

Employers
Vision
Trust

APPLICATION FOR PARTICIPATION AND AGREEMENT

1. Name of Firm _____
Street Address _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
Phone () _____ Fax () _____ Email Address _____
Contact Person _____ Title _____

2. Nature of Business _____ Employer Federal Tax ID # _____

3. Subsidiary or Affiliated Companies (Companies under common control through stock ownership, contract, or otherwise) whose employees are to be covered:

Name	Address	Nature of Business
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4. **Eligible Employees:** All full-time employees (who work at least 30 hours per week). Total # of eligible employees _____

5. Total # of enrolled employees _____

6. **Eligible Dependents:** All covered employee's spouses and unmarried dependent children who have not attained their 19th birthday, (also includes an unmarried child if incapable of self-support because of physical or mental incapacity that commenced prior to reaching the above age), or their 25th birthday if attending school full-time.

7. **Waiting Period for Eligible Employees:** Employees employed on or prior to the effective date will have no waiting period. Employees employed after the Group effective date become eligible on the 1st day of the month coincident with or next following: One month Two months Three months Date of full-time hire Other _____

8. **Plan Participation:** The employer agrees to follow participation requirements as stated in the sales guide.

9. **Employer Contributions:** for Employees _____ % for Dependent Units _____ %

10. **Plan (must select one):** Plan A (24/24/24) Plan B (12/12/24) Plan C (12/12/12)

11. **Rate Structure:** Two Tier Three Tier

12. **Effective Date:** _____ (All coverage subject to home office approval)

The undersigned Employer acknowledges that neither the Administrator nor the trustee shall be ultimately liable for the payment of claims under the Plan, nor shall they be considered the insurer or underwriter of any liability of the undersigned Employer to make any contributions or provide any benefits under the Plan.

The undersigned Employer further acknowledges that for purposes of the Employee Retirement Income Security Act of 1974, the Employer and not The Managing Agency Group, Inc., is the Plan Administrator and Named Fiduciary of this employee welfare benefit plan.

The undersigned Employer requests that it be approved as a participant under the Employers Vision Trust and agrees to be bound by all the terms and conditions.

The undersigned Employer agrees to the appointment of First County Bank, a Connecticut Chartered Bank Corporation with offices at 117 Prospect Street, Stamford, CT 06901, as Trustee and to The Managing Agency Group, Inc. of Shelton, CT as the Administrator.

The Administrator will be paid an administrative fee by the Employers for the administrative services it renders to the Plan. Such fee is presently \$18 to \$23 per month and may change in the future at the discretion of the Administrator with prior written notice to the Employer.

Employer Signature X _____ Title _____ Date _____

Agent Certification

I certify, as primary Agent, that to the best of my knowledge and belief all of the foregoing statements and answers are true. I also certify that I have no knowledge or information regarding the applicant which is not fully set forth herein.

Name of Producing Agent (print) X _____ Signature of Producing Agent Date _____

Commissions Payable To: _____