DOLLAR BANK APPLICATION

Company Information

Company: _____ Effective Date Requested: _____

Dollar Bank Contact Name: _____ Title: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

Dollar Bank Contribution and Eligibility Provisions

Maximum Amount in Dollar Bank (months of premiums) ☐ 6 ☐ 9 ☐ 12

Dollar Bank Limited to specific classifications of employees? ☐ Yes ☐ No

If yes, list classifications: _____

Number of employees currently eligible per employer guidelines to enroll in the Dollar Bank: _____

Documents Attached

Census of all employees enrolling in Dollar Bank.

Please include: Name, SSN, Enrollment Tier, Date of Hire, Total Hours worked since date of hire.

Employer Statement

- ✓ We wish to enroll in AGC Health Benefit Trust Dollar Bank administration for the attached list of employees.
- ✓ We understand the eligibility rules applicable to employee enrollment.
- ✓ We have read and understand the Dollar Bank Policy made available to us by AGC Health Benefit Trust.
- ✓ We certify we have received a fully completed and unaltered enrollment form from each participating employee and we will keep these forms on file in their original state indefinitely. They will be immediately available to the AGC Health Benefit Trust or Carrier upon request.
- ✓ We understand Dollar Bank report forms will be provided to us by AGC Health Benefit Trust's administrator on the first of the month and are to be completed and returned to the administrator by the 10th of the month. Delinquent reporting could result in a $30 late fee.

Executed at _____ Date accepted _____
(City, ST)

_____ _____ _____
Signature of Authorized Employer Group Representative | Print Name | Title