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 Percentage
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 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.

Prior Year

- Number of full-time equivalent employees:_____

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 affiliated 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? _____

3 ELIGIBILITY

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

Eligibility for coverage:
❑ 20 - 29 hrs/wk ❑ 30 or more hrs/wk

4 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: ❑ Health ❑ Dental ❑ Life (AD&D Discontinued at Retirement) ❑ Voluntary Dental ❑ Voluntary Vision

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

5 PLAN OF BENEFITS. See marketing materials for benefit options available by group size.

(check one for each coverage you are applying for)

❑ **Medical**

Life (Attach a copy of quote):
❑ Flat amount $_____
❑ _____ times salary to max. amt: $_____
❑ Other: _____
Reduction: 35% at age 65; 50% of original amount at age 70
❑ Other: _____

❑ **Supplemental Life**
Reduction: 35% at age 65; 50% of original amount at age 70
Note: Retirees are not eligible for supplemental life insurance

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

Vision
❑ 12/12/12 ❑ 12/12/24

Long-term Disability* (Attach a copy of quote):
❑ 90-day elim. period ❑ 180-day elim. period
❑ 50% ❑ 60% ❑ 66-2/3% to max of: $_____
❑ Other: _____

Short-term Disability* (Attach a copy of quote):
❑ _____ %
❑ 1-8-13 ❑ 1-8-26
❑ 8-8-13 ❑ 8-8-26 max. amount: $_____
❑ Other: _____

Additional No-cost Services
❑ COBRA/State Continuation Administration
❑ HRA Administration
❑ Wellness Program
Separate forms are required to set-up of each of these services.

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

Continued on reverse

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).

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.
- A minimum of 50% of the full-time eligible employees enrolling in the CBIA Health Connections program (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 active full-time eligible employees participating in all offered lines of coverage at all times. If there are less than three active full-time employees enrolled in any line of coverage, that line of coverage will not be renewed. This enrollment requirement is not applicable to Voluntary lines coverage.
- At least 75% of the undersigned employer's eligible employees are enrolling in the Program unless the undersigned employer contributes 100% of the eligible Employees premium in which case 100% of the eligible employees are to be enrolled in the Program unless the employee has completed an approved waiver. This requirement is not applicable to Voluntary lines of coverage.
- The undersigned employer has a place of business in Connecticut.
- The undersigned Employer agrees to provide annual certification of continued adherence to the CBIA Health Connections 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. This requirement is not applicable to Voluntary lines of coverage.
- The undersigned employer will maintain 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.
- Groups 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 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 CBIA Health Connections 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