

Application for Group Supplemental Medical Reimbursement Insurance



601 Poydras Street
New Orleans, LA 70130



8310 Clinton Park Drive
Fort Wayne, IN 46825

Name of Group Applying: _____ Federal ID # _____

Address: _____
Street city state zip code

Phone: _____

Effective date of Insurance: (Month) _____ 1, 20____ Nature of business: _____

Type of Business: C Corporation ____ S Corporation ____ Sole Proprietor ____ Partnership ____ Other _____

Name of employee contact: _____ Title: _____ Email: _____

Names & locations of any subsidiaries or affiliates to be insured: _____

Classes of eligible employees (and any outside directors, retired and or surviving spouses):

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Total no. of employees employed: _____ Total no. of eligible employees: _____ Total no. of eligible outside directors : _____

Total no. of eligible retired employees and surviving spouses: _____

Plan: \$10,000 ____ \$15,000 ____ \$20,000 ____ \$25,000 ____ \$35,000 ____ \$50,000 ____ \$ 75,000 ____ \$ 100,000 ____

Amount of premium submitted \$ _____ Carrier underwriting Base Health Plan: _____

Have you had group insurance with Pan American before? _____ % of premium paid by ER for EE's: _____ Dep: _____

The employer authorizes the administrator to pay a service fee of \$50 per year, per employee covered to the designated agent beginning on the effective date of coverage. This service fee is payable only as long as the indicated agent continues to service the employer and is considered to be the agent by the employer.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of applicant: _____ Date: _____ Signed at: _____

Applicants' title: _____ Witnessed by: _____

Agent name: _____ Agents state license no. _____ Phone: _____

Name of firm: _____ Address: _____

Taxpayer I.D. no: _____ Agent email address: _____

Please submit this form, the individual employee enrollment cards and premium to:
Attention: Doris Hughes at BeniComp 8310 Clinton Park Drive, Ft. Wavne, IN 46825