarding the Group Insurance Policy or Policies. Furthermore, the agent (including National Employee Benefit Companies, Inc.) which sells the Group Policy or Policies, or its affiliate, will receive a sales commission from The Lincoln National Life Insurance Company ranging from 10 - 15% of premiums depending on the applicable Group Policy or Policies. The undersigned Employer further agrees that is shall serve as the Plan Sponsor and named fiduciary of this benefit plan.

EMPLOYER CERTIFICATION

I certify that this business was organized on ____ Month Day Year

I certify, as the employer, that to the best of my knowledge and belief all forgoing statements and answers are true.

Date at ______________________________ , this ________ day of, __________, 20______.

Legal Name of Applicant: ____

Name of Officer, Partner or Proprietor (*PRINT*) ____

Signature of Officer, Partner or Proprietor ____

Witness ____

Administrator National Employee Benefit Companies, Inc. ____________________________________.
(*Signature*)

Employers Group Trust

CASE COMPLETION FORM FOR: ____
(Plan Participant/Applicant)

GROUP CONTACT PERSON: ____

To help ensure that your case is set up properly, the following are *standard provisions* within the EGT program:

All full-time employees working a minimum of 30 hours per week on a regular basis are eligible.

PLEASE COMPLETE AND MAKE YOUR SELECTIONS

Total Number of Full time Employees: __________

Eligibility: Employees employed on or prior to the Effective Date: Waiting Period applies: ☐ Yes ☐ No

Employees employed after the Effective Date are to become eligible on the 1st day of the month coincident with or next following (check one):

☐ One Month's Service ☐ Two Month's Service ☐ Three Month's Service ☐ Date of full-time hire ☐ Other______________

Eligible employees who are disabled on the date their insurance would otherwise become effective shall become insured on date they return to active work.

Employer's contribution: Life/AD&D: ____________% *(Employer must pay 25% min.)* STD: ______________% *(Employer must pay 25% min.)* LTD: ________________% *(Employer must pay 50% min.)*

Are more than 50% of the employees to be insured members of the same immediate family? ☐ Yes ☐ No

GROUP INSURANCE COVERAGE REQUESTED

☐ LIFE & AD&D ☐ Flat Amounts Available: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

If Flat Amount by class, indicate class descriptions and amount: _______________________________________

☐ Multiple of Salary: All Full Time Employees

☐ 1x ☐ 2x to a maximum of $ _________________

☐ Multiple of Salary by Class:

Class Description: _________________Multiple ☐ 1x ☐ 2x to a maximum of $_______________

Class Description: _________________Multiple ☐ 1x ☐ 2x to a maximum of $_______________

☐ DEPENDENT LIFE

☐ SHORT TERM DISABILITY (non-occupational) ☐ Plan I (1-8-13) ☐ Plan II (1-8-26)

Maximum of $_______________

☐ LONG TERM DISABILITY Elimination Period: ☐ 90 Days ☐ 180 Days

Maximum of: ☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $7,500

Are all employees covered under Worker's Compensation? ☐ Yes ☐ No*

*If no, contact EGT Administrator

COMMENTS/REMARKS: ____

____

Note: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping defraud) an insurance company.

The Lincoln National Life Insurance Company

Office Use Only ID#

Group Insurance Service Office
8801 Indian Hills Drive
Omaha, Nebraska 68114-4066

APPLICATION FOR GROUP INSURANCE

is hereby made to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company).

A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy):______________________

____

2. **Main Office Address** (physical location and group situs state):

Street______________________ City______________________ State__________

Zip__________ Phone # __________ FAX # __________ E-Mail Address (if available)__________

B. REQUESTED COVERAGES

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each coverage.

- ☐ Life & AD&D with Effective Date __________
- ☐ Long Term Disability with Effective Date __________
- ☐ Short Term Disability with Effective Date __________
- ☐ Dental with Effective Date __________
- ☐ Voluntary Life with Effective Date __________
- ☐ Voluntary Life & AD&D with Effective Date __________
- ☐ Voluntary Long Term Disability with Effective Date__________
- ☐ Voluntary Dental with Effective Date__________

C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify):______________________

Years in Business__________ Federal Tax ID#__________

2. **Business is Organized As** (select one):

☐ Corporation ☐ Non-Profit Organization
☐ Partnership ☐ Proprietorship ☐ Other__________

3. **Financial Risk** (If Yes to any part, please explain below.)

☐ Yes ☐ No Has Applicant ever filed for bankruptcy?
☐ Yes ☐ No Does Applicant anticipate ceasing or materially reducing active business operations?
☐ Yes ☐ No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?

Explanation:______________________

4. **Binder** payment submitted: Amount $__________(if applicable)

D. REPLACEMENT COVERAGE

☐ Yes ☐ No Will all or part of this coverage **replace** any similar coverage? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.**

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date

E. FRAUD WARNING

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

NOTICE: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.

F. AGREEMENT. The Applicant hereby applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

(a) be issued only if the requested insurance is acceptable to the Company and is legally permissible;
(b) be issued under a group Policy or Policies in the language customarily used by the Company;
(c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
(d) be subject to all exclusions and limitations of the Policy; and
(e) take effect on the date determined by the Company.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to the Active Work requirement. The Applicant agrees not to:

(a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
(b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law. Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms. If this Application is approved, it will be made a part of any Policy issued.

Writing Agent
Or Broker's Signature______________________________

Typed or Printed Name______________________________

License Number____________________ State________

Signed by Applicant's Authorized Representative:

Signature____________________________________

Typed or Printed Name______________________________

Title____

State Signed________________Date________________

Must be signed prior to Effective Date