

Sponsor's Legal Name		Alternative Name – DBA:	
Address		Contact Person	
City, State & Zip Code		Phone	Fax
Principal Industry	SIC Code	Email	Tax ID Number
Location Name (if different from above)		Contact Person	
Mailing Address (if different from above)		Phone	Fax
City, State & Zip Code		Email	

Sponsor Contribution:

Contributory—Indicate amount (\$ or %) _____
(Requires 50% minimum Sponsor contribution)

Voluntary
(No minimum Sponsor contribution required)

<p>Requested Effective Date:</p> <p>_____</p> <p align="center">mm/dd/yy</p> <p>Annual Open Enrollment Month:</p> <p>_____</p> <p align="center">mm/dd/yy</p>	<p>Rating Method:</p> <p><input type="checkbox"/> Monthly</p>	<p>Billing Mode:</p> <p><input type="checkbox"/> Monthly</p> <p><input type="checkbox"/> Quarterly</p>	<p>Total Number of:</p> <p>Eligible Employees: _____</p> <p>Participating Employees*: _____</p> <p><small>*Markel requires a minimum 4 enrollees unless a higher minimum enrollment is mandated by state filings.</small></p>
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<p>Describe Classes of Eligible Employees to Include:</p> <p>Class 1</p> <p>Waiting Period: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, indicate time period below)</p> <p>Initial Enrollment: _____ Days</p> <p>New Participants: _____ Days</p>	<p>Describe Classes of Eligible Employees to Include:</p> <p>Class 2</p> <p>Waiting Period: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, indicate time period below)</p> <p>Initial Enrollment: _____ Days</p> <p>New Participants: _____ Days</p>
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Check One:

This request is for NEW INSURANCE COVERAGE

This request is for INSURANCE TO REPLACE THE FOLLOWING:

<u>Name of Carrier</u>	<u>Coverage(s)</u>	<u>Plan or Policy No.(s)</u>	<u>Date(s) of Replacement</u>
_____	_____	_____	_____

SELECT BENEFIT(S) TO BE OFFERED TO EMPLOYEES

If applicable, note any Class distinctions for each selection made.

<p><input type="checkbox"/> Value Plan 1</p> <p>\$30 Doctor's Office Visit (5 visits including 1 for wellness) \$30 Diagnostic Testing (3 visits including 1 for wellness) \$30 Child Wellness Visit \$100 Hospitalization \$75 Emergency Room (3 visits for injury and 1 visit for sickness)</p>	<p><input type="checkbox"/> Value Plan 2</p> <p>\$40 Doctor's Office Visit (5 visits including 1 for wellness) \$40 Diagnostic Testing (3 visits including 1 for wellness) \$40 Child Wellness Visit \$200 Hospitalization \$500 / \$200 Surgery (1 inpatient / 1 outpatient) \$100 Emergency Room (3 visits for injury and 1 visit for sickness)</p>
<p><input type="checkbox"/> Standard Plan 1</p> <p>\$45 Doctor's Office Visit (5 visits including 1 for wellness) \$45 Diagnostic Testing (3 visits including 1 for wellness) \$45 Child Wellness Visit \$250 Hospitalization \$1,000 / \$400 Surgery (1 inpatient / 1 outpatient) \$150 Emergency Room (3 visits for injury and 1 visit for sickness)</p>	<p><input type="checkbox"/> Standard Plan 2</p> <p>\$50 Doctor's Office Visit (5 visits including 1 for wellness) \$50 Diagnostic Testing (3 visits including 1 for wellness) \$50 Child Wellness Visit \$350 Hospitalization \$1,500 / \$600 Surgery (1 inpatient / 1 outpatient) \$250 Emergency Room (3 visits for injury and 1 visit for sickness)</p>
<p><input type="checkbox"/> Enhanced Plan 1</p> <p>\$55 Doctor's Office Visit (5 visits including 1 for wellness) \$55 Diagnostic Testing (3 visits including 1 for wellness) \$55 Child Wellness Visit \$400 Hospitalization \$1,500 / \$600 Surgery (1 inpatient / 1 outpatient) \$250 Emergency Room (3 visits for injury and 1 visit for sickness)</p>	<p><input type="checkbox"/> Enhanced Plan 2</p> <p>\$65 Doctor's Office Visit (5 visits including 1 for wellness) \$65 Diagnostic Testing (3 visits including 1 for wellness) \$65 Child Wellness Visit \$500 Hospitalization \$2,000 / \$800 Surgery (1 inpatient / 1 outpatient) \$300 Emergency Room (3 visits for injury and 1 visit for sickness)</p>
<p><input type="checkbox"/> Dental Plan (Can be selected by itself or added to the Value, Standard or Enhanced plans)</p> <p>\$1,500 annual maximum (Gold Plan) \$ 500 periodontics maximum \$ 750 orthodontics maximum</p>	
<p>Discount Cards (Can be added to the selected Market Medical/Dental Plans)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Value Plan w/o PPO <input type="checkbox"/> Enhanced Plan w/o PPO <input type="checkbox"/> Value Plan w/PPO <input type="checkbox"/> Enhanced Plan w/PPO <input type="checkbox"/> Standalone Rx Discount card 	<p>Insured Prescription Card (Can be added to the selected Market Medical/Dental Plans)</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$ 5.00 Copay <input type="checkbox"/> \$10.00 Copay <input type="checkbox"/> \$15.00 Copay

Request for Acceptance as Participating Sponsor

- (1) The Sponsor requests coverage for its participants, as indicated, under the policy(ies) of insurance made available. The Sponsor also agrees to be bound by all of the terms, conditions and limitations of the policy(ies). The Sponsor further understands and agrees that:
- a) This request shall not cause insurance coverage to become effective on any person. In order for coverage to take effect on the date specified by Markel Insurance Company: (A) the Sponsor must be accepted; and (B) each person must satisfy the eligibility requirements of the policy(ies).
 - b) In the event that (A) the Sponsor normally remits premium on behalf of its participants, and (B) one or more participants is not actively at work but is eligible for continuation of coverage, the Sponsor must continue to remit the applicable premiums for such participants in order for them to maintain coverage. In such instances, it may be necessary for the Sponsor to collect premiums from these participants.
- (2) Acceptance of this request is subject:
- a) to all of Markel Insurance Company's requirements; and b) to all of the terms of the group policy(ies) issued.
- (3) Markel Insurance Company will notify the Sponsor of any approval or disapproval of this request. Any notice of approval will specify the Sponsor's plan or plan change effective date. For participants, Markel will issue certificates of insurance summarizing the provisions of the Group Policy(ies) principally affecting the insurance.
- (4) **This plan is not intended to replace comprehensive Major Medical Insurance.**

X _____
Signed at

X _____
Date

X _____
Agent/Broker Signature

X _____
Signature of Sponsor's Authorized Representative

X _____
Agent/Broker Company

X _____
Title

AGENT/BROKER INFORMATION

NAME		COMPANY NAME	
ADDRESS (Street, City, State, ZIP)			
PHONE NO.	FAX NO.	LICENSE ID NO.	TAX ID NO.

All administrative correspondence and inquiries should be directed to:
Markel Insurance Company
Accident & Health Dept.
PO Box 3870
Glen Allen, VA 23058
800-431-1270