

6 I designate Agent of Record as:	Agency _____
Address (Street) _____	Address (City, State, ZIP Code) _____

AGENT USE ONLY	7 Commissions payable to:
	Address (if different from above) _____ Telephone _____
	Tax Identification number (if commissions are being paid to the agency) _____ Social Security Number (if commissions are being paid to the agent) _____

8 CONNECTICUT SMALL EMPLOYER HEALTH INSURANCE VERIFICATION (For employers with 50 or fewer eligible employees)
 In order to comply with Connecticut Public Act 90-134 effective 5/1/91, we must have current and accurate information concerning your company and your employees and their dependents.

Company Information

How long in business _____
 Current Medical Carrier _____ Number of years with current carrier _____
 If not currently covered, how long have you been without coverage? _____
 Company's State Unemployment Compensation Number _____
 Is your company part of or affiliated with another company or eligible to file a combined tax return under Chapter 208? Yes No
 If yes, name of affiliated company: _____ # of employees at affiliated company: _____
 Does your company have more than one location? Yes No If yes, how many locations are there? _____
 Where are the offices and/or facilities located: _____

Employee Information

<p><i>During the preceding 12 months:</i></p> <ul style="list-style-type: none"> • Number of employees, including full-time, part-time and seasonal employees: _____ • Number of full-time who worked a minimum of 30 hours per week: _____ • Number of retired employees covered under your medical plan: _____ 	<p><i>As of today:</i></p> <ul style="list-style-type: none"> • Number of individuals on COBRA/continuation: _____ • Number of employees not actively at work (excluding vacations): _____ • Number of full-time employees who work in Connecticut: _____
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9 AUTHORIZATIONS AND ATTESTATIONS

In consideration of the promises and mutual covenants herein contained and other good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually covenanted and agreed by and between the parties as follows:
 The undersigned employer hereby covenants that it meets the Participation Qualifications set forth in Section 5 of this Agreement. If accepted as a participating employer in the CBIA Health Connections Program (Program), it agrees to be bound by all provisions and amendments of applicable participating carriers' Group Service Agreements and the CBIA Health Connections Employer Administration Manual. It acknowledges that it is the plan administrator for its employees health benefit plan and that it is responsible for complying with applicable provisions of federal ERISA, COBRA, and HIPAA laws.
 The undersigned employer agrees to pay monthly premiums to CBIA Service Corporation in advance, along with any applicable fees, for coverage provided by carriers who participate in the CBIA Health Connections program (Participating Carriers). It understands that CBIA Service Corporation accepts premium payments as an agent of Participating Carriers and that CBIA Service Corporation is not an insurer or carrier and is not liable for payment of benefits.
 The undersigned employer agrees to give a minimum 15-days advance written notification to CBIA Service Corporation if it wants to cancel any coverages. Otherwise, it will be liable for the premium until the termination of its participation in the Program.
 Should any information furnished by the Owner/Officer/Employee of the undersigned employer be a misrepresentation or fraudulent, CBIA Service Corporation may rescind enrollment for coverage(s) back to the date of this Agreement.
 I hereby attest to the accuracy and truthfulness of the information provided, and I agree to comply with the above provisions.

Owner/Officer of the company print name	Witness (Agent) print name
Owner/Officer signature	Witness (Agent) signature
Date	Date

CBIA Service Corporation accepts the undersigned employer as a Participating Employer in the Program. It agrees to enroll designated Eligible Employees and Dependents for coverage(s), and to forward premium received for coverage(s) to designated Participating Carriers.

Authorized CBIA Service Corporation signature	Date
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