Employer Request For Coverage Form

AXIS Insurance Company

Participating Employer (Policyholder) Information

Business Name: EIN/TAXID:

Contact Name and Title:

Street Address:

City: State: Zip Code:

Check preferred contact method: ☐ Phone: ☐ E-mail:

Number of Eligible Employees: Requested Plan Effective Date: *(Must be the first of the month.)*

SIC Code: 5812 Industry: Food Service: Quick Service Restaurants

Broker/Agent Information

Agent Name: Adam Joseph Besnard

Agency Name: JLBJR Enterprises LLC dba Besnard Insurance

Street Address: 3000 Bayport Drive Suite 400

City: Tampa State: FL Zip Code: 33607

Phone: (813) 287-1721 Email: adam.besnard@besnardinsurance.com

Acknowledgment And Agreement

BY SIGNING BELOW: The employer ("Group") understands and agrees that the requested insurance coverage will not become effective on the proposed effective date until this completed Request for Coverage form is reviewed, approved, and signed by Ternian. The group insurance policy will serve as the contractual agreement between the Group and the insurance company with respect to the terms of the insurance coverage and the cost thereafter. Group acknowledges that the information on this form is complete and accurate to the best of knowledge. Group understands that the medical plans to be offered (if any) are fi xed indemnity sickness and accident policies and are not co nsidered creditable coverage under HIPAA, and are not intended to be a substitute or replacement for comprehensive or major medical health insurance plans or workers' compensation plans. Group agrees that it is solely responsible for any applicable obligations under employer legislation and that Ternian and the insurance carrier assume no liability. Group also accepts the above named producer as Broker of Record and their appointed representative for this program.

Signature: Date:

Print Name: Title:

PLEASE RETURN COMPLETED FORM TO:

EMAIL Peter.Barraco@Ternian.com

Questions? Call 1-754-226-7943

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An AXIS Capital Company