WMI MUTUAL® INSURANCE COMPANY™

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EMPLOYER RENEWAL QUESTIONNAIRE

Please complete and return this form by fax or mail to the WMI Enrollment Department.

General Information

Date __________________

Company Name _______________________________ Contact Person/Title _______________________________

Address ___________________________________ City _____________________ State _______ ZIP __________

Phone (_____) ______________ Fax (_____) ______________ Email address _________________________

Employee Classification Information

The following employee classification(s) is/are eligible to participate in the company's group health plan: ___________

____

Waiting Period for New Employees: 30 days _____ 60 days _____ 90 days _____ 120 days _____ Other _____

Explain: ____

Employees are required to work a minimum of _________ hours per ______________ to be eligible for group insurance

Total number of employees of all related companies: ______ Full-time: _____ Part-time: ______ Seasonal/Other: _____

Did all employers maintaining the plan normally employ fewer than 20 employees on a typical business day during the preceding calendar year: **Yes:** □ **No:** □ Number of employees employed on a typical business day in the ***preceding*** calendar year: _________ (For COBRA purposes, part-time employees must be counted as a fraction of an employee.)

Total number of employees ***eligible to participate*** in the company's group health insurance plan:____________________

Total number of employees ***participating*** in the company's group health insurance plan:___________________________

Total number of eligible employees ***not participating*** in the company's group health insurance plan:________________

Reason(s) for waiving coverage: ____

*WMI requires that companies with 2-5 eligible employees enroll 100% of eligible employees; companies with 6-9 employees must enroll at least 80% of all eligible employees; and companies with 10+ employees must enroll at least 75% of all eligible employees. An eligible employee is one who satisfies the eligibility criteria for WMI and the employer, works a minimum of 80 hours per month and does not carry other major medical insurance coverage.

Employer Premium Contribution Information

Employee Premium: The employer pays ______% and the employee pays ______% (total must equal 100%)

Dependent Premium: The employer pays ______% and the employee pays ______% (total must equal 100%)

Signature

I hereby certify that the information provided herein is true and complete to the best of my knowledge.

____

Signature of Authorized Company Representative Title Date