SMALL BUSINESS PARTICIPATING EMPLOYER AGREEMENT

By completing this Small Business Participating Employer Agreement (*the "Agreement"*), the Proposed Participating Employer (*"Employer," "You"* or *"Your"*) named below requests participation in the Group Benefits Insurance Trust for Employers in General Services Industries (*"Trust"*) for insurance coverage issued under one or more insurance policies (*"Policy"* or *"Policies"*) issued to the Manufacturers and Traders Trust Company, located at 1350 I Street, NW, Suite 200, Washington, DC 20005, as Trustee. The Policies are issued by Hartford Life and Accident Insurance Company (*"We", "Our"*, or *"Us"*).

CUSTOMER NUMBER(S):

EMPLOYER INFORMATION: Enter information exactly as it should appear in the certificate.

Full legal name of Employer:	**Address:** _____ *Street and number* _____ *City* *State* *Zip* *County*
Contact: ☐ **Mr.** ☐ **Ms.** _____ *Last* *First*	**Phone:** *( )* _____ **Fax:** *( )* _____
Federal Tax ID Number: _____	**E-mail:** _____

Coverage Requested:

The proposed insurance coverage(s) is/are those You elected in the *Proposal of Employee Benefits* (the "Proposal").

SIGNATURES

By signing below, You understand and agree that:

1) The insurance coverages You are requesting and the initial rates and rate guarantees are as stated in the Proposal.
2) This Agreement is subject to the terms of the Trust. Insurance coverage, if issued, is subject in every respect to the terms of the Policies, which alone constitute the contracts under which benefits are paid. The Policies are available for review upon request.
3) To determine whether You qualify for coverage, We will look at the information You have provided to Us. We will not put any insurance coverage(s) into force under any of the Policies if You do not satisfy the requirements of the Trust for becoming a Participating Employer or if You do not qualify for coverage based on our established underwriting criteria.
4) If You satisfy the requirements of the Trust for becoming a Participating Employer and if We agree to put coverage into force for You under the Policies, We will issue certificates of insurance as evidence of Your employees' coverage under the applicable Policies. In no event will any insurance coverage take effect until the latest of the following: (i) the date the first premium is received; (ii) the *Requested Effective Date of Coverage* stated below; or (iii) the date We agree to put coverage into force pursuant to this Agreement, the Policies and Our underwriting rules. We will return any premium We have accepted if coverage cannot be put into force for any reason.
5) Once Your coverage under a Policy is in force, Your coverage will terminate if:
   a) You cease to be a participating employer of the Trust;
   b) The Policy terminates; or
   c) Your premium is due but not paid, subject to the grace period.

   In addition, Your coverage may terminate if:
   a) You fail to perform any of Your obligations pertaining to the Policy;
   b) Less than 100% of Your employees eligible for coverage under Your employer-paid plan are insured;
   c) Less than 75% of Your employees eligible for coverage under Your employee-paid voluntary plan are insured; or
   d) Fewer than 4 of Your employees are insured under the Policy.

   If We terminate Your coverage under a Policy for reasons other than Your failure to pay premium, a written notice will be delivered to You at least 31 days prior to the termination date. We allow a grace period for payment of all premiums after the first. During this 31-day period, Your coverage under the Policy stays in force. If the owed premium is not paid by the 31st day, Your coverage under the Policy will automatically terminate. If You give Us written advance notice of an earlier cancellation, Your coverage under the Policy will terminate on the earlier date. Premium is due for each day the Policy is in force.

Requested Effective Date of Coverage:

Dated at **this** **day of** **, 20 .**

Witness: _____ *Licensed Resident Agent*	**Employer:** _____
California/Florida Only: _____ *Agent'sLicense/Identification number*	**By:** _____ *Signature* *Title*

STATE NOTICES

All states except CO, FL, NJ, and VA: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

VA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Additional notice for NC: Under North Carolina General Statute section 58-50-40, no person, employer, principal, agent, trustee, or third party administrator, who is responsible for the payment of group health or life insurance, or health care plan premiums, will: (1) cause the cancellation or nonrenewal of group health or life insurance, hospital, medical, or dental service plan, multiple employer welfare arrangement, or health care plan coverages and the consequential loss of the coverages of the persons insured, by willfully failing to pay such premiums in accordance with the terms of the insurance or plan contract, and (2) willfully fail to deliver, at least 45 days prior to the termination of such coverages, to all persons covered by the group policy a written notice of the person's intention to stop payment of premiums. Violation of this law is a felony. Any person violating this law is also subject to a court order requiring the person to compensate persons insured for expenses or losses incurred as a result of the termination of the insurance.

Group Benefits Disclosure Notice

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions regarding your insurance producer's compensation directly to your insurance producer.