

Employer Application for Coverage

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):				
Mailing Address (street, city, state, zip):				
Phone:			Fax:	
Employer Tax ID Number (EIN):			Legal Domicile (state where company is headquartered):	
Organization Type: <input type="checkbox"/> C Corp <input type="checkbox"/> S Corp <input type="checkbox"/> Partnership <input type="checkbox"/> Individual/Sole Proprietor <input type="checkbox"/> Taxable Trust <input type="checkbox"/> Tax-exempt Trust <input type="checkbox"/> LLC – C Corp <input type="checkbox"/> LLC – S Corp				
AGC Membership Type: <input type="checkbox"/> General Contractor <input type="checkbox"/> Specialty Contractor <input type="checkbox"/> Associate		SIC Code:	Primary Business Activity:	
Benefits Administrator:		Phone:	Email:	
		Fax:		
Billing Contact (if different):		Phone:	Email:	
		Fax:		
Medical Product Selection (all medical plans provided by United Healthcare of Washington, Inc.)				
<input type="checkbox"/> Premier 250	<input type="checkbox"/> Preferred 1000	<input type="checkbox"/> Primary Advantage 2000	<input type="checkbox"/> Select Plus 500	<input type="checkbox"/> Navigate 500
<input type="checkbox"/> Premier 500	<input type="checkbox"/> Preferred 2000	<input type="checkbox"/> HSA 1500	<input type="checkbox"/> Select Plus 1000	<input type="checkbox"/> Navigate 1750
<input type="checkbox"/> Premier 1000	<input type="checkbox"/> Preferred 2500	<input type="checkbox"/> HSA 2000	<input type="checkbox"/> Select Plus 1500	<input type="checkbox"/> Navigate 2500
<input type="checkbox"/> Premier 1500	<input type="checkbox"/> Preferred 3000	<input type="checkbox"/> HSA 3500	<input type="checkbox"/> Select Plus 2000	<input type="checkbox"/> Navigate 3500
<input type="checkbox"/> Premier 2000	<input type="checkbox"/> Preferred 5000	<input type="checkbox"/> HSA 5000	<input type="checkbox"/> Select Plus 2500	
Ancillary Product Selection				
Group Dental <small>(provided by Delta Dental)</small>	Group Vision <small>(provided by Standard Insurance Company)</small>	Group Life/AD&D <small>(provided by UnitedHealthcare Insurance Company)</small>	Life/AD&D Eligibility Election	LifeBalance
<input type="checkbox"/> \$1,000 Annual Max	<input type="checkbox"/> Plan \$10/\$0	<input checked="" type="checkbox"/> \$10,000 (included in medical)	<input type="checkbox"/> All Eligible	<input type="checkbox"/> Elect
<input type="checkbox"/> \$1,500 Annual Max	<input type="checkbox"/> Plan \$10/\$25	<input type="checkbox"/> Additional \$10,000 (\$20,000 total)	<input type="checkbox"/> Medical Enrollees Only	<input type="checkbox"/> Decline
<input type="checkbox"/> \$2,000 Annual Max	<input type="checkbox"/> Plan \$10/\$0V (<i>Voluntary</i>)	<input type="checkbox"/> Additional \$20,000 (\$30,000 total)		
<input type="checkbox"/> Orthodontia Rider	<input type="checkbox"/> Plan \$10/\$25V (<i>Voluntary</i>)	<input type="checkbox"/> Additional \$30,000 (\$40,000 total)		
<input type="checkbox"/> Decline All	<input type="checkbox"/> Decline All	<input type="checkbox"/> Additional \$40,000 (\$50,000 total) <small>(Available to employers of 6+ employees)</small>		

Consumer Driven Health Products – If electing any of the below products, additional forms are required.

CDHP Election (Additional charge of \$6.50/PEPM applies.)	<input type="checkbox"/> Flexible Spending Account (FSA) <input type="checkbox"/> Health Reimbursement Account (HRA) <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Dependent Care Assistance Program (DCAP) <input type="checkbox"/> Decline All
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Premium Payment

Premiums Will Be Paid By	<input type="checkbox"/> EFT – Draws on the 10th of the month (Please also complete EFT Authorization Form) <input type="checkbox"/> Check (Requires additional 2% Fee)
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Contribution and Eligibility

Employer Contribution	Employee: _____ Dependent: _____ (% of Premium or \$ Amount Allowed)
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Eligibility	<i>Minimum Requirement: 20 hours per week, administered on a non-discriminatory basis, based on conditions of employment.</i> Eligible Employees are required to work _____ hours per week. Other Eligibility Requirements: _____
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Waiting Period	First of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days Waiting Period waived for initial enrollees: <input type="checkbox"/> Yes <input type="checkbox"/> No (Available for Initial Install only)
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Rehire Waiting Period	First of the month following: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days
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Eligibility Look Back Measurement/Stability Period	Has your company adopted a look back measurement/stability period under the ACA? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes
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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) : _____
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COBRA

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.) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Dollar Bank

Dollar Bank	<input type="checkbox"/> Elect <input type="checkbox"/> Decline Number of employees currently eligible per employer guidelines to enroll in this program: _____ An AGC Health Benefit Trust Dollar Bank Application is required in addition to this application.
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Language and Enrollment Packets

Primary Language (if not English)	
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Enrollment Packets Needed for Open Enrollment	
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Employer Statement and Signature

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 membership in good standing. **Your medical benefits will be terminated with 30-day notice upon notification of non-payment of membership dues to AGC of Washington or Inland Northwest AGC.**

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium, rates, and other purposes, and that any intentional misrepresentation, fraudulent statement, or omission that constitutes fraud may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

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.

In some instances, we pay brokers and agents (referred to collectively as “producers”) compensation for their services in connection with the sale of our products, in compliance with applicable law. We may pay “base commissions” based on factors such as product type, amount of premium, group/company size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be subject to disclosure on Schedule A of the ERISA Form5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

SIGNATURE & TITLE OF EMPLOYER REPRESENTATIVE

DATE

Producer 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: _____

UnitedHealthcare of Washington, Inc. – 1111 3rd Avenue, Suite 1100, Seattle, Washington 98101
UnitedHealthcare Insurance Company – 185 Asylum Street, Hartford, Connecticut 06103-3408
Delta Dental of Washington – PO Box 75688, Seattle, Washington 98175
Standard Insurance Company – 900 SW Fifth Avenue, Portland, Oregon 97204-1282