Company Enrollment Form

for Group Term Life, Disability, and Medical Insurance

MWG INTERNATIONAL
A division of Morgan White Group
75 Valencia Avenue, Suite 801
Coral Gables, FL 33134

Product Enrollment Information

Medical Plan Name	Medical Deductible
	$

Product

❑ Term Life ❑ Disability ❑ Medical

Optional Coverage

❑ Critical Illness *(applicable to Disability only)* ❑ Dental & Vision *(applicable to Medical only)* ❑ N/A

Term Life Coverage Information

❑ Percentage of Salary* _____ % or ❑ Fixed Amount* $ _____

**Term Life coverage amount cannot exceed maximum of 8x salary.*

Company Information

Company Name	Type of Business

Company Representative Information

Name	Phone Number	Email
Job Title		What percentage of group quote would employer be responsible for? %

Payment Information

Mode of Payment

❑ Check* ❑ Wire Transfer*

**Please make checks payable to: MWAll Premium Trust*
**$15.00 fee applies for wire transfer*

Frequency of Payment

❑ Annual ❑ Monthly*

**Monthly frequency is available only for annual premium amounts above $5,000*

Total Premium

$ _____

*Once your application has been submitted, you will receive a **Customer ID** and **Certificate Number**. Please use those numbers to submit your payment information in the **Online Payment Portal**.*

Census requirement: *Name, Age, Date of Birth, Gender, Dependent Information, Salary Information (Life and Disability), Job Titles, Claims Loss Information*
(Clearly indicate on census the employee, dependent spouse, and/or dependent child)

❑ I certify that all employees are Actively at Work.

It is hereby warranted that all employees Insured are in good health and are actively at work at the inception date of this Policy or on the day he is eligible to be included in the Scheme and must not have been absent as a result of accident or illness for more than 10 working days in the preceding six months.

If the Insured does not satisfy this condition then HEALTH QUESTIONNAIRE MUST BE COMPLETED BY EMPLOYEE AND IS SUBJECT TO ACCEPTANCE BY UNDERWRITERS, OR COVERAGE will not be provided.

Actively at work and good health means that Lives Insured are not only present at their place of work on the prescribed day but are mentally and physically capable of carrying out their normal regular duties associated with the job for which they are employed.

Employees not Actively at Work

Anyone that does not qualify as Actively at Work is subject to underwriting and must complete the Application for those not Actively at Work.

Company Representative's Statement

I hereby certify all responses, census, quotes, attachments and declarations contained in this enrollment are true, complete and correct and I understand and agree any inaccuracy or omission in responses will constitute grounds for the insurer to deny a claim, invalidate, modify benefits or cancel any of the insurance coverage applied for. In the event the insurer cancels or otherwise invalidates the insurance coverage applied for as a result of the failure to fully disclose past medical history, salary information, or pre-existing conditions, the insurer reserves the right to recover from the applicant all costs and fees incurred in reasonably investigating those matters not fully disclosed.

I understand the broker, agent or agency receiving this application does not have the authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and all information requested in the application must be set forth in writing on this application. I further understand this application will become part of the insurance policy to be issued and the insurer will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand the broker, agent or agency taking this application from me is an independent representative and is acting on my behalf and not the administrator nor the insurance company offering this insurance. Neither the administrator nor the company offering this insurance can be held liable for any circumstance if the broker, agent or agency, who is taking this application, fails now or in the future to transmit or communicate any documentation or funds from the administrator to me and/or any documentation or funds from me to the administrator.

It is understood the insurance applied for shall not become effective until this application is approved and accepted by the insurer, full payment of the first premium is made, and the policy issued, subject to all conditions and restrictions contained therein. I understand this policy is not available to permanent residents of the United States or others who reside in the United States. However, if any applicant for coverage, who is accepted and insured by the insurer in the applicant's country of residence, moves to the United States of America, the insurer will provide an option to continue insurance coverage.

Agent Name:_____Agent code:_____

Agent email: _____ Date _____ /_____ /_____
Day Month Year

Name of Company Representative_____ Date _____ /_____ /_____
Day Month Year

Signature of Company Representative _____ Date _____ /_____ /_____
Day Month Year