Print Form

WMC INSURANCE

WMC Employee Benefit Plan

Employer Request For Participation

The undersigned hereby requests participation in the Wisconsin Manufacturers & Commerce master policy(ies) which are underwritten and fully insured by The Hartford.

Employer Information

Full Legal Name of Employer _____

Primary Street Address _____
Street City State Zip Code

Billing Address _____
(if different than above) PO Box / Street City State Zip Code

Executive Contact _____ Phone (____)_____
Name Title

Billing Contact _____ Phone (____) _____ Fax (_____) _____
Name

Federal ID# (EIN) _____ SIC Code _____ Nature of Business _____

Form of Organization (Check the appropriate box)

☐ Corporation
☐ S Corporation
☐ Partnership
☐ Sole Proprietorship
☐ Association
☐ Other *(describe)* _____

Affiliated/Subsidiary Companies

List any affiliates or subsidiaries to be insured *(include name, location, nature of business & EIN):*

1. _____

2. _____

Requested Effective Date_____ **-** Please do not cancel your existing coverage until notified of approval

Employee Schedule of Benefits (please provide a class description if benefit plans vary by class of employee)

Please Provide Detailed Description of Eligible Class	BENEFIT ELIGIBILITY	
	Waiting Period *	# of Work Hours/Week (Min.: 20+ Life, 30+ STD/LTD)
1.		
2.		
3.		
4.		

* New employees are eligible for coverage as of the first day of the month coinciding with or following the Waiting Period.

Exclusions

Will any subsidiaries or classes of employees be excluded? ☐ No ☐ Yes (If yes, please define classes to be excluded)

_____

Benefit Specifications – Application for sold benefits must be supported by a Hartford proposal. Changes to proposed benefits are subject to carrier/policyholder approval. Approved rates will be based on final census and plan design.

Basic Life / AD&D Plan Specifications			
Class #	Flat Benefit Amount	Salary Multiple & Maximum Benefit Amount	
		Salary Multiple	Benefit Max. $
		Salary Multiple	Benefit Max. $
		Salary Multiple	Benefit Max. $
		Salary Multiple	Benefit Max. $

Life Reduction

☐ 35% @ ages 65, 60% @ 70 & 75% @ ages 75 *(std.)* ☐ Other _____

Basic Dependent Life ***(optional coverage)***

Eligible Class(es): _____ Spouse/Child(ren): ☐ $10,000/$5,000 ☐ $5,000/$2,000 ☐ Other _____

Supplemental Employee Life ***(optional coverage available with the purchase of basic life)***

Eligible Class(es): _____ ☐ Flat $ Increments of: $ _____ **or** ☐ Times Salary to a Max. Benefit: $ _____

Eligible Class(es): _____ ☐ Flat $ Increments of: $ _____ **or** ☐ Times Salary to a Max. Benefit: $ _____

Supplemental Dependent Life ***(optional coverage available with the purchase of supplemental employee life)***

Eligible Class(es): _____ Spouse: ☐ Flat $ Increments of: $ _____ to a Max. Benefit: $ _____

Child: ☐ Flat $ Increments of: $ _____ to a Max. Benefit: $ _____

Short Term Disability (Weekly Income)				
Class #	Accident Benefits	Sickness Benefits	Maximum Benefit Duration	Weekly Benefit Plan Design
	☐ 1st Day	8th Day	☐ 13 Weeks	Flat Dollar $_____
	☐ 8th Day	8th Day	☐ 26 Weeks	**Or**
	☐ _____	_____	☐ _____	% of Salary _____ % Max. Benefit $_____/Week
	☐ 1st Day	8th Day	☐ 13 Weeks	Flat Dollar $_____
	☐ 8th Day	8th Day	☐ 26 Weeks	**Or**
	☐ _____	_____	☐ _____	% of Salary _____ % Max. Benefit $_____/Week

Long Term Disability (LTD)					
Class #	Benefit %	Elimination Period	Definition of Disability	Monthly Max.	COLA
	☐ 50% ☐ 60% ☐ Other _____	☐ 90 Days ☐ 180 Days	☐ 2 Year Own Occupation *(std.)* ☐ Other _____	☐ $5,000 *(std.)* ☐ $ _____	☐ Yes ☐ No
	☐ 50% ☐ 60% ☐ Other _____	☐ 90 Days ☐ 180 Days	☐ 2 Year Own Occupation *(std.)* ☐ Other _____	☐ $5,000 (*std.)* ☐ $ _____	☐ Yes ☐ No
	☐ 50% ☐ 60% ☐ Other _____	☐ 90 Days ☐ 180 Days	☐ 2 Year Own Occupation *(std.)* ☐ Other _____	☐ $5,000 *(std.)* ☐ $ _____	☐ Yes ☐ No

Premium Contributions & Employee Participation						
	Life / AD&D	Dep. Life	Supp. Emp'e Life	Supp. Dep. Life	STD	LTD
Employer Prem. %						
# of Eligible Emp's						
# of Enrolled Emp's						

Replacement Coverage - Enter the name, cancellation date and submit a copy of prior carrier's booklet with this application.		
Coverage	**Name of Carrier**	**Cancellation Date**
Life		
STD		
LTD		

Actively at Work Information

Do you have any eligible employees who are not currently "Actively At Work" due to injury or sickness?

☐ No ☐ Yes If yes, please provide a list of the employee(s) with their name, explanation of condition(s), last date worked and estimated return to work date. Coverage is subject to an active work rule, unless otherwise approved.

W-2 Services (for Short and/or Long Term Disability coverage only)

The Hartford, based on their interpretation of WI statues, will issue federal Form W-2 to report sick-pay to STD and/ or LTD claimants, where applicable.

Additional Comments

_____

_____

_____

Agent Information	**Agent Compensation**
Application Taken At (City & State)	☐ Standard Hartford Commission Schedule ☐ Waiver of Commissions Pursuant to Client Agreement ☐ Non-Std. Comm. _____ Pursuant to Client Agreement

Commissions Payable To: Agency/Agent Name & Mailing Address

Agent & Agency Name			
Street	City	State	ZIP Code
Telephone Number	E-mail Address	If multiple agents, % split	Federal ID # or S.S. #

For Second Agent or Sub-Agent:

Agent & Agency Name			
Street	City	State	ZIP Code
Telephone Number	E-mail Address	If multiple agents, % split	Federal ID # or S.S. #

The undersigned agree that plan provisions were fully explained to the Employer requesting participation in this group plan. Coverage, eligibility, pre-existing condition limitations and exclusions, the effect of misrepresentations and termination provisions were discussed and explanatory materials were presented to the Employer.

Dated on:_____ Name of Agent _____
(Month, Day, Year) (Please Print)

Signature of Agent _____

Dated on:_____ Name of Agent_____
(Month, Day, Year) (Please Print)

Signature of Agent_____

Certification

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this request BEFORE action is taken on this request. **Insurance coverage is not in effect until I receive notification from Wisconsin Manufacturers & Commerce (WMC)**. If this request is declined, WMC will return the premium deposit submitted with the request. If coverage is approved, the advanced premium deposit is applied to the first month's premium.

I understand the insurance coverage may be terminated by the participating employer (or me) at any time, provided The Hartford or WMC receives written notice of termination by the requested termination date. Otherwise I understand and agree that failure to pay premium when due will be considered a default of premium payment, and WMC may terminate coverage following the grace period (time extension for payment of premium) of 31 days from the date of non-payment of premium. The termination will be effective at midnight on the third business day after written notice has been provided to the Employer. If the coverage is terminated by WMC for non-payment of premium, WMC at the request of The Hartford, reserves the right to collect premium for the grace period.

I represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand that the said answers and statements form the basis upon which insurance will be made effective.

I understand that omissions or misrepresentations could result in voiding or reformation of insurance.

In that WMC is the policyholder with administrative services provided by WMC Service Corporation:

I agree that the group insurance coverage shall be subject to the terms of the group master insurance policy or policies and the Administrative Agreement issued to WMC by The Hartford.

I acknowledge that WMC Service Corporation may receive a fee from The Hartford in connection with the performance of various administrative and other services related to the group insurance program, and that said fee is based on a percentage of premium paid to The Hartford under the group policy. If any part of the program is subject to retrospective experience rating, The Hartford and/or WMC does not guarantee future dividends and such dividends, if any, will be paid solely at the discretion of The Hartford following the end of the plan year, when administratively feasible.

Full Legal Name of Employer/Firm _____

Dated on: _____ By: _____
(Month, Day, Year) (Signature)

Dated at: _____ _____
(City and State) (Title)

A copy of this request will be furnished to you for your records.

To Be Completed By Wisconsin Manufacturers & Commerce

WMC, as the Policyholder and Plan Sponsor, requires Participating Employers to be a WMC member in good standing. The WMC Service Corporation hereby certifies that the Employer named in the application is a current WMC member, is eligible to participate in the Plan and the request for participation is hereby approved.

Member #: _____ By: _____

Date: _____ Title: _____

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