

# 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.

FRAUD STATEMENT: Any solicitor, agent, examining physician or other person who knowingly and willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

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