



# AGC SECURITY PLAN 2010-11 RENEWAL APPLICATION

*Please Fax or Email Completed Applications to the AGC Service Center:  
Fax: (866)999-3485 Email: agcak@thincservice.com*

## COMPANY INFORMATION

|                   |   |
|-------------------|---|
| Legal Name: _____ | Renewal Date: _____   |
| Address: _____    | EIN: _____  |
| City: _____       | SIC: _____  |
| ST: _____         | Group No: _____   |
| ZIP: _____        | Rate Level: _____   |
| Contact: _____    | <b>IMPORTANT:</b> Please provide your physical address if different from your mailing address:<br><br>Street: _____<br><br>City: _____<br><br>State: _____ ZIP: _____ |
| Title: _____      |   |
| Phone: _____      |   |
| Fax: _____        |   |
| E-mail: _____     |   |

## PARTICIPATION / ELIGIBILITY PROVISIONS

**PLEASE NOTE: YOU MUST COMPLETE ALL QUESTIONS IN THIS SECTION**

The Employer must employ at least two eligible employees and must meet the definition of a business under Alaska state law. All enrolled employees must have a bona fide employee relationship with the Employer Group. If the employer requires employees to contribute to the employee-only premium, a minimum of 75% of all employees must enroll in the plan. An enrollment form indicating waiver must be submitted for all employees and dependents declining coverage. If the employer contributes 100% of the employee-only premium, 100% of eligible employees must enroll in the plan. The employer must contribute at least 75% of the cost of the employee-only coverage. Eligible employees must be regular, full-time employees, as defined on the application. Employees must enroll within 31 days of eligibility. **Eligibility provisions may only be changed at annual contract renewal.**

|  | <u>Current Plan Year Choices</u> | <u>Renewal Choices</u> |
|--|----------------------------------|------------------------|
| <i>Eligible Employees must work a minimum of:</i><br>(Must be between 20 and 40 hours)   | _____                            | _____                  |
| <i>Probationary Period - First of month following:</i><br>(Options: date of hire, 30, 60, 90, 180, or 365 days)                        | _____                            | _____                  |
| <i>Rehire Provision - Former employees do not have to repeat the probationary period if rehired within:</i><br>(Options: 0 – 6 months) | _____                            | _____                  |
| <i>Contribution to Employee Premium:</i><br>(Options: 75-100%)   | _____                            | _____                  |
| <i>Contribution to Dependent Premium:</i><br>(Options: 0-100%)   | _____                            | _____                  |

|  |  |
|--|--|
| Total number of employees: _____                               | Eligible Employees <b>not</b> enrolling due to |
| Number of employees eligible per these guidelines: _____       | Other Group Coverage: _____                    |
| Number of employees enrolling: _____                           | Government Coverage: _____                     |
| Number of early retirees*: _____                               | Union Plan: _____                              |
| (For early retirees – see Contract definition and limitations) | No other coverage: _____                       |
| Number of employees working outside Alaska*: _____             | Individual coverage: _____                     |

*\*Please list early retirees and out of area employees on next page*

## PARTICIPATION / ELIGIBILITY PROVISIONS (cont'd)

Please list early retirees:

Please list Name/State of those working outside Alaska:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## RENEWAL PLAN CHOICES

**Current Plans:** \_\_\_\_\_

**Medical Plan Options**  
**(Includes \$10K Life)**

Classic 250

Classic 500

Frontier 750

Frontier 1000

Frontier 1500

Frontier 2000

Frontier 2500

Envoy 3000

Envoy 5000

Frontier HSA 2500

Frontier HSA 5000

**Dental Plan Options**

\$2000 Max

\$1500 Max

\$1000 Max

**Vision Plan Options**

VSP \$0 / \$10

VSP \$10 / \$25

**Rates** \*\*

*Please enter renewal rates from your renewal proposal for your choices here:*

|  |                |               |               |
|--|----------------|---------------|---------------|
|  | <u>Medical</u> | <u>Dental</u> | <u>Vision</u> |
|--|----------------|---------------|---------------|

EE

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| _____ | _____ | _____ |
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E+S

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| _____ | _____ | _____ |
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E+Fam

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| _____ | _____ | _____ |
|-------|-------|-------|

E+Ch(rn)

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
|-------|-------|-------|

\*\* Actual billed rates may vary within 2 cents.

**Life & STD Enrollment Election (Must Choose One)**

Medical Enrollees Only

All Eligible

**Life and STD Buy-Up Options**

**\*\*\* Lifewise Additional Life**

Add'l \$10K - \$2.88

Add'l \$20K - \$5.76

Add'l \$30K - \$8.64

Add'l \$40K - \$11.52

**Short-Term Disability**

\$300 - \$9.33

\$500 - \$15.55

\*\*\* Available only to Groups of 10 or more Eligible Employees

## FEDERAL REQUIREMENTS

**Helpful Hint:** We strongly urge you to consult legal counsel in answering the questions below. The summaries below are not intended to be or to replace legal advice on your particular group. It is the group's responsibility to inform the AGC Security Plan immediately if facts change which would cause the group's answers below to change.

Your group is subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a spouse's) current employment status who have Medicare due to age or disability. If you have less than 20 employees, and have retirement aged employees, have you submitted an exemption letter and received approval?

Yes.

No. Please provide an exemption letter per instructions on the thincservice.com website.

**Helpful Hint:** The following is an explanation of TEFRA AND THE MEDICARE SECONDARY PAYER RULES. **This is important to you if you have any employees or employee spouses age 65 or older on the AGC Health Plan.** Your AGC Health Plan must pay Medicare recipients as primary unless you take the action instructed in this explanation. In order to avoid potential impact to your group's medical rates, you must take action to have Medicare pay primary. **You must return a letter using the sample provided along with an attachment that lists all employees and/or dependent spouses age 65 or older.** You must do this if you had less than 20 employees for each working day in each of 20 or more calendar weeks (not necessarily consecutive) in the current calendar year or the preceding calendar year. This count must include all fulltime, part-time, employees on disability benefits (up to six months following termination of employment) and leased employees. Also, if applicable, you must include all employees of all affiliated businesses owned by a common entity.

Is the group subject to COBRA?

Yes.

No. Give the legal reason for exemption: \_\_\_\_\_

**Helpful Hint:** Generally, these laws apply to any non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year. "Employees" are full-time and part-time common-law employees. Self-employed workers as defined in IRC §401(c)(1), corporate directors, or independent contractors should not be counted unless they qualify as common-law employees. "Employees" may also include leased employees who qualify as common-law employees. Please see COBRA regulations at 26 CFR § 54.4980B-2 Q/A 5 for guidance on counting a part-time employee as a fraction of a full-time employee.

Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a family member's) current employment status who have Medicare due to disability?

Yes. This plan will pay primary to Medicare as required by federal law. Please also provide the number of employees who now meet Medicare's definition of "employee." \_\_\_\_\_

No. Under 100 employees:

**Helpful Hint:** Generally, these laws apply to any employer that employed at least 100 employees on 50% or more of its working days in the preceding calendar year.

## 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. Coverage's, 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: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## EMPLOYER STATEMENT

- This application becomes a part of the contract to provide health care coverage after:
  - The application is signed by you;
  - The application is received and approved by us; and
  - We receive the initial month's premium.
- We understand the eligibility rules applicable to employee enrollment.
- We understand premiums are prepaid and due no later than the tenth day of each month.
- We certify that we have received a fully completed and unaltered Enrollment and Change 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 Premera or the AGC Security Plan upon request.
- 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.

- There will be one open enrollment period per contract year 30 days prior to the renewal effective date.
- We authorize our AGC appointed agent to access information relative to this plan via the AGC website using a username and password.

I have read, understood, and agreed to the statements above. This Agreement consisting of the Plan Contract/Group Policy as supplemented by this Application has been entered into between the AGC Security Plan / Premera Blue Cross Blue Shield of Alaska 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.

Executed at \_\_\_\_\_ Date accepted \_\_\_\_\_  
(City, ST)

\_\_\_\_\_  
Signature of Authorized Employer Group Representative                      Print Name                      Title