Employer Application for Coverage

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):		
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
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 Vimly Benefit Solutions, Inc. to administer COBRA on terminating employees. (If yes, please complete a Vimly COBRA Administrative Agreement.) ☐ Yes ☐ No

Product Selection & Employer Contribution			
Dental Plan (provided by Delta Dental)	**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	☐ Elect
☐ $1,500 Annual Max	☐ VSP Signature $10/$25	☐ $20,000	☐ Decline
☐ $2,000 Annual Max	☐ Eye Med $10/$25	☐ $30,000	
☐ Orthodontia Rider	☐ Balanced Care Vision III	☐ $40,000	
☐ Decline All	☐ Decline All	☐ $50,000 *(Available to employers of 6+ employees)*	

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. Mid-year changes to eligibility provisions are subject to Trust and/or underwriting approval.

☑ 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 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 Name (Print/Sign): _____ Date: _____

Agency: _____