



ASSURANT
Health

SUPPLEMENTAL PARTICIPATION AGREEMENT FOR SPECIFIC CLASSES

Company Name _____

1. Total number of full-time employees in your firm _____

2. Please specify the job duties and titles of full-time employees in:

Eligible Class _____

Ineligible Class _____

3. Current number of full-time employees in the eligible class _____

4. Current number of full-time employees in the eligible class to be covered under this plan _____

5. Was your prior medical coverage for the eligible class only? Yes No

6. Will full-time employees in the ineligible class be covered by another group plan? Yes No

Agreement

The Employer understands that only eligible/full-time employees in the eligible class (as defined above) and their dependents are eligible for coverage. The Employer is hereby advised that the establishment of eligible and ineligible classes for insurance coverage is subject to federal and state rules governing employee benefit plans. It is the Employer's responsibility to ensure its compliance with these rules. It is understood and agreed that eligibility and participation requirements have been explained to me by the agent. I hereby understand and agree that failure to maintain eligibility and participation on a continuous basis will result in termination of the group coverage.

The undersigned has the authority to make decisions on behalf of the employer and agrees that all the information shown above is correct and complete.

Signature and Title: _____

Print Name: _____ Date: _____