Employers Dental Trust©

MetLife

Employer Participation Agreement

To: U.S. Bank National Association, as Trustees of the MetLife Pennsylvania Multiple Employer Trust

We, the employer named below, wish to participate in and obtain group insurance from Metropolitan Life Insurance Company ("MetLife") providing benefits under and subject to the provisions of the group policy issued by MetLife to the U.S. Bank National Association, as Trustees of the MetLife Pennsylvania Multiple Employer Trust that provides the group insurance coverage selected below:

COVERAGE

Dental Insurance: ☐ Employees Only ☐ Employees and Dependents

We request that the group insurance indicated above become effective _____.
Mo. Day Year

We hereby agree to be bound by the terms, conditions and provisions of the group insurance arrangement, including the policy, certain provisions of which are summarized at the end of this Agreement. We understand that the insurance will not become effective until this Employer Participation Agreement is accepted by or on behalf of the U.S. Bank National Association, as Trustees of the MetLife Pennsylvania Multiple Employer Trust by MetLife for the insurance involved. No insurance for any person proposed for coverage will become effective until that person has applied for such insurance and such person's enrollment form has been approved by MetLife, if MetLife's approval of such person is required. If our coverage becomes effective, we shall be deemed a Participating Employer under the policy issued to the U.S. Bank National Association, as Trustees of the MetLife Pennsylvania Multiple Employer Trust.

We further understand that, if the group insurance indicated above will replace existing coverage, the basis for the premium rate quoted by MetLife was the reliance placed by MetLife on the accuracy and completeness of the documentation substantiating the scope and level of the coverage previously in force and the rate we were previously paying. We agree that if, subsequent to the date the insurance indicated above becomes effective, such documentation shall be found to have been inaccurate or incomplete, MetLife may, retroactively to the effective date of coverage, adjust the rate for such insurance to the rate that would have been applicable if MetLife had known the true state of facts. Finally, we understand that the policy is subject to termination by the U.S. Bank National Association, as Trustees of the MetLife Pennsylvania Multiple Employer Trust.

_____
Date

_____
Name of Employer

_____
Signature & Title

SUMMARY OF CERTAIN TERMS, CONDITIONS AND PROVISIONS OF THE POLICY REFERRED TO ABOVE:

1. **Definition of Participating Employer:** The term "Participating Employer" means an employer that has executed an Employer Participation Agreement to insure its employees through the policy that is issued to the U.S. Bank National Association, as Trustees of the MetLife Pennsylvania Multiple Employer Trust.

2. **Definition of Employee:** The term "Employee" means a person who is directly employed and compensated for services by a Participating Employer and who is in a class designated as eligible for insurance by that Participating Employer. No person may be considered an Employee of more than one Participating Employer, nor may any class of Employees be designated as eligible for insurance without the consent of MetLife.

3. **MetLife's Responsibility:** In return for a Participating Employer's payment of premiums when they fall due, MetLife will provide the insurance and pay the benefits described in the group insurance certificate furnished to that Participating Employer for delivery to the Participating Employer's covered Employees.

4. **Premium Due Dates:** Premiums are due and payable by each Participating Employer on the first day of each month for which insurance coverage for that Participating Employer is to be provided. The Participating Employer's first premium must be paid within 31 days of the effective date of the Participating Employer's coverage. If a premium payment, other than the Participating Employer's first premium payment, is not received within 31 days after the due date, coverage under the policy with respect to that Participating Employer will terminate on the earlier of the 31st day following the due date and the date requested in writing by the Participating Employer, provided such request is made before such 30th day following the due date. The Participating Employer will be liable for the payment of the premium which accrues while any coverage remains in force.

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5. **Change in Rates:** MetLife may change any or all of the premium rates without prior notice if there is a change in the policy; when a class of eligible persons is added to or deleted from a Participating Employer's plan; when, with MetLife's consent, a Participating Employer's subsidiary, affiliate, divisions branch or other similar entity is added to or deleted from the policy; when there is a significant change in the geographic distribution of insured Employees; when applicable law requires a change in insurance or the class of persons eligible for insurance; or when a Participating Employer's premium due date coincides with or next follows: a change greater than 10% in the number of covered persons or a change greater than 10% in the amount of insurance. MetLife may change rates for any coverage at any time if data furnished to MetLife, and relied upon by MetLife as a basis for its rates, is found to be inaccurate or incomplete.

6. **Information Needed and Policy Administration:** All information necessary to compute Premiums and carry out the terms of this policy will be provided by the Policyholder and Participating Employer to MetLife. Such information:

   - Will be provided in a timely manner and in a format as agreed to by MetLife and the Policyholder;
   - Will be provided, maintained and administered as agreed to in Writing by MetLife and the Policyholder; and
   - If maintained by the Policyholder, may be examined by MetLife at any reasonable time.

   If MetLife or the Policyholder or the Participating Employer makes a clerical error in keeping or providing the information, the Premium and/or benefits will be adjusted as warranted, according to the correct information. An error will not end insurance validly in effect, nor will it continue insurance validly ended or create insurance coverage where no coverage existed.

   Any act undertaken by the Policyholder or Participating Employer that relates to the insurance provided under this policy must be consistent with the terms of such insurance and with MetLife's requirements; including but not limited to the eligibility requirements of the Policyholder's plan or Participating Employer's plan as set forth in the certificates to this policy.

7. **Termination:** In addition to the termination provisions set forth above, MetLife will have the right to terminate the policy on any policy anniversary and the right to terminate the Participating Employer's plan: on a date premium is not paid when due; or on any premium due date upon 30 days notice if less than 25% of the eligible Employees are insured for contributory insurance; or fewer than 100% of the eligible Employees are insured for non-contributory insurance; or less than 25% of all eligible dependents are insured for contributory dependent insurance. MetLife may also terminate the Participating Employer's plan on any premium due date by giving 30 days notice if the Participating Employer fails to provide information on a timely basis or perform any obligations required by the policy or any applicable law; or on the date a Participating Employer ceases to satisfy the criteria for a Participating Employer as contained in the definition of Participating Employer upon 30 days notice. The Participating Employer may end the plan by giving 30 days notice to MetLife or the U.S. Bank National Association, as Trustees of the MetLife Pennsylvania Multiple Employer Trust. The plan will end on the later of: the date stated in the notice or the date the notice is received. If a plan ends all premiums due for the plan must be paid. MetLife will refund any unearned premium.

8. **Changes in the Policy:** The policy may be changed at any time without the consent of the covered persons or anyone else with a beneficial interest in it. MetLife will issue amendments or endorsements to effect such changes. MetLife will only make changes that are consistent with applicable law. An amendment or endorsement will not affect the insurance provided under certificates issued before the effective date of the change, unless retroactivity is consistent with applicable law. An officer of MetLife must approve in writing any change or waiver of the terms and provisions of this policy. A sales representative or other MetLife employee, who is not an officer of MetLife, does not have MetLife's authority to approve such changes or waivers. A change or waiver will be evidenced by an amendment signed by an officer of MetLife, and the Policyholder or its designee. An endorsement will be signed by an officer of MetLife. A copy of the amendment or endorsement will be provided to the Policyholder for attachment to the policy.

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CUSTOMER INFORMATION

Legal Name of Company: _____

Legal Address of Company (No PO Boxes): _____

Address Line 2: _____

City, State, Zip: _____

Employer Tax Identification Number (TIN): _____

SIC Code: _____ Year Company Founded: _____

Effective Date: _____ Number of eligible employees:_____

Coverage sold: PPO Dental

Is this case a takeover from a prior carrier? ☐ Yes ☐ No

If yes, prior carrier's most recent billing statement is required with submission.

Does this group have existing coverage with MetLife? ☐ Yes ☐ No

If yes, please include the group #: _____

BROKER INFORMATION

Broker First and Last Name: _____

Social Security #: _____

Corporation Name: _____

Federal Tax ID: _____

Resident State: _____

Broker Address 1: _____

Broker Address 2: _____

Broker City, State, Zip: _____

Broker Contact Name: _____ Phone: _____ Email: _____

Is Broker appointed with MetLife? ☐ Yes ☐ No If no or unsure, please contact your MetLife Implementation team.

Commissions Paid to: ☐ Writing Producer ☐ Brokerage

GENERAL AGENCY INFORMATION

General Agency Name (must be different than corporation name above): Amwins Group Benefits Inc. BKC 4002826

General Agency Writing Producer's Name (must be different than Broker's name above): Timothy J. Falanga

General Agency Writing Producer's Social Security #: BKR4011546

GA Sales Office:[1] _____

General Agency Conatact Name: _____ Phone: _____ Email: _____

[1]For GA's with multiple locations, please specify which GA sales office/location is attached to this sold case

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TPA INFORMATION

TPA Name: GBS-Amwins (T00255)__

PRIMARY CONTACT/BENEFIT ADMINISTRATOR INFORMATION

Contact First and Last Name: _____

Billing Address Line 1: _____
(if different than legal address above)

Billing Address 2: _____

City, State, Zip: _____

Contact Email: _____ Phone: _____ Fax: _____

CUSTOMER EXECUTIVE CONTACT INFORMATION - ☐ Same as Above

Contact First and Last Name: _____

Contact Email: _____ Phone: _____ Fax: _____

ELIGIBILITY INFORMATION

Class Description: **All Active Full Time Employees** Number of hours worked: **30 hours**

EMPLOYEE WAITING PERIODS

For Present Employees: _____ months First of the Month

For Future Employees: _____ months First of the Month

If you have additional classes or if class description or number of hours worked differs from above, please provide the eligibility information mentioned above for each class in the space provided below (multiple cases must be quoted by MetLife Underwriting).

_____
_____
_____
_____

Domestic Partners: If your state does not require domestic partner and you would like it removed, please check here:

☐ Please Remove Domestic Partner

PREMIUM CONTRIBUTIONS

Employer Contribution Percentage - If the employer pays 100% of the premium, all eligible employees must participate.

Employer's Contribution On Behalf Of:

	Dental PPO
Employee	_____%
Dependent	_____%

Section 125: Do you have a Section 125 Plan in place? ☐ Yes ☐ No

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ERISA INFORMATION

MetLife provides a standard service for ERISA plans a document entitled "ERISA Information" that, together with your insurance certificate, can be used as your Summary Plan Description. This includes a grant of discretion to MetLife, as claims administrator. If you do not want MetLife to provide this "ERISA Information" please notify your broker so the appropriate modifications can be completed.

Special Case Notes (FOR METLIFE INTERNAL USE ONLY):

_____

_____

_____

AUTHORIZATIONS

MetLife will deliver the group insurance policy and certificates to the company via e-mail as Adobe pdf documents and confirms that it is able to save them as electronic records and print them (if requested) for distribution to individuals who become covered under the group insurance policy.

HIPAA Information

☐ I am an authorized representative of the MetLife customer named above. By checking this box, I understand and confirm that no access will be given to employee's Protected Health Information (PHI).

This section is to be completed by the individual authorized by the company to sign the application for Group Insurance in order to confirm that the company has requested or undertaken with respect to the implementation of MetLife Insurance and/or service program(s). Please read carefully and complete by checking all boxes that apply.

☐ By checking this box and signing below, I certify that I received a copy of the Intermediary Compensation Notice (included below)

☐ By checking this box and signing below, I certify that the Gramm-Leach-Bliley Privacy Notice (included with their document) has been distributed to all affected employees.

_____ _____

Signature of Executive Contact or Benefit Administrator Date