Employer Application for Coverage

Requested Effective Date:	Anniversary Month: **June**
Legal Name of Business:	
dba (if applicable):	
Name of Direct Controlling Entity (if applicable):	
Physical Address (street, city, state, zip):	
Mailing Address (street, city, state, zip):	
Phone:	Fax:
Employer Tax ID Number (EIN):	Legal Domicile (state where company is headquartered):

Organization Type:
☐C Corp ☐S Corp ☐Partnership ☐Individual/Sole Proprietor ☐Taxable Trust ☐Tax-exempt Trust ☐LLC – C Corp ☐LLC – S Corp

AGC Membership Type: ☐ General Contractor ☐ Specialty Contractor ☐ Associate	SIC Code:	Primary Business Activity:
Benefits Administrator:	Phone: Fax:	Email:
Billing Contact (if different):	Phone: Fax:	Email:

Method of Premium Payment	☐ EFT – Draws on the 10th of the month (Please also complete EFT Authorization Form) ☐ Check – Due on the 1st of the month (Requires additional 2% Fee)
Eligibility	Eligible Employees are required to work _____ hours per week. (Minimum Requirement: 20 hours per week, administered on a non-discriminatory basis, based on conditions of employment.)
Probationary Period	First of the month following: ☐ Date of Hire ☐ 30 Days ☐ 60 Days Waiting Period waived for initial enrollees: ☐ Yes ☐ No (Available for Initial installation only)
Re-hire Waiting Period	☐ 1st of Policy Month following Date of Hire ☐ 1st of Policy Month following ____months of employment
Eligibility Look Back Measurement/Stability Period:	Has your company adopted a look back measurement/stability period under the ACA? ☐ Yes ☐ No If Yes, the Measurement Period is ___ months and the Stability Period is ___ months. Please confirm that this measurement period is being applied due to a good faith uncertainty about whether the employee meets the eligibility criteria referenced above: ☐ Yes
Employee Count	Number of employees enrolling in the plan: _____ Number of employees with valid waivers*: _____ Number of employees declining coverage: _____ Number of ineligible employees: _____ Total number of employees (including seasonal, part- time, full-time and union employees) : _____ *See Underwriting Guidelines for definition of valid waivers.

COBRA	All employer groups enrolled with AGC Health Benefit Trust are subject to COBRA. Please indicate if you would like to authorize Benefit Solutions, Inc. to administer COBRA on terminating employees. (If yes, please complete a Vimly COBRA Administrative Agreement.) ☐ Yes ☐ No
Dollar Bank	Number of employees currently eligible per employer guidelines to enroll in this program: _____ Please complete Dollar Bank Application in addition to this application (available on www.agchealthplansnw.com/AGCAK.htm).

Product Selection & Employer Contribution

Medical Plan* (provided by UnitedHealthcare Insurance Company)	**Plan Type**	**Deductible**	**Medical Plan Election (Multi-Choice)**	**Employer Contribution**	
				Employee (% or $ Amount)	**Dependent (% or $ Amount)**
Premier 500	Flat Copay	$500	☐		
Premier 750	Flat Copay	$750	☐		
Premier 1500	Flat Copay	$1,500	☐		
Premier 2500	Flat Copay	$2,500	☐		
Premier 3000	Flat Copay	$3,000	☐		
Preferred 1500	Split Copay	$1,500	☐		
Preferred 2000	Split Copay	$2,000	☐		
Preferred 3000	Split Copay	$3,000	☐		
Preferred 4000	Split Copay	$4,000	☐		
Preferred 5000	Split Copay	$5,000	☐		
Consumer 1000	Consumer	$1,000	☐		
Consumer 2000	Consumer	$2,000	☐		
HSA 1750	HSA	$1,750	☐		
HSA 2500	HSA	$2,500	☐		
HSA 3000	HSA	$3,000	☐		

Dental Plan (provided by Standard Insurance Company)	**Vision Plan** (provided by Standard Insurance Company)	**Group Life/AD&D** (provided by UnitedHealthcare Insurance Company)	**Life Balance** (provided by LifeBalance)
☐ $1,000 Annual Max	☐ VSP Signature $10/$0	☑ $10,000 *(Minimum Requirement; Included in all medical benefits)*	☐ Elect
☐ $1,500 Annual Max	☐ VSP Signature $10/$25	☐ Additional $10,000 ($20,000 total)	☐ Decline
☐ $2,000 Annual Max	☐ Eye Med $10/$25	☐ Additional $20,000 ($30,000 total)	**Life Eligibility Election** (must choose one)
☐ Orthodontia Rider	☐ Balanced Care Vision III	☐ Additional $30,000 ($40,000 total)	☐ All Eligible
☐ Decline All	☐ Decline All	☐ Additional $40,000 ($50,000 total) *(Available to employers of 6+ employees)*	☐ Medical Enrollees Only

CDHP Election (Additional charge of $6.50/PEPM applies. Enrollment forms are required.)	☐ Flexible Spending Account (FSA) ☐ Health Savings Account (HSA) ☐ Health Reimbursement Account (HRA) ☐ Dependent Care Assistance Program (DCAP) ☐ Decline All
Enrollment Packets Needed for Open Enrollment	

* All medical plans include the required minimum $10K Life/AD&D benefit, and Health Advocate

Employer Statement and Signature

This Agreement consisting of the Plan Contract/Group Policy as supplemented by this Application has been entered into between the AGC Health Benefit Trust and the Employer Group in order to provide eligible subscribers and eligible dependents electing to enroll hereunder with the health care benefit as specified in the Plan Contract/Group Policy. I have read, understood, and agree to the statements below. We wish to enroll our firm as a group account with the AGC Health Benefit Trust.

☑ We wish to enroll our firm as a group account with the AGC Health Benefit Trust.

☑ We acknowledge that coverage is not in effect until the carrier accepts this application and risk, and AGC Health Benefit Trust provides us with an effective date of coverage and group number.

☑ We understand the eligibility rules applicable to employee enrollment.

☑ We certify that we have received a fully completed and unaltered Enrollment Application from each participating employee and that we will keep these forms on file in their original state indefinitely. They will be immediately available to the AGC Health Benefit Trust upon request.

☑ I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. I understand that the issuer will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Group after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group no longer qualifies for the Rate quoted, I understand that the issuer will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the Rate adjustment within 30 days of the date of notice by the issuer. In addition, the issuer will have the right to collect any claims payments or other damages.

☑ A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

☑ We understand premiums are prepaid and are due no later than the 10th day of each month if paying by EFT. **If paying by check, premiums are due on the first day of the month.** We understand the delinquency policies and termination process as outlined by the AGC Health Benefit Trust.

☑ We understand that participation in the AGC Health Benefit Trust requires AGC Alaska Chapter membership in good standing. **If dues are not paid, your medical benefits will be terminated with 30 day notice upon of non-payment of membership dues to AGC Alaska Chapter.**

☑ We understand an individual's coverage terminates the last day of the month in which an employee or dependent ceases to be eligible under group eligibility provisions.

SIGNATURE & TITLE OF EMPLOYER REPRESENTATIVE DATE

Agent Statement

I certify that all information contained in this application is correct to the best of my knowledge. I also certify that: This firm is a bona-fide business establishment. All participation requirements have been met. Coverages, enrollment provisions, eligibility requirement, benefits, limitations, and exclusions have been fully explained and understood by the applicant or employer. Co-payments (if applicable) have been fully explained and understood by the employer. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be offered.

Agent Signature: _____

Date: _____

Agent Name: _____

Agency: _____

Address: _____

Phone: _____

Email: _____