MARKEL INSURANCE COMPANY

Sponsor Application for Group Insurance

Underwritten by: Markel Insurance Company

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

Sponsor Contribution:

q **Contributory—Indicate amount ($ or %)** ____________
(Requires 50% minimum Sponsor contribution)

q **Voluntary**
(No minimum Sponsor contribution required)

Requested Effective Date:	**Rating Method:**	**Billing Mode:**	**Total Number of:**
____________ mm/dd/yy **Annual Open Enrollment Month:** ____________ mm/dd/yy	q Monthly	q Monthly q Quarterly	Eligible Employees: ____________ Participating Employees*: ____________ *Markel requires a minimum 4 enrollees unless a higher minimum enrollment is mandated by state filings.

Describe Classes of Eligible Employees to Include:

Class 1

Waiting Period: q No q Yes (if yes, indicate time period below)

Initial Enrollment: ___________ Days

New Participants: ___________ Days

Describe Classes of Eligible Employees to Include:

Class 2

Waiting Period: q No q Yes (if yes, indicate time period below)

Initial Enrollment: ___________ Days

New Participants: ___________ Days

Check One:

q This request is for NEW INSURANCE COVERAGE

q This request is for INSURANCE TO REPLACE THE FOLLOWING:

Name of Carrier	Coverage(s)	Plan or Policy No.(s)	Date(s) of Replacement

SELECT BENEFIT(S) TO BE OFFERED TO EMPLOYEES

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

☐ **Value Plan 1**

$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)

☐ **Value Plan 2**

$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)

☐ **Standard Plan 1**

$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)

☐ **Standard Plan 2**

$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)

☐ **Enhanced Plan 1**

$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)

☐ **Enhanced Plan 2**

$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)

☐ **Dental Plan** (Can be selected by itself or added to the Value, Standard or Enhanced plans)

$1,500 annual maximum (Gold Plan)
$ 500 periodontics maximum
$ 750 orthodontics maximum

Discount Cards (Can be added to the selected Markel Medical/Dental Plans)

- ☐ Value Plan w/o PPO
- ☐ Enhanced Plan w/o PPO
- ☐ Value Plan w/PPO
- ☐ Enhanced Plan w/PPO
- ☐ Standalone Rx Discount card

Insured Prescription Card (Can be added to the selected Markel Medical/Dental Plans)

- ☐ $ 5.00 Copay
- ☐ $10.00 Copay
- ☐ $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