



CENTRAL RESERVE LIFE INSURANCE COMPANY

17800 Royalton Road • Cleveland, OH 44136-5197 • 440-572-2400
www.centralreserve.com • www.ceresgroupinc.com

CRL PAYROLL DEDUCTION AUTHORIZATION

Payroll Deduction is not permitted in the states of: NC, TN and WI.

It is not permitted for self-employed individuals in the state of MS.

TO CRL: Please send the billing statement to my employer/company at the following address:

EMPLOYER/COMPANY NAME		APPLICANT'S NAME		
STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE
EMPLOYER CONTACT PERSON		TELEPHONE ()		

TO MY EMPLOYER, _____, **AND CENTRAL RESERVE LIFE INSURANCE COMPANY (CRL):** (company name)

As a convenience to me, I request and authorize my employer to:

- (1) deduct the amount of the insurance premium, administration charges and membership dues from my compensation by way of payroll deduction; and
- (2) receive the insurance billing statement and remit the amount due directly to CRL on my behalf. (In S.C., remit with the amount due to the ECA)

I further request and authorize CRL to:

- (1) send the insurance billing statement directly to my employer; and
- (2) accept the premium, membership dues, and administration charges, if any, directly from my employer on my behalf.

I understand and agree that:

- (1) my employer is not acting as an agent of CRL by performing any of the above activities but is, instead, at all times acting as my agent;
- (2) I am responsible for the payment of the premium, membership dues and administration charges. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date;
- (3) if my employer fails to submit the required amounts when due, CRL has no obligation to seek payment directly from me;
- (4) I agree to indemnify my employer and CRL and hold them harmless from any loss, claim, or liability that may arise out of, or be related to, this authorization, including, but not limited to, loss of coverage or benefits due to failure to remit payment in a timely manner; and
- (5) I understand and agree that my employer and CRL may rely on this authorization and act accordingly. I may revoke this authorization with 15 days advance written notice to my employer and to CRL.

Applicant's Signature

Date

I certify that I am not paying any part of the premium, fees or other cost of insurance; nor am I reimbursing my employee for any portion of the cost of this insurance.

I understand that any new employee applying for coverage will be subject to the then current underwriting rules of CRL.

I understand that if this is a list bill arrangement, it does not constitute an employer health plan within the meaning or purpose of Sections 106, 125, and 152 of the Internal Revenue Code.

I understand that as the employer, I am responsible for providing copies of all correspondence to my employees.

Signature of Authorized Employer Representative

Date