CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

EMPLOYER PARTICIPATION AGREEMENT

check one: ❑ New Group ❑ Change Group Number _____

3-50 EMPLOYEES

1 COMPANY INFORMATION

Company Name | Company Phone Number ( ) | 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
Medical _____% 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 or more hrs/wk

3 CONNECTICUT SMALL EMPLOYER HEALTH INSURANCE VERIFICATION (For employers with 50 or fewer full-time equivalent employees)

In order to comply with Connecticut Public Act 90-134 effective 5/1/91, you must qualify as a small employer.

- Average number of full-time equivalent employees in 2017:_____

Current

- Number of eligible employees:_____
  - Number of employees working 30+ hours per week:_____
  - Number of employees working 20+ hours per week:_____
- Number of individuals on COBRA: _____
- Number of employees not actively at work (excluding vacations): _____
- Number of approved waivers: _____
- Number of retirees: _____

- Do more than 50% of your employees work in Connecticut? ❑ Yes ❑ No
- 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 affliliated company: _____
  Number of employees at affilated company: _____
- Does your company have more than one location? ❑ Yes ❑ No
  If yes, how many locations? _____
  Where are they located? _____

Did your business have 20 or more total employees (including full-time, owners, and partners, excluding retirees and COBRA enrollees) in all locations for 20 or more calendar weeks of calendar year 2017? ❑ Yes ❑ No

Did your business have 100 or more total employees (including full-time, owners, and partners, excluding retirees and COBRA enrollees) in all locations for 50% or more calendar weeks of calendar year 2017? ❑ Yes ❑ No

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.

❑ **Medical**

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

Additional No-cost Services

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

❑ CBIA COBRA Administration
❑ CBIA HRA Administration
❑ CBIA Healthy Connections Wellness Program

❑ **Group Dental** Prior dental coverage? ❑ Yes ❑ No
❑ 10+ eligible employees; with orthodontia? ❑ Yes ❑ No
❑ 3 to 9 eligible employees (orthodontia not available)

❑ **Voluntary Dental**

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

❑ **Voluntary Vision** - select one
❑ 12/12/12 ❑ 12/12/24

❑ **Voluntary Accident & Illness Benefits**

❑ **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.**

5 RETIRED EMPLOYEES

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: ❑ Medical ❑ 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 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 and also specifically into a Medicare Advantage with Prescription Drug "MAPD" Plan. 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

7 PARTICIPATION REQUIREMENTS

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

- The undersigned employer is a small employer as defined in Connecticut Public Act 90-134.
- The undersigned employer is, or will become, 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 wish to provide coverage 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 in Connecticut.
- The undersigned employer employs a minimum of three (3) full-time active eligible employees and not more than 50 full-time equivalent employees in the preceding calendar year.
- The undersigned employer must maintain a minimum of three (3) active full-time eligible employees participating in all offered Group lines of coverage at all times. If there are less than three (3) active full-time employees enrolled in any Group line of coverage, that line of coverage will not be renewed.
- The undersigned employer must meet a minimum of 75% participation of eligible employees. Valid waivers can be excluded from the calculation for medical and dental coverage.
- 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 3-9 employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of 3 employees.
  - Voluntary Dental, Vision & Accident and Illness have a requirement of 2 lines of coverage offered by CBIA Health Connections and 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 or more employees:
  - Voluntary Life, Short Term Disability and Long Term Disability have a minimum participation requirement of 3 employees.
  - Voluntary Dental, Vision, and Accident and Illness have a requirement of 1 line of coverage and 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 will contribute an amount equal to at least fifty percent (50%) of the lowest monthly employee-only medical rate for each employee based on age.
- The undersigned employer will maintain Basic Group Life insurance through CBIA Health Connections for all medical enrollees.
- 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 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.
- Employers with three (3) to nine (9) eligible employees must enroll and maintain a minimum of two (2) lines of coverage.

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 7 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. It acknowledges that it is the plan administrator and sponsor for its employees' health benefit plan and that it is responsible for complying with applicable provisions of federal ERISA, COBRA, and HIPAA laws.

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

The undersigned employer acknowledges that by their signature and participation in Health Connections they are contracting with ConnectiCare, Inc, its affiliates, subsidiaries and successor corporations (CCI) to provide Medicare Advantage with Prescription Drug "MAPD" coverage to their Medicare Eligible employees or retirees as permitted by the Centers for Medicare and Medicaid Services (CMS) effective on the effective date of coverage set forth in this agreement. The undersigned employer is also agreeing to the terms and conditions contained in the ConnectiCare Medicare Advantage Group Agreement which can be found at cbia.com/medicare.

Should any information furnished by the Owner/Officer/Employee of the undersigned employer be a misrepresentation or fraudulent, CBIA Service Corporation may rescind enrollment for coverage(s) back to the date of this Agreement.

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	Witness (Agent) signature
Date	Date
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 received for coverage(s) to designated Participating Carriers.

Authorized CBIA Service Corporation signature	Date