



## Subscription Agreement

EAM is a statewide association benefiting employer members throughout the State of Montana. Through your membership with EAM you will have access to discounted services for employers. Please see the EAM website for further information.

In addition, your membership with the EAM entitles you to many other benefits:

- Health Insurance coverage – 9 plan options available through an arrangement with Blue Cross Blue Shield of Montana (BCBSMT) and Western States Insurance Agency.
- Dental Insurance – 2 plan options available through BCBSMT
- Vision Insurance – Coverage through BCBSMT
- Life Insurance – Coverage through UNUM
- Travel Assistance – Coverage available through UNUM
- Employee Assistance Program (EAP) – Coverage available through UNUM

Dues Schedule: Dues are calculated based on the number of full-time employees, with dues payable by April 1. Failure to pay dues will result in the inability to renew insurance products offered by the EAM. Below is a basic schedule. Dues are pro-rated the first year for groups that join mid-year. A full schedule can be found at [www.eaofmt.com](http://www.eaofmt.com).

1-10 employees	\$175.00	51-60 employees	\$575.00
11-20 employees	\$225.00	61-70 employees	\$675.00
21-31 employees	\$300.00	71-80 employees	\$775.00
31-40 employees	\$375.00	81-90 employees	\$875.00
41-50 employees	\$475.00	91-100 employees	\$975.00
		(\$100.00 increase for each additional 10 employees)	

I, the undersigned, hereby indicate the intent to participate in one or more of the insurance plans available through the Employers Association of Montana, Inc., Insurance Fund (EAM). Furthermore, the undersigned hereby agrees to pay all premiums for such insurance as they become due. I understand that failure to submit premiums will result in cancellation of the policy.

In consideration of the availability of group insurance, the undersigned further agrees to be bound by the terms and conditions of the Employers Association of Montana, Inc., Insurance Fund Declaration of Trust.

### *Required Information*

_____ <b>BUSINESS NAME</b>	_____ <b>BUSINESS MAILING ADDRESS                      STATE              ZIP</b>
_____ <b>CONTACT NAME</b>	_____ <b>TITLE</b>
<b>PHONE NUMBER: (     )</b>	<b>EMAIL ADDRESS:</b>
<b>TOTAL EMPLOYEES:                                      TOTAL ELIGIBLE:                                      TOTAL ENROLLED:</b>	
<b>CONTACT SIGNATURE:</b>	

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_ Effective: \_\_\_\_\_