CBIA HEALTH CONNECTIONS
THE POWER OF CHOICE

EMPLOYER PARTICIPATION AGREEMENT

51+ EMPLOYEES

check one: ❑ New Group ❑ Change Group Number ___________

1 COMPANY INFORMATION

Company Name			Effective date of Coverage (Subject to approval by CBIA Health Connections)
Address (Street)	P.O. Box	City, State ZIP Code	
Company Phone Number ( )	Company Fax Number ( )	Taxpayer Identification Number:	
Benefits Administrator	Benefits Administrator Email Address	SIC Code	

2 ELIGIBILITY

Eligibility period:
Coverage begins first of the month following _______ days of employment.

Eligibility for coverage:
❑ 30 or more hrs/wk ❑ 20 or more hrs/wk

Number of eligible employees who work 30+ hours per week ________.
Number of eligible employees who work 20 - 29 hours per week ________.
Number of eligible employees who are not actively at work (excluding vacations) ________.
Number of retirees ________.

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

❑ **Group Basic Life**
- ❑ Contributory ❑ Non-contributory

❑ **Voluntary Life**
❑ **Voluntary Dependent Life**
❑ **Voluntary Dental**
❑ **Voluntary Vision - select one**
- ❑ 12/12/12 ❑ 12/12/24

Additional No-cost Services

Separate forms are required to set up each of these services.
❑ CBIA COBRA Administration
❑ CBIA Healthy Connections Wellness Program

❑ **Short-term Disability*** - select one
- ❑ Group
  - ❑ Contributory ❑ Non-contributory
- ❑ Voluntary

❑ **Long-term Disability*** - select one
- ❑ Group
  - ❑ Contributory ❑ Non-contributory
- ❑ 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.**

4 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: ❑ Voluntary Dental ❑ Voluntary Vision ❑ Group Basic Life

5 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 a 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

Continued on reverse

6 PARTICIPATION REQUIREMENTS

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

- The undersigned employer is, or will become, a member of the Connecticut Business & Industry Association (CBIA) and will renew membership annually.
- The undersigned employer agrees to provide annual certification of continued adherence to the CBIA Health Connections program (Program) participation requirements listed here.
- The undersigned employer employs more than 50 eligible employees.
- The undersigned employer has a place of business in Connecticut.
- 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 that reinstatement after cancellation for non-payment (including NSF payments) can only occur two (2) times during a rolling twelve (12) month period.
- 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 understands that a minimum of 10 employees must enroll in Voluntary Life, Voluntary STD, and Voluntary LTD insurance.
- The undersigned employer understands that a minimum of 75% of eligible employees must enroll in Group Life, Group STD, and Group LTD insurance.
- 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.

7 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 Employer 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.

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