AGC Health Benefit Trust
OREGON COLUMBIA CHAPTER

Application for Insurance Coverage

Office Use Only:
Group #: _____
Rate Level: _____

Company Information			
Requested Effective Date:		Anniversary Month:	
Legal Name of Business:			
dba (if applicable):			
Name of Direct Controlling Entity (if applicable):			
Physical Address (street, city, state, zip):		County:	
Mailing Address (street, city, state, zip):		County:	
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			
SIC Code:	Primary Business Activity:		
Benefits Administrator:	Phone: Fax:	Email:	
Billing Contact (if different):	Phone: Fax:	Email:	

Product Selection				
Medical Plans* (May choose up to 3)		**Dental Plan** (Provided by Standard Insurance Company)	**Vision Plan** (Provided by Standard Insurance Company)	**Group Life/AD&D**
❑ PPO $500	❑ Value $1,000	❑ $1,000 Annual Max	❑ Plan 100	❑ $10,000 *(Minimum Requirement)*
❑ PPO $1,000	❑ Value $2,500	❑ $1,500 Annual Max	❑ Plan 150	❑ $20,000
❑ PPO $1,500	❑ Value $5,000	❑ $2,000 Annual Max	❑ Plan 100 V	❑ $25,000
❑ PPO $2,000	❑ HSA $2,500	❑ Orthodontia Rider	❑ Plan 150 V	❑ $30,000
❑ PPO $3,000	❑ HSA $6,550	❑ Decline All	❑ Decline All	❑ $50,000
❑ PPO $5,000				

Prescription Plan**	**LifeBalance Program**	**Voluntary Employee Life/ Accident Coverage**	**Life Eligibility Election (Must Choose One)**
❑ RX 1 ($15/$50/$200/$10/$30/$150)	❑ Elect	❑ Voluntary Employee Life	❑ All Eligible
❑ RX 2 (20% 30%/30%/40%/40%/50%)	❑ Decline	❑ Voluntary Accident	❑ Medical Enrollees Only
		❑ Decline All	

* All Medical Plans Include Complementary Care (Alternative Medical Care Coverage) and EAP benefits.
**Must choose one Rx plan.

Consumer Driven Health Products – If yes to any of the below options, please complete the appropriate BSI enrollment form(s).	
CDHP Election (Additional charge of $5.75/PEPM applies.)	❑ Flexible Spending Account (FSA) ❑ Health Reimbursement Account (HRA) ❑ Health Savings Account (HSA) ❑ Dependent Care Assistance Program (DCAP) ❑ Decline All
Premium Payment	
Premiums Will Be Paid By	❑ EFT – Draws on the 10th of the month (Please also complete EFT Authorization Form) ❑ Check (Requires additional 2% Fee)
Contribution and Eligibility	
Participation and Contribution Requirements	Minimum 75% of the eligible employees must enroll after valid waivers Minimum 50% employer contribution for employee coverage
Employer Contribution	Employee: _____ Dependent: _____ (% of Premium or $ Amount Allowed) If you contribute 100% to the employee premium, do you require all eligible employees to enroll? ❑ Yes ❑ No
Eligibility	Eligible Employees are required to work _____ hours per week. (Minimum Requirement: 17.5 hours per week, administered on a non-discriminatory basis, based on conditions of employment.) Other Eligibility Requirements: _____
Waiting Period	First of the month following: ❑ Date of Hire ❑ 30 Days ❑ 60 Days
Employee Count	Number of employees enrolling in the plan: _____ Number of employees offered coverage 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) : _____
COBRA	
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 BSI COBRA Administrative Agreement.) ❑ Yes ❑ No
Dollar Bank	
Dollar Bank	❑ Elect ❑ Decline If electing, please complete Dollar Bank Application in addition to this application (available on www.agchealthplansnw.com/AGCOR). Number of employees currently eligible per employer guidelines to enroll in this program: _____
Language and Enrollment Packets	
Primary Language (if not English)	
Enrollment Packets Needed for Open Enrollment	

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 Employer Group as a group account with the AGC Health Benefit Trust.
- ☑ We acknowledge that coverage is not in effect until the issuer accepts this application and risk, and AGC Health Benefit Trust provides us with an effective date of coverage, group number and rates.
- ☑ We understand the eligibility rules applicable to employee enrollment.
- ☑ If we offer wellness incentives, rewards or penalties in connection with group health coverage provided by the AGC Health Benefit Trust, we certify that any such incentives, rewards or penalties meet all applicable legal requirements.
- ☑ 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. Completed enrollment forms 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 Plan Contract/Group Policy with the Employer Group after untrue, incorrect, or incomplete information is discovered, and if as a result of correcting false information the Employer 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 Employer 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 that are a direct result of the misrepresentation.
- ☑ We understand premiums are prepaid and are due no later than the 10th day of each 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 Oregon - Columbia Chapter membership in good standing. **If AGC membership dues are not timely paid, your medical benefits will be terminated with 30 day notice upon of non-payment of membership dues to AGC Oregon-Columbia 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 requirements, 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: _____