AGC Health Benefit Trust
OREGON COLUMBIA CHAPTER

Employer Application for Coverage

Company Information	
Requested Effective Date:	Anniversary Month:
Legal Name of Business:	
dba (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:

Medical & Prescription Product Selection (provided by UnitedHealthcare Insurance Company and UnitedHealthcare of Washington, Inc)
All medical and prescription plans are available to Oregon-domiciled employers. 'Advanced' plans are not available to Washington-domiciled employers.

❑ Premier 500	❑ Preferred 500	❑ Preferred 6000	❑ Advanced 500	❑ RX 1 ($10/$30/$50/$150)
❑ Premier 1000	❑ Preferred 1000	❑ HSA 2500 – RX 5 (30%/30%/30%/30%)	❑ Advanced 1000	❑ RX 2 ($15/$40/40%/40%)
❑ Premier 1500	❑ Preferred 2500	❑ HSA 2500 – RX 6 ($10/$35-$150/$70-$500)	❑ Advanced 2000	❑ RX 3 ($25/30%/40%/50%)
❑ Premier 2000	❑ Preferred 3500	❑ HSA 4500 – RX 5 (30%/30%/30%/30%)	❑ Advanced 3000	❑ RX 4 ($10/$35-$150/$70-$500)
❑ Premier 3000	❑ Preferred 5000	❑ HSA 4500 – RX 6 ($10/$35-$150/$70-$500)	❑ Advanced 5000	

Ancillary Product Selection

Group Dental (provided by Standard Insurance Company)	**Group Vision** (provided by Standard Insurance Company)	**Group Life/AD&D** (provided by UnitedHealthcare Insurance Company)	**Life/AD&D Eligibility Election**	**LifeBalance**
❑ $1,000 Annual Max	❑ Plan $100	☒ $10,000 *(included in medical)*	❑ All Eligible	❑ Elect
❑ $1,500 Annual Max	❑ Plan $150	❑ Additional $10K ($20,000 total)	❑ Medical Enrollees Only	❑ Decline
❑ $2,000 Annual Max	❑ Plan $100 *(Voluntary)*	❑ Additional $15K ($30,000 total)		
❑ Orthodontia Rider	❑ Plan $150 *(Voluntary)*	❑ Additional $20K ($40,000 total)		
❑ Decline All	❑ Decline All	❑ Additional $40K ($50,000 total)		

Consumer Driven Health Products – If electing any of the below products, additional forms are required.	
CDHP Election (Additional charge of $6.50/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	
Employer Contribution	Employee: _____ Dependent: _____ (% of Premium or $ Amount Allowed)
Eligibility	*Minimum Requirement: 17.5 hours per week, administered on a non-discriminatory basis, based on conditions of employment.* Eligible Employees are required to work _____ hours per week. Other Eligibility Requirements:
Waiting Period	First of the month following: ❑ Date of Hire ❑ 30 days ❑ 60 days Waiting Period waived for initial enrollees: ☐ Yes ☐ No (Available for Initial Install only)
Rehire Waiting Period	First of the month following: ❑ Date of Hire ❑ 30 days ❑ 60 days
Eligibility Look Back Measurement/Stability Period	Has your company adopted a look back measurement/stability period under the ACA? ❑ Yes ❑ 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: ❑ Yes
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): _____
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.) ❑ Yes ❑ No
Dollar Bank	
Dollar Bank	❑ Elect ❑ 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.
Language and Enrollment Packets	
Primary Language (if not English)	
Enrollment Packets Needed for Open Enrollment	

IMPORTANT INFORMATION – PLEASE READ

Sponsor – The undersigned Employer acknowledges and agrees that the Association of General Contractors of Oregon-Columbia Chapter is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. AGC may charge a service fee for services performed on behalf of Trust. Additionally, AGC may charge a membership fee for participating in the Trust. Membership fees are not used to provide health plan benefits and are not considered Trust or Plan assets. The undersigned Employer understands participation in AGC Health Benefit Trust requires AGC membership in good standing and benefits will be terminated with 30-day notice upon notification of non-payment of dues to AGC Oregon-Columbia Chapter.

Authority of Trustees – The undersigned Employer acknowledges and agrees that all Trustees appointed under the Trust Agreement shall have all rights and powers described here under and as set forth in the Trust Agreement.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trustees and the Sponsor from any and all loss, damages or liability incurred in the course and scope of their respective duties as described in this Agreement, except those resulting from their gross negligence, willful misconduct or dishonesty. In the event the Trustees or the Sponsor are made party to any legal proceeding of any kind or nature arising out of their respective duties hereunder, directly or indirectly, the undersigned Employer agrees to indemnify and hold them harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting there from. Any damages assessed or expenses required to be paid or incurred by reason of this indemnification shall be borne equally by all Member Companies, unless it shall be determined that the damages, expenses, or losses incurred result directly from the actions or inactions of a specific Member Company, its employees, or producers. In such event, that specific Member Company shall be primarily responsible for payment, with other Member Companies being responsible only in the event of the specific Member Company's inability by reason of financial insolvency to respond.

Third Party Administrator – The undersigned Employer agrees that the Trust may select one or more service providers to act as a third-party administrator ("TPA") for the Trust and/or the Welfare Benefits Plans, and that such service providers may be one or more of the Member Companies.

Changes – The undersigned Employer acknowledges that this Agreement may only be changed at contract renewal or as mutually agreed between the Employer and Trust, and subject to the insurance carrier's approval. The undersigned Employer agrees to notify the Trust when there is a change to the Employer's name, address, phone number, contact person, or ownership status.

Contributions – The undersigned Employer agrees to pay the contributions established by the Trust every month. Premiums are prepaid and due no later than the 10th day of each month. We understand the delinquency policies and termination process as outlined by AGC Health Benefit Trust. The undersigned Employer further understands and agrees that benefits for employees shall not be provided by the Trust during any month for which contributions are not paid.

Plan Documents and Notices – The undersigned Employer understands documents such as Certificates of Coverage, Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to Employers and/or to the Employer's employees.

Producers – The undersigned Employer acknowledges that it may hire a producer to represent the Employer when joining the Trust. The undersigned Employer authorizes the Trust to pay its producer a commission for its services in connection with the sale of our products, in compliance with applicable law. "Base commissions" are 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. Producer commissions received by the Trust shall not be used to provide Plan benefits and are not considered Trust or Plan assets. In addition, the Trust 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.

Termination – This Adoption Agreement may be terminated by the undersigned Employer, which may withdraw from participation in the Trust by giving thirty (30) days written notice of intent to withdraw to the Trustees in accordance with the Trust Agreement. Such Member Company shall have the rights and duties specified therein. This Agreement may be terminated by the Trust, in the event that the undersigned Employer (a) shall fail or refuse to pay contributions due to the Trust in accordance with the Trust Agreement, or (b) shall be in breach of any of its other obligations under the Trust Agreement of this Adoption Agreement, which breach shall not have been cured within ten (10) days after the undersigned Employer receipt of written notice thereof.

Governing Law – This Agreement shall be construed and enforced in accordance with ERISA and, to the extent applicable, the laws of the State of Oregon.

Employer Statement & Signature

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 AGC Health Benefit Trust and its contracted service providers will rely on the information provided to determine eligibility for coverage, setting premium, 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.

Employer Signature:	Date:
Printed Name:	Title:

Producer Statement & Signature

I certify:

- All information contained in this application is correct to the best of my knowledge and 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.

I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be offered.

Producer Signature:	Date:
Producer Name:	Agency:
Agency Address:	
Producer Phone:	Producer Email:

Coverage and benefits underwritten and administered by:

UnitedHealthcare Insurance Company - 185 Asylum Street, Hartford, CT 06103-0450
UnitedHealthcare of Washington, Inc. - 1111 3rd Avenue Suite 1100 Seattle, WA 98101
UnitedHealthcare Insurance Company – 185 Asylum Street, Hartford, CT 06103-3408
Standard Insurance Company – 900 SW Fifth Avenue, Portland, Oregon 97204-1282