cbia health connections

# EMPLOYER PARTICIPATION AGREEMENT

## Non-Medical Benefits

check one: ❑ New Group ❑ Change Group Number _____

## 1 COMPANY INFORMATION

| | | |
|---|---|---|
| Company Name | | Company Phone Number ( )<br>Company Fax Number ( ) |
| Address (Street) | P.O. Box | City, State ZIP Code |
| Benefits Administrator | Benefits Administrator Email Address | Taxpayer Identification Number: |
| Employer Contribution Toward Group Benefits<br>Life _____% Dental _____% LTD _____% STD _____% | Effective date of Coverage (Subject to Approval by CBIA Health Connections) | SIC Code |

Current Medical Carrier: _____ Date of policy termination: _____

Current Dental Carrier: _____ Date of policy termination: _____ (Attach proof of prior dental coverage)

## 2 ELIGIBILITY

Eligibility period:
Coverage begins first of the month following ❑ 30 ❑ 60 days

Eligibility for coverage:
❑ 30 or more hrs/wk ❑ 20 - 29 hrs/wk; Specify number of hours: _____

## 3 EMPLOYER VERIFICATION

**Information for Current Calendar Year**

- Number of full-time equivalent employees_____
- Number of employees eligible for coverage_____
- Number of COBRA individuals_____
- Number of approved waivers_____
- Number of retirees_____
- Number of employees not actively at work (excluding vacations)_____
- Is your company part of or affiliated with another company AND eligible to file a combined tax return under Chapter 208? ❑ Yes ❑ No
  If yes, name of affiliated company _____ Number of employees at affiliated company_____

**Information for Prior Calendar Year (for COBRA/State Continuation)**

- Did your company have 20 or more employees on more than 50 percent of its typical business days in the previous calendar year? ❑ Yes ❑ No

  *When determining your group size, count each full-time employee as one, and each part-time employee as a fraction of a full-time employee, with the fraction equal to the number of hours worked divided by the hours an employee must work to be considered full time.*

- If you answered No, do you choose to offer continuation? ❑ Yes ❑ No
- Would you like CBIA to administer your group's continuation? ❑ Yes ❑ No
  If yes, separate form is required.

## 4 BENEFIT ELECTIONS. See marketing materials for benefit options available by group size.

**A copy of the sold proposal for Life and Disability benefits must be signed and attached.**

☐ Group Basic Life
☐ Supplemental Life (3 to 9 eligible employees)
☐ Voluntary Life (10+ eligible employees)
☐ Voluntary Dependent Life (10+ eligible employees)

☐ Dental
- ☐ Group
- ☐ Voluntary

☐ Voluntary Vision - select one
- ☐ 12/12/12
- ☐ 12/12/24

☐ Voluntary Accident & Illness Benefits

☐ Short-term Disability* - select one
- ☐ Group
- ☐ Voluntary

☐ Long-term Disability* - select one
- ☐ Group
- ☐ Voluntary

Note: LTD is not available to employees who work fewer than 30 hours per week.

* If electing STD or LTD coverage an original completed Tax Service Agreement must be submitted. Separate Tax Service Agreements are required if electing both STD and LTD coverage.

**Additional No-cost Services**

Separate forms are required to set up each of these services.

☐ CBIA COBRA Administration

☐ Identity Theft Protection
- ☐ Employer paid
  - ☐ Gold ☐ Platinum
  - ☐ Employee only ☐ Employee & family
- ☐ Employee paid

**5** **RETIRED EMPLOYEES—**A retired employee is defined as a former employee who is age 65 or older and worked for your company as a full time employee for a minimum of 10 years and was retired by your company. Coverage is not available to retirees under age 65.

Are you selecting retiree coverage? ❑ Yes ❑ No

Check the retiree group you are selecting coverage for: ❑ Existing and future retired employees ❑ Existing only ❑ Future only

Check all the retiree coverages you are applying for: ❑ Dental ❑ Group Basic Life (AD&D discontinued at retirement) ❑ Voluntary Dental ❑ Voluntary Vision

Retirees are only eligible for coverage in Medicare plans offered in CBIA Health Connections.

**6** **PARTICIPATION AND CONTRIBUTION GUIDELINES AND OTHER IMPORTANT INFORMATION**

The undersigned employer attests that it meets and will abide by all of the following participation requirements:

- The undersigned employer is a member of the Connecticut Business & Industry Association (CBIA) and will renew membership annually.
- The undersigned employer is a firm, corporation, partnership or association that has been actively engaged in business for at least three consecutive months.
- The undersigned employer acknowledges that an active eligible employee is an employee who works more than 30 hours per week. Some employers may also wish to provide cover-age to employees who work 20-29 hours per week.
- A minimum of 50% of the full-time eligible employees enrolling in the CBIA Health Connections program work/reside in Connecticut.
- The undersigned employer must meet a minimum of 100% participation for all coverages that are non-contributory, whereby the employer pays 100% of the premiums.
- The undersigned employer understands that there are separate participation requirements for voluntary coverages:

  Employers with nine (9) or fewer employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of three (3) enrolled employees.
  - Voluntary Dental, Vision & Accident and Illness have a requirement of two (2) lines of coverage offered by CBIA Health Connections and three (3) employees enrolled in one line of coverage.
  - Supplemental Life does not have a minimum participation requirement; The employee must be also be enrolled in basic life coverage.

  Employers with 10 to 50 employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of three (3) enrolled employees.
  - Voluntary Dental, Vision, and Accident and Illness have a requirement of one (1) line of coverage and three (3) employees enrolled for coverage.
  - Supplemental Life is not available.

  Employers with 51 or more employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of ten (10) enrolled employees.
  - Voluntary Dental, Vision, and Accident and Illness have a requirement of one (1) line of coverage and three (3) employees enrolled for coverage.
  - Supplemental Life is not available.
- The undersigned employer has a place of business in Connecticut.
- The undersigned Employer agrees to provide annual certification of continued adherence to the Program participation requirements listed here.
- One hundred percent (100%) of the eligible employees enrolling in the Program are covered by Workers' Compensation insurance, except those eligible employees who are not legally required to be covered by Workers' Compensation insurance.
- The undersigned employer agrees to give a minimum 15-days advance written notification to CBIA Service Corporation if it wants to cancel any coverages. Otherwise, it will be liable for the premium or applicable charges until the termination of its participation in the Program.
- The undersigned employer agrees that reinstatement after cancellation for non-payment (including NSF payments) can only occur two (2) times during a rolling twelve (12) month period.

## 7 AGENT INFORMATION

I designate Agent of Record as: | Agency

Address (Street) | Address (City, State, ZIP Code)

The undersigned agent attests they are individually, and the applicable commissionable agent, are duly licensed and have the required training and appointments with the appropriate government agency, authority, and carrier(s) to solicit enrollment of qualified employees or former employees of an employer participating in CBIA Health Connections. The agent of record represents that he/she is authorized to execute this Agreement on behalf of the commissionable agent.

Commissions payable to:

Address (if different from above) | Telephone

Tax Identification number (if commissions are being paid to the agency) | Social Security Number (if commissions are being paid to the agent)

The undersigned agent of record and/or commissionable agent agrees that commissions shall only be paid to agents of records/commissionable agents that are properly licensed with government authorities and appointed with applicable carrier(s). In the event CBIA Service Corporation is assigned commissions due to lack of proper license/appointment all relevant parties acknowledge and agree the relationship is strictly limited to commission and no advice regarding any product was provided.

Agent of Record: Print Name | Agent of Record: Signature

## 8 AUTHORIZATIONS AND ATTESTATIONS

In consideration of the promises and mutual covenants herein contained and other good and valuable consideration, the sufficiency of which is hereby acknowledged, it is mutually covenanted and agreed by and between the parties as follows:

The undersigned employer hereby covenants that it meets the Participation Requirements set forth in Section 6 of this Agreement. If accepted as a participating employer in the CBIA Health Connections program (Program), it agrees to be bound by all provisions and amendments of applicable participating carriers' Group Service Agreements and the CBIA Health Connections Administration Manual.

The undersigned employer agrees to pay monthly premiums or applicable charges to CBIA Service Corporation in advance, along with any applicable fees, for coverage provided or administered by carriers who participate in the Program (Participating Carriers). It understands that CBIA Service Corporation accepts payments for insured coverage as an agent of Participating Carriers.

The undersigned employer acknowledges that CBIA Service Corporation is not an insurer or carrier and is not liable for payment of benefits.

The undersigned employer acknowledges that coverage will automatically renew unless a notice of termination is provided.

I hereby attest to the accuracy and truthfulness of the information provided, and I agree to comply with the above provisions.

Owner/Officer of the Company - print name | Witness (Agent) - print name

Owner/Officer signature | Date | Witness (Agent) signature | Date

Company Name

Street Address

City, State ZIP

Owner/Officer email address

CBIA Service Corporation accepts the undersigned employer as a Participating Employer in the Program. It agrees to enroll designated eligible employees and dependents for coverage(s), and to forward premium or applicable charges received for coverage(s) to designated Participating Carriers.

Authorized CBIA Service Corporation signature | Date