EVT
EMPLOYERS GROUP TRUST - VISION

APPLICATION FOR PARTICIPATION AND AGREEMENT

Name of Firm _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Phone ( ) _____ **Fax ( )** _____ **Email Address** _____

Contact Person _____ **Title** _____

Nature of Business _____ **Employer Federal Tax ID #** _____ **SIC Code** _____

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

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

Total # of enrolled employees _____

Eligible Dependents: *All covered employee's spouses and unmarried dependent children up to age 26 regardless of student status.*

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** _____

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

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

Plan (must select one): ☐ Plan B (12/12/24) ☐ Plan C (12/12/12)

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 AmWINS Group Benefits, 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 Group Trust - Vision 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 AmWINS Group Benefits, Inc. of 50 Whitecap Drive, North Kingstown, RI 02852.

The Administrator will be paid an administrative fee by the Employers for the administrative services it renders to the Plan. Such fee is presently $20 to $25 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.

_____ X _____ Date_____

Name of Producing Agent (print) Signature of Producing Agent

Commissions Payable To: _____