

ADOPTION & PARTICIPATION REQUEST FOR PARTICIPATION IN THE INDUSTRY OF:

GHAI USE ONLY	
GROUP # _____	
PLANCODE _____	
CHECK \$ _____	
ASSOCIATION _____	
MARKETING REP. INITIALS _____	

- ÿ INSURANCE SERVICES INDUSTRY TRUST-Pennsylvania (ISIT- PA)
 established under a Declaration of Trust dated August 1, 1982 insured for the benefits provided
 under Group Insurance Policies issued to the Trustee(s) by:
- ÿ Delta Dental of Pennsylvania ("the Dental Company") Plan Numbers 6520 through 6529
- ÿ Harleysville Life Insurance Company ("the Insurance Company") Policy Number G-532-01-53801
- ÿ Inter County Hospitalization/Health Plan, Inc.
- ÿ Mutual Service Life Insurance Company

Administrator: Gettysburg Health Administrators, 404 Baltimore Street, P.O. Box 1060, Gettysburg, PA 17325-1060 (717-334-9247)

The undersigned, subject to acceptance by the Administrator hereby makes application to become a participant in and to be bound by all the terms, provisions, conditions and limitations of the Trust Agreement as amended between the Trust or the Fredericktown Bank or PNC Bank and Gettysburg Health Administrators and the master insurance policy (Policy) providing benefits for the employees of the undersigned Participant/Employer to the same extent as if we 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 Insurance Company as shall be required to effect and continue coverage for the undersigned's employees under such policy or policies. 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 portion of such 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 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 Trustee(s), we shall make in advance to the Trustee(s) such premium contributions and/or participating employer assessments as are requested of us by the Trustee(s) 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 are 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 Administrator reserves 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 policy issued pursuant to this application.

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 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 INSURANCE SERVICES PREMIUM ACCOUNT.**

GROUP NAME: _____ BY: _____ TITLE: _____
SIGNATURE

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

EFFECTIVE DATE: ____/____/____

Gettysburg Health Administrators By: _____ / ____/____

PLAN OF COVERAGE

NAME OF FIRM _____ TAX ID # (E.I.N.) _____

CORRESPONDING PERSON & TITLE _____ TEL. # (____) _____

STREET ADDRESS _____ FAX # (____) _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

(1) Effective Date: The requested effective date for this plan is _____, 20_____

(2) Type Of Business Corporation Partnership Sole Proprietor

(3) Nature Of Business _____ SIC Code _____

(4) How long has this particular business been in operation? _____

(5) Subsidiary or affiliated companies to be covered (if trusteeship or association, list contributing employers or employer-members on a separate sheet and attach with this application):

Name & Address

Relationship to Policyholder (Subsidiary or Affiliate)

a) Are any employees outside coverage area quoted by Gettysburg Health Administrators? # of employees _____
Location _____

(6) Total Number Of Employees: Full-Time _____ To Be Insured _____ Waivers _____ COBRA _____

a) List classes of employees to be covered: _____

All full-time employees who devote a minimum of 30 hours each week to the service of the applicant at their regular and customary place of employment are considered eligible. It is agreed that the insurance applied for shall not become effective unless the number of persons insured is no less than the minimum number of lives required by law. It is also agreed that if contributions are required, at least 75% of the persons eligible for insurance make written request for the insurance. In addition to part-time and temporary employees, the following classes of employees or employees by name are NOT to be considered eligible: _____

b) Are 50% of the employees to be insured of the same immediate family? YES NO Proof of full-time employment is attached.

c) Individuals to be covered receiving extended benefits under COBRA? NO YES Identify individuals, effective date and termination date of COBRA: _____

(7) Waiting Period For Eligible Full-Time Employees:

a) Initial employees employed ON or BEFORE effective date: No Waiting Period _____ Months

b) Subsequent employees employed AFTER the effective date: _____ Months

c) Are any employees currently absent due to illness or injury or receiving disability benefits? YES* NO

*If YES, specify whom and provide explanation on separate sheet.

NOTE: Eligible employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to active work. If a dependent of an insured employee is hospital confined on the effective date, he or she shall be covered under this plan when discharged from the hospital.

(8) Does your company have a policy for Continuation of Coverage for disabled employees or those on leave of absence? YES* NO

*If YES, attach copy of policy.

(9) Does your company provide health benefits for laid off employees? NO YES, # of Days: " 30 " 60 " 90 " _____

(10) Are all employees and owner/partners covered by Workers' Compensation? YES NO Name of Carrier _____

Name of owner/employee not covered by Workers' Compensation: _____

(11) Is HMO currently offered? YES* NO *Specify HMO: _____

*Specify HMO Enrollment Period: _____

(12) Insurance coverage hereby applied for is to replace insurance in force as stated below: **(Attach copy of previous carrier's bill)**

a) Coverage applied for is is not in addition to coverage below:

TYPE OF INSURANCE	DATE DISCONTINUED	INSURANCE COMPANY	YEARS WITH CURRENT CARRIER
_____	_____	_____	_____

(13) EMPLOYEE CONTRIBUTIONS: Insurance is non-contributory Insurance is contributory
 The Applicant Employer agrees to make the payroll deduction authorized in writing by each employee.

EMPLOYEE'S CONTRIBUTION TOWARD COST

MEDICAL	LIFE AD&D	DEPENDENT LIFE	SHORT TERM DISABILITY	DENTAL
<u> </u> %/ %	<u> </u> %	<u> </u> %	<u> </u> %	<u> </u> %
EE/Dependent	Employee	Dependent	Employee	EE/Dependent

COVERAGES REQUESTED

MEDICAL COVERAGE REQUESTED:			
* All Plans include drug card through PAID prescription.			
<input type="checkbox"/> Par Pro Flex I	<input type="checkbox"/> Par Pro Inp. Copay (Flex II)	<input type="checkbox"/> Par Pro First \$ Inpatient Hospital	<input type="checkbox"/> KBA 1
<input type="checkbox"/> First Dollar Coverage	<input type="checkbox"/> \$100 80/20/\$2,000	<input type="checkbox"/> \$100 80/20/\$5,000	<input type="checkbox"/> \$250 80/20/\$2,500
<input type="checkbox"/> \$300 80/20/\$3,500	<input type="checkbox"/> \$500 80/20/\$5,000		

MATERNITY COVERAGE: <input type="checkbox"/> Normal Delivery <input type="checkbox"/> Complications Only

LIFETIME MAXIMUM: <input type="checkbox"/> \$2,000,000

LIFE, AD&D AND/OR DISABILITY INCOME COVERAGE REQUESTED:

Life Insurance and AD&D (24 Hour)

Short Term Weekly Disability Income: Waiting Period: _____ Accident / _____ Sickness / _____ Benefit Period

24 Hour on owners/partners only who are not eligible for Worker's Compensation

Maternity Coverage for Weekly Disability Income (For groups with 15 or more employees with Harleysville Life Insurance Company Only)

SCHEDULE OF BENEFITS

CLASS	CLASSIFICATION	LIFE & AD&D PRINCIPAL SUM	SHORT TERM DISABILITY INCOME BENEFIT
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: Any change in amount of an employee's insurance resulting from change in classification will become effective on the first day of the insurance month coincident with or next following the date of change in classification. If the employee is disabled on the date the change would become effective, such change will take effect on the date of the employee returns to active full-time employment subject to evidence of insurability.

DELTA DENTAL COVERAGE REQUESTED:
 Waiting period for subsequent employees (eligible full-time) employed after the effective date is 90 days.

<input type="checkbox"/> 100% Participation of Employees or 100% Employees & Dependents / 100% Employer Paid of Employee & Dependent Cost	<input type="checkbox"/> 75% Participation of Employees or 75% Employees & Dependents / Minimum 25% Employer Paid of Employee & Dependent Cost
<input type="checkbox"/> Plan 1-6520 \$0 DED - \$500 MAX (2+ EE's)	<input type="checkbox"/> Plan 6-6521 \$0 DED - \$500 MAX (10+ EE's)
<input type="checkbox"/> Plan 2-6522 \$25 DED - \$750 MAX (2+ EE's)	<input type="checkbox"/> Plan 7-6523 \$25 DED - \$750 MAX (2+ EE's)
<input type="checkbox"/> Plan 3-6524 \$25 DED - \$750 MAX (2+ EE's)	<input type="checkbox"/> Plan 8-6525 \$25 DED - \$750 MAX (10+ EE's)
<input type="checkbox"/> Plan 4-6526 \$0 DED - \$1200 MAX (2+ EE's)	<input type="checkbox"/> Plan 9-6527 \$0 DED - \$1200 MAX (10+ EE's)
<input type="checkbox"/> Plan 5-6528 \$25 DED - \$1000 MAX (2+ EE's)	<input type="checkbox"/> Plan 10-6529 \$25 DED - \$1000 MAX (10+ EE's)

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 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.

Independent Producer/Solicitor _____ SIGNATURE _____ / _____ % Date _____ / _____ / _____

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

Agency (If Applicable) _____ Phone#(_____) _____ GHAI Agency ID# _____

Super Producer (If Applicable) _____ SIGNATURE _____ GHAI Agency ID# _____

Super Producer _____ PRINT NAME _____

Independent Producer/Solicitor _____ SIGNATURE _____ / _____ % Date _____ / _____ / _____

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

Agency (If Applicable) _____ Phone#(_____) _____ GHAI Agency ID# _____

Super Producer (If Applicable) _____ SIGNATURE _____ GHAI Agency ID# _____

Super Producer _____ PRINT NAME _____

Mail Commissions

To _____ (Street) _____ (City) _____ (State) _____ (Zip)

Commission payable to Independent Producer/Solicitor Agency Super Producer

NOTICE REGARDING LIMITATIONS ON HEALTH INSURANCE COVERAGE

While we believe that the insurance coverage you are purchasing is among the finest obtainable, you should be aware of certain limitations in the coverage being offered. In particular, please note the following:

- There may be a "waiting period" which would delay the insurance coverage effective date (see page 2 of this form);
- Certain exclusions from coverage are contained in the policy (see the policy);
- Some "pre-existing conditions" may not be covered for up to 12 months (see the policy);
- The policy discusses the various optional coverages and limitations upon some of these benefits.