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 (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.) 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)
Re-hire 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	All employer groups enrolled with AGC Health Benefit Trust are subject to COBRA. Please indicate if you would like to authorize Benefit Solutions, Inc. to administer COBRA on terminating employees. (If yes, please complete a BSI COBRA Administrative Agreement.) ☐ Yes ☐ No
Dollar Bank	☐ Elect ☐ Decline Number of employees currently eligible per employer guidelines to enroll in this program: _____ Please complete Dollar Bank Application in addition to this application (available on www.agchealthplansnw.com/waadmin.htm).

Product Selection & Employer Contribution

Medical Plan* (provided by United Healthcare of Washington, Inc.) * All medical plans include the required minimum $10K Life/AD&D benefit.	**Plan Type**	**Deductible**	**Medical Plan Election**	**Employer Contribution**	
				Employee (% or $ Amount)	**Dependent (% or $ Amount)**
Choice Plus Premier 250	Flat Copay	$250	☐		
Choice Plus Premier 500	Flat Copay	$500	☐		
Choice Plus Premier 1000	Flat Copay	$1,000	☐		
Choice Plus Premier 1500	Flat Copay	$1,500	☐		
Choice Plus Preferred 1000	Split Copay	$1,000	☐		
Choice Plus Preferred 2000	Split Copay	$2,000	☐		
Choice Plus Preferred 3000	Split Copay	$3,000	☐		
Choice Plus Preferred 5000	Split Copay	$5,000	☐		
Choice Plus HSA 1500	HSA	$1,500	☐		
Choice Plus HSA 3500	HSA	$3,500	☐		
Charter 500	Charter	$500	☐		
Charter 1000	Charter	$1,000	☐		
Charter 1750	Charter	$1,750	☐		
Charter 2500	Charter	$2,500	☐		
Charter 3500	Charter	$3,500	☐		
Navigate 500	Navigate	$500	☐		
Navigate 1000	Navigate	$1,000	☐		
Navigate 1750	Navigate	$1,750	☐		
Navigate 2500	Navigate	$2,500	☐		
Navigate 3500	Navigate	$3,500	☐		

Dental Plan (provided by Standard Insurance Company)	**Vision Plan** (provided by Standard Insurance Company.)		**Group Life/AD&D** (provided by UnitedHealthcare Insurance Company)	**Life/AD&D Eligibility Election**	**LifeBalance**
	Contributory	**Voluntary**			
☐ $1,000 Annual Max	☐ Plan $10/$0	☐ Plan $10/$0V	☒ $10,000 (included in medical)		
☐ $1,500 Annual Max	☐ Plan $10/$25	☐ Plan $10/$25V	☐ Additional $10,000 ($20,000 total)	☐ All Eligible	☐ Elect
☐ $2,000 Annual Max	☐ Decline All		☐ Additional $20,000 ($30,000 total)	☐ Medical Enrollees Only	☐ Decline
☐ Orthodontia Rider			☐ Additional $30,000 ($40,000 total)		
☐ Decline All			☐ Additional $40,000 ($50,000 total)		

CDHP Election (Additional charge of $5.75/PEPM applies. Enrollment forms are required.)	☐ Flexible Spending Account (FSA) ☐ Health Savings Account (HSA) ☐ Health Reimbursement Account (HRA) ☐ Dependent Care Assistance Program (DCAP) ☐ Decline All

Section 125 (POP) Account (Additional fee applies: $150/first year and $100 for subsequent years. Includes annual discrimination testing.)	☐ Elect ☐ Decline
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. 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.

Producer Signature: _____Date: _____

Producer 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
Standard Insurance Company – 900 SW Fifth Avenue, Portland, Oregon 97204-1282