

ADOPTION & PARTICIPATION REQUEST FOR PARTICIPATION IN:



INSURANCE SERVICES INDUSTRY TRUST-Pennsylvania (ISIT- PA), established under a Trust Agreement dated January 1, 1991 insured for the benefits provided under group insurance policies issued to the Trustee(s) by:

- ☐ National Vision Administrators (NVA)

FOR GBA USE:

Group #: _____

Plan Code# _____

Check # _____

ADMINISTRATOR: Gettysburg Benefits Administrators, Inc.
PO Box 1060, 777 Baltimore Street, Suite 97, Gettysburg PA 17325
800-497-4474 / 717-334-9247

COMPANY INFORMATION:

Name of Firm
NVA COVERAGE REQUESTED (For 2-99 Employees) .
NVA Plans – 2 options (100% or 50% based on contribution level)
<input type="checkbox"/> 0% Employer Paid / 100% Employee Participation - Full Service Program ; voluntary program
<input type="checkbox"/> Plan 1A \$85 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment
<input type="checkbox"/> Plan 2A \$130 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment
<input type="checkbox"/> Plan 3A \$130 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment
<input type="checkbox"/> Plan 4A \$200 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment
<input type="checkbox"/> 50% Employer Paid / 75% Employee Participation - Full Service Program
<input type="checkbox"/> Plan 1B \$85 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment
<input type="checkbox"/> Plan 2B \$130 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment
<input type="checkbox"/> Plan 3B \$130 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment
<input type="checkbox"/> Plan 4B \$200 - Benefits Include: Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment

ADOPTION & PARTICIPATION SIGNATURE PAGE:



The undersigned, subject to acceptance by the Administrator, hereby makes application to become a participant in and to be bound by all of the terms, provisions, conditions and limitations of the Trust and Trust Agreement, as amended, between the Trust and Gettysburg Benefits Administrators, Inc. and the master insurance policy or policies (Policy) issued thereunder and providing benefits for the employees of the undersigned Participant/Employer to the same extent as if it were the Policyholder named therein. The undersigned further agrees from time to time to execute and deliver such papers and documents and to furnish such records and information to said Administrator and Insurance Company as shall be required to effect and continue coverage for the undersigned's employees under such Policy. The undersigned further agrees that if it withdraws from the Trust and cancels its insurance plan, it thereby relinquishes any claim it may then or thereafter have to any benefits provided through the Trust. We understand and agree as follows:

1. The Trust may be amended, revised, supplemented, or terminated by the Trustee(s) as provided therein, and any such change shall be binding upon us.
2. The Policy may be amended, canceled or discontinued, according to its terms, by the Trustee(s) and the Insurance Company, and all of the terms of the Policy including such change shall be binding upon us.
3. Since premiums for said policy are payable in advance to the Administrator, we shall make in advance to the Administrator such premium payments and/or participating employer assessments as are requested of us by the Administrator to cover the cost of insuring our employees. An initial premium deposit must accompany this application for group insurance, but the remittance of this deposit does not constitute automatic acceptance of this group insurance application by the Insurance Company. We may be subject to having personal health statements for both employees and dependents completed prior to approval by the Insurance Company. Attending physician statements and other investigations may be requested by the Insurance Company through the Administrator. We understand that the submitted materials are subject to review for acceptability and that the insurance, as applied for, will not be in force until we have received formal, written notification of acceptance, and of the effective date of the coverage applied for, from the Administrator. Appropriate declinations may be made prior to acceptance. The initial premium deposit will not be credited to our account until such time as the formal notification has been released by the Administrator. We understand that this premium deposit will be returned to us in the event that the application is not approved by the Insurance Company.
4. The Insurance Company and Administrator reserve the right to adjust rates (with 30 days notice) from time to time to assure the actuarial soundness of the trust upon the recommendation of the Insurance Company.
5. All disclosures and declarations on Plan of Coverage and Coverage Requested (pages 2 and 3) and Field Underwriting Information (page 4) shall become a part of the coverage issued pursuant to this application.
6. It is critical that eligibility and coverage terminations be reported to Gettysburg Benefits Administrators, Inc. immediately upon termination of employment. If we fail to promptly terminate an employee's coverage, the Insurance Company reserves the right to recoup repayment of any claims incurred and paid beyond the employee's date of termination or expiration of eligibility.
7. Conversion Notice: It is the employer's responsibility under the terms of the Policy and Trust Agreement to present the employee with notification of his right to convert medical insurance to a non-group type of insurance, under certain conditions, after termination of employment.

The insurance benefits, eligibility requirements and effective date of the insurance are requested herein. I certify, as the employer, that to the best of my knowledge and belief all statements and answers in this Application are true. I have read and understand the Notice Regarding Limitations on Health Insurance Coverage (page 4). Advance payment, herewith, of \$_____ is to be applied toward the payment of premiums under the group insurance coverage hereby requested.

PLEASE MAKE CHECK PAYABLE TO: GBA PREMIUM ACCOUNT.

EMPLOYER NAME: _____

SIGNATURE: _____ TITLE: _____ Date: _____

PRINT: _____

The above named Employer is eligible to participate in the above described Trust and is approved as a participant therein.

EFFECTIVE DATE: ____/____/____

Gettysburg Benefits Administrators, Inc. By: _____ /____/____

Form#GBAMA07222019

Gettysburg Benefits Administrators, Inc.

PO 1060

Gettysburg, PA 17325

Initials _____

PRODUCER SECTION



PRODUCER OF RECORD: The below signed producing agent is hereby recognized as the Agent of Record to receive credit for this application according to the Insurance Company rules and regulations on coverages issued in accordance with this application, provided he or she is duly licensed as required by law.

PRODUCER CERTIFICATION: I certify, as primary agent, that to the best of my knowledge and belief all of the statements and answers on this Adoption & Participation Agreement are true. I also certify that I have no knowledge or information regarding the applicant group which is not fully set forth herein.

Date ____/____/____

Independent Producer/Solicitor _____/_____%
SIGNATURE

Independent Producer/Solicitor _____ Phone#(____)_____ GBA Agent ID#_____
PRINT NAME

Producer Email _____

Agency _____ Phone#(____)_____ GBA Agency ID#_____

Agency Email _____

General Agency (If Applicable) _____ Phone#(____)_____ GBA Agent ID#_____

General Agency Agent (If Applicable) _____ GBA Agent ID#_____
SIGNATURE

General Agency Agent _____
PRINT NAME

Commission payable to ☐ Independent Producer/Solicitor ☐ Agency ☐ General Agency

Commissions payable via ACH. Please complete ACH Authorization Form if not already on file.