

Name of Employer: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Employer Information						
Billing Address						
Physical Address (Only if different than billing)						
Administrator Name						
Church Contact Information		Phone	Fax		E-mail	
Census	Workers Compensation	COBRA <i>*(MEBT has opted out of providing CAL-COBRA coverage)</i>			Waiting Period	
1. Total EE's _____ 2. Total Eligible EE's _____ 3. # Declining: _____	Are all employees covered by Workers' Compensation as required contractually by MEBT? <input type="checkbox"/> Yes. Carrier: _____	# of former employees or dependents enrolled in Federal or Cal-COBRA? # _____ <input type="checkbox"/> None	# of former employees or dependents in eligibility period for Federal or Cal-COBRA? # _____ <input type="checkbox"/> None	<input type="checkbox"/> 0day <input type="checkbox"/> 30day <input type="checkbox"/> 60day <input type="checkbox"/> 90day (With a 0 wait: <input type="checkbox"/> 1 <sup>st</sup> day of hire month or <input type="checkbox"/> 1 <sup>st</sup> day of following month)		
Employer Contribution: Is the Employer Contribution the same for all benefits elected? <input type="checkbox"/> Yes. <input type="checkbox"/> No Employee: _____ % Dependent: _____ % or Flat Dollar Amount: _____ \$						
MEBT	Sharp	PPO Dental	HMO Dental	VSP Materials	LFG Group Life	LFG LTD
<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$2,250 <input type="checkbox"/> Decline	<input type="checkbox"/> \$10 <input type="checkbox"/> \$15 <input type="checkbox"/> \$25 <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> \$25K <input type="checkbox"/> \$50K <input type="checkbox"/> \$75K <input type="checkbox"/> \$100K	<input type="checkbox"/> Elect
<b>Supplementary Information:</b> Participant(s) are current or former employees and their dependents or anyone enrolled in or eligible for Federal COBRA or Cal-COBRA.						
1. Are there any participants who have paid or pending claims in excess of \$100,000 in the past (12) months or could have claims in excess of this amount? If none, write NONE.						
Participant	Diagnosis	Amount Paid / Pended / Expected			Prognosis/Status	
2. Are there any participants known to have cancer (specify type), leukemia, severe cardiovascular disease, any severe disorder of a major organ system, severe burns or trauma, neonatal disorders, brain or spine injuries, or a potential organ (specify type) transplant? If none, write NONE.						
Participant	Diagnosis	Amount Paid / Pended / Expected			Prognosis/Status	
3. Are there any participants who are hospital confined at this time? If none, write NONE.						
Participant	Diagnosis	Amount Paid / Pended / Expected			Prognosis/Status	

**\*\*\*Please read the following important information\*\*\***

Employer acknowledges that MEBT, the Trustees, and the vendors shall not be responsible for any tax or legal aspects of the coverages selected. Employer assumes responsibility for these matters. Employer acknowledges that they have sought counsel, to the extent Employer has deemed necessary, with selected legal and tax advisors. The obligations of MEBT, the Trustees, and the vendors shall be governed solely by the provisions of the plan documents and the contracts and policies issued thereunder. MEBT, the Trustees, and the vendors shall not be required to look into any action taken by Employer and shall be fully protected in taking, permitting, or omitting any action on the basis of Employer's actions. Employer and shall be fully protected in taking, permitting, or omitting any action on the basis of Employer's actions. Employer acknowledges that by enrolling in MEBT, Employer is seeking insurance coverage and is not making an investment. Employer acknowledges that this is an application for coverage. No coverage will be provided unless MEBT completes its review, communicates to the applicant that coverage will be extended, and receives confirmation from the applicant that the coverage offered is accepted. Employer has been informed of the eligibility requirements. Employer agrees that coverage applied for shall not become effective or remain effective unless Employer: (i) is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and (ii) meets the participation and contribution requirements. The preexisting condition restrictions for medical and/or long term disability insurance have been explained to and understood by Employer. Employer understands that receipt and deposit of advanced payment is not a guarantee of coverage. If coverage is offered as a result of this application, and if the offer is accepted by Employer, we will apply the premium deposit to the first premium due for such coverage. If no coverage is put into force, the premium deposit will be refunded. Acceptance by Employer of any coverage offered as a result of this application shall constitute approval of any corrections, additions, changes, or other differences between this application and the coverage as offered. Employer's agent or broker cannot change or waive any provision of this application or the coverage without the written approval of MEBT. Employer acknowledges that if this application is approved, the terms of the plan and trust (and any policy issued thereunder) will determine all rights and benefits. Employer understands that it is Employer's obligation to provide MEBT with timely notification of any employee termination, status change, or other material changes that may affect the eligibility of employees or their dependents. Timely notification is no more than 31 days past the actual date of such change. Employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. Employer understands that coverage may be terminated for other reasons as well. I, the undersigned, certify that I have the legal authority to bind the employer for whom application is being made. I, the undersigned, certify that to the best of my knowledge and belief, all of the responses given above are true, correct, and complete. I, the undersigned, understand that if I have misrepresented or omitted any material fact, coverage offered by MEBT may be terminated, or the applicable premium rate adjusted.

**Employer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Statement of Faith**

We believe in the inerrancy of Scripture, that the Bible, Old and New Testaments are the inspired, infallible Word of God. We believe that God is eternally existent in three separate persons: Father, Son and Holy Spirit. We believe that Jesus Christ is fully God and fully human, that He was born of a virgin, lived a sinless life, provided for the atonement of our sins by His vicarious death on the Cross, was bodily resurrected by the power of the Holy Spirit, ascended back to the right hand of God the Father, and ever lives to make intercession for us. We believe that after Jesus ascended to Heaven, He poured out His Holy Spirit on the believers in Jerusalem, enabling them to fulfill His command to preach the Gospel to the entire world, an obligation shared by all believers today. We believe that all people are by nature separated from God and responsible for their own sin, but that salvation, redemption, and forgiveness are freely offered to all by the grace of our Lord Jesus Christ.

**Employer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**\*\*\*Please read the following important information\*\*\***

**Association Agreement**

THIS AGREEMENT, effective as of the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_ (the "Effective Date"), by and between the undersigned

\_\_\_\_\_ (the "Employer") and the Ministry Employee Benefits Trust (the "Trust"). WHEREAS, the Employer has signed a Statement of Faith that properly explains the Employer's religious beliefs and convictions; WHEREAS, by signing the Statement of Faith, the Employer agrees to be associated with the other churches participating in the Trust through the shared common religious bonds and convictions that the Employer has with the association of other churches participating in the Trust; WHEREAS, the Employer wishes to make contributions to the Trust for work performed on and after the Effective Date by its employees; and WHEREAS, the Trust is willing to accept the Employer as an Employer under the Trust in accordance with the terms and conditions set forth herein. NOW, THEREFORE, for and in consideration of the promises and mutual covenants herein contained, the Employer and the Trust hereby agree as follows: **1.)** By execution of this Association Agreement, the Employer adopts and agrees to be bound by all of the terms and provisions of the Ministry Employee Benefits Trust Agreement, as amended from time to time (the "Trust Agreement"), as fully as if the Employer was an original party thereto. A copy of such Trust Agreement has been made available to the Employer. The Employer agrees to be bound by all actions taken by the Trustees of the Trust pursuant to the powers granted them by the Trust Agreement to include without limitation, the rules, regulations and benefit plan(s) adopted by the Trustees. **2.)** By execution of this Association Agreement, the Trustees accept the Employer for participation in the Trust pursuant to the terms of this Association Agreement. The Trust Agreement and the Trust adopted by the Trustees, as in effect from time to time, shall fully apply to the Employer and its employees accepted for participation in the Trust. **3.)** If at any time during the period of the Employer's participation in the Trust the Trustees determine that the Employer's then current contribution rate is too high or too low to fund the total cost (including administrative expenses) of the benefits being provided to the Employer's employees, the Trustees may decrease or increase the Employer's required contribution to the Plan. **4.)** This Agreement shall remain in effect until terminated by the Trustees or the Employer upon 30 days' advance written notice to the other party. The Trustees, however, reserve the right to terminate the Employer's participation in the Trust: **(a)** On account of the Employer's failure to make contributions to the Trust in accordance with the requirements hereunder; or **(b)** As otherwise provided in the Trust Agreement. **5.)** The commencement and continuance of the Employer's participation in the Trust is contingent upon such participation not impairing the qualification of the Trust as a church plan under section 3(33) of the Employee Retirement Income Security Act of 1974, as amended, and section 414(e) of the Internal Revenue Code of 1986, as amended. **6.)** All contributions shall be due and payable at the Trust office or at any other location which the Trustees may, from time to time, designate, in accordance with the collection procedures established by the Trustees. The Employer understands that failure to make payments in a timely manner pursuant to such rules may result in liquidated damages, interest, costs of collection, including reasonable attorneys' fees, and termination of participation and coverage. **7.)** The Employer agrees to take any and all actions which the Trust or its representative may reasonably request to insure compliance with the eligibility requirements of the Trust. IN WITNESS WHEREOF, the Employer has caused this Agreement to be executed on its behalf by a duly authorized officer, and a duly authorized Trustee has executed this Agreement on behalf of the Trust.

**EMPLOYER**

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(print title)

\_\_\_\_\_  
(date)

**MINISTRY EMPLOYEE BENEFITS TRUST**

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print name)

**TRUSTEE**  
\_\_\_\_\_  
(print title)

\_\_\_\_\_  
(date)