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:
❑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 Product Selection (all medical plans provided by United Healthcare of Washington, Inc.)

❑ Premier 250	❑ Preferred 1000	❑ Primary Advantage 2000	❑ Nexus 500	❑ Navigate 500
❑ Premier 500	❑ Preferred 2000	❑ HSA 1500	❑ Nexus 1000	❑ Navigate 1750
❑ Premier 1000	❑ Preferred 2500	❑ HSA 2000	❑ Nexus 1500	❑ Navigate 2500
❑ Premier 1500	❑ Preferred 3000	❑ HSA 3500	❑ Nexus 2000	❑ Navigate 3500
❑ Premier 2000	❑ Preferred 5000	❑ HSA 5000	❑ Nexus 2500	

Ancillary Product Selection

Group Dental (provided by Delta Dental)	**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 $10/$0	☒ $10,000 (included in medical)	❑ All Eligible	❑ Elect
❑ $1,500 Annual Max	❑ Plan $10/$25	❑ Additional $10,000 ($20,000 total)	❑ Medical Enrollees Only	❑ Decline
❑ $2,000 Annual Max	❑ Plan $10/$0V *(Voluntary)*	❑ Additional $20,000 ($30,000 total)		
❑ Orthodontia Rider	❑ Plan $10/$25V *(Voluntary)*	❑ Additional $30,000 ($40,000 total)		
❑ Decline All	❑ Decline All	❑ Additional $40,000 ($50,000 total) *(Available to employers of 6+ employees)*		

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: 20 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	

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, Harford, Connecticut 06103-3408
Delta Dental of Washington – PO Box 75688, Seattle, Washington 98175
Standard Insurance Company – 900 SW Fifth Avenue, Portland, Oregon 97204-1282