DOLLAR BANK APPLICATION

Company Information			
Company Name:		Effective Date:	
Dollar Bank Contact Name:		Title:	
Address:			
Phone:		Fax:	
Email:			

Contribution and Eligibility Provisions		
Employer Contribution	Prevailing Wage Hours	Private Hours
Employee	$ /hour	$ /hour
Dependent	$ /hour	$ /hour
Waiting Period	First of the month following ☐ 130 hours ☐ 260 hours ☐ 390 hours	
Maximum Amount Allowed (months of premium)	☐ 6 ☐ 9 ☐ 12 ☐ 15 ☐ 18	

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

Documents Attached

Census of all employees enrolling in Dollar Bank. Please include employee name, SSN, benefit elections, date of hire, and 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.

Signature

Executed at _____ Date accepted _____

Signature of Authorized Employer Representative | Print Name | Title