Employer's Request for Participation Agreement (PA) & Employer's Statement

Exchange/Association:

☐ California Groundwater Assoc. ☐ California Tow Truck Assoc. ☐ Central Calif. ☐ Central Coast ☐ Kern ☐ Santa Clara
☐ Shasta ☐ Stockton ☐ Ventura ☐ Valley Contractors Exchange ☐ Other_____

The Undersigned Employer requests participation in the above named Exchange/Association's Insurance Program, elects the Plan of Benefits shown, and hereby adopts and agrees to be bound by the terms and provisions of the Program and Administration Agreement establishing such Program.

1. Full Legal Name of Firm (including DBA, name must match company's membership name)

2. Billing Address

3. Physical Address (if different from above)

4. Phone	**5. Fax**	**6. Federal Tax ID# (FEIN) REQUIRED**	**7. SIC/NAICS Code**

8. List all contacts to whom administrator is authorized to speak to (later updates to this must be in writing)

	Contact Name	**Title**	**Email**
Company Owner/Officer:			
Administrative Contact:			
Billing Contact:			
Online Account Access [1]			

Do you authorize your broker, Q&A Insurance Marketing, to have access to your online account? ☐ Yes ☐ No

[1] *If you are interested in establishing an online account with the Plan Administrator, Vimly Benefit Solutions, please designate and provide the contact information for your group online administrator above.*

10. Employer is a:

(Check one box in each column. Refer to your benefit book for eligibility requirements.)

☐ **Sole Proprietor without Employees**
Attach a copy of your most recent IRS 1040 Schedule C, Fictitious Business Name Filing, or California Business License.

☐ **Sole Proprietor with Employees**
Attach a copy of your most recent CA State EDD Quarterly Wage Report (DE-9C) and your most recent IRS 1040 Schedule C; Fictitious Business Name Filing; or California Business License showing the owner if not listed on the DE-9C.

☐ **Partnership**
Attach a copy of your most recent CA State EDD Quarterly Wage Report (DE-9C) and K-1 or Business License showing any partner not listed on the DE-9C.

☐ **Corporation**
Attach a copy of your most recent CA State EDD Quarterly Wage Report (DE-9C) and Articles of Incorporation showing any owner if not listed on the DE-9C.

☐ **Active Licensed Contractor**

☐ **Construction Supplier/Vendor**

☐ **Other** *(Please define)*

_____

11. Eeffective Dates

☐ **Existing CBX Member Firm** **2022 Effective Date:** _____**/1/ 2022**

☐ **New CBX Member Firm**

BX/Assoc Membership Activation Date: _____

12. Employee Waiting Period

Continuous, full-time employment is required for eligibility. Eligible employees must all be active and working full-time, a minimum of 30 hours per week (or 20+ hours as stated in your employee handbook). If employees do not enroll when first eligible (upon satisfying the waiting period), they may NOT enroll until the next Open Enrollment or they experience a valid Qualifying Event.

The employee's coverage will be effective ***the first of the month following***: (choose one)

☐ **Date of hire** ☐ **30 days of employment** ☐ **60 days of employment**

13. PLAN SELECTION(S) THAT YOU WOULD LIKE TO OFFER:

Choose **one** benefit level for each Carrier choice (please see Eligibility and Enrollment in your benefit booklet).

MetLife Group Dental

☐ Premier + Ortho ($2,500)
☐ Premier ($2,500)
☐ Standard + Ortho ($2000)
☐ Standard ($2000)
☐ Savings Plus ($1,000)
☐ Dental DHMO
☐ Dual Option: Choose Base
☐ HMO ☐ Savings+ PPO
Choose ONE of the below as buy up
☐ Standard ☐ Standard+Ortho
☐ Premier ☐ Premier+Ortho
(50% ER Contribution of BASE is req.)

Metlife Basic Group Life/AD&D – 100% Employer Paid

☐ $10,000 ☐ $25,000
☐ $50,000*
☐ $10/25/50K Scheduled*
☐ Employer Paid Dependent Life/AD&D

*Available to firms with 6 or more eligible

Landmark HealthPlan – Expanded Plan

☐ Chiropractic Only
☐ Chiropractic / Acupuncture

Group Vision (Vision Service Plan)

☐ Plan "C" (12/12/12)
☐ Plan "B" (12/12/24)
☐ Full Plan ☐ Mtls Only
☐ Both
☐ Add ProTek
(if offered, ProTek will be on all plans)

VSP Enrollment Option

☐ 100% eligible enrollment (Stand alone)
☐ Enrollment matches Dental
☐ Enrollment matches Medical

VOLUNTARY BENEFITS (100% Employee Paid, No Minimum Participation)

☐ **MetLife Voluntary Dental**
☐ DHMO ☐ PPO ☐ Dual Option

☐ **MetLife Voluntary Term Life/AD&D**

☐ **Voluntary Vision (Anthem Blue View)**

☐ **Colonial Life Products**
You will be contacted to set up

14. EMPLOYER CONTRIBUTION

For group plans, the employer must contribute at least 50% of the employee only rates; if VSP Group plans are 100% Stand-alone, the contribution must be 100% Employer Paid. A minimum 50% contribution is ok if the group vision is paired with dental or medical. Dual Option Dental requires the employer contribution to be a minimum of 100% of the base plan.
Note: If an employer pays 100%, all Eligible Employees MUST enroll.

Group Dental Contribution (Non-voluntary)	**Group Vision Contribution** (Non-voluntary)	**Chiropractic/Acu Contribution**
Employees ____ % Dependents ____ %	Employees ____ % Dependents ____ %	Employees ____ % Dependents ____ %

15. ADDITIONAL COVERAGE ELIGIBILITY – OWNERS/EMPLOYEES ENROLLING

a. METLIFE DENTAL: How many are enrolling in a MetLife Dental Plan? ☐ None ☐ 1-5 ☐ 6-49 ☐ 50+ ☐

b. LANDMARK CHIRO/ACU: How many are enrolling in a Landmark Healthplan? ☐ 2-19 ☐ 20+

16. COBRA STATUS (Please indicate which applies to your company). For at least 50% of the working days of the prior year, did your firm…

a) ☐ Cal-COBRA: …have 2 to 19 employees on payroll (including union, part time & temporary)?
b) ☐ Federal COBRA: …have 20 or more employees on payroll (including union, part time & temporary)?
c) ☐ Not COBRA Eligible: …not have any employees on payroll (including union, part time & temporary)?

17. COBRA ADMINISTRATION

If FEDERAL COBRA is marked above, you need to indicate if you would like Vimly to be the Federal COBRA Administrator for these plans. ☐ Yes** ☐ No	If Cal-COBRA is marked above, Vimly will Administer.	If Not COBRA Eligible, nothing needs to be done here.

**This service is available at no charge for member companies that are subject to COBRA; A separate application is required in order to activate service.
Please ask your Benefits Consultant for the agreement and submit it with your group paperwork.

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As a member in good standing of the above Builders Exchange/Association ("your Exchange/Association"), I hereby certify that all the information contained in the Employer and Employee applications are true and correct to the best of my knowledge. I have read and understand the following statements and confirm that my firm complies with all the rules and regulations of the program, as specified in the Proof of Eligibility and Enrollee Requirements, and I do hereby agree to the following:

To abide by the Participation Agreement and the By-Laws of the California Builders Exchanges (CBX) and our Exchange/Association.

To maintain a current membership in good standing in our Exchange/Association and to assume liability for any changes incurred in said membership during the time this firm is a participant in the Health Program.

To abide by the Group Participation Requirements as stated in the Proof of Eligibility. To enroll the required percentage of all eligible (full-time) owners, partners, officers and employees not covered by a collective bargaining agreement within 30 days of the employee date of eligibility as stated on the current Participation Agreement or a qualifying event and to pay at least 50% of the employee only premium for coverage except for Basic Life which will be paid at 100%.

To notify the Plan Administrator of all employee changes and terminations of employment. Such notification is to be in writing and submitted in a timely manner on the appropriate form. It is understood that failure to submit these notifications in a timely manner will not reduce liability for any premiums incurred prior to the date of notification. No changes or terminations will be accepted on a retroactive basis. The following defines a Qualifying Event:

Additions*	**Terminations***
New hire	End of employment
Increased hours to full-time employment status	Reduced hours to part-time status
Marriage	Death of an employee
Birth of a child	Legal start of bankruptcy proceedings
Legal adoption of a child	Divorce or legal separation from employee
Loss of coverage due to a qualifying event	Lost of dependent child status

* Additions & Terminations: Written notification must be received by the Plan Administrator within thirty (30) days of a qualifying event. Terminations will not be processed further back than the first of the current month of coverage.

To pay premiums and fees as billed upon written demand of amounts due and to furnish the Plan Administrator with any statements or reports required to carry out the program. Fees may include a late payment penalty of $25 or 5% of the outstanding balance, whichever is greater, or a $25 penalty plus any bank charges incurred for payments returned by the bank. Payment is due and payable in advance by the first (1st) day of the month of coverage. Upon enrolling in the Health Program a participating employer must prepay a minimum of one month's premium. Please note, all premiums include a 5% Administration fee.

To hold harmless the CBX Insurance Program Board of Directors for any action taken or omitted by them in good faith. The CBX Insurance Program Board of Directors reserves the right to make policy, plan and carrier changes at any time.

To participate in elected insurance programs and to be bound by and entitled to all rights as set forth in the CBX By-Laws and policies as well as the sponsored carrier contracts.

To respect and protect the confidentiality of health information of employees and other participants; and to acknowledge that the group insurance plan(s) are subject to the HIPAA Privacy Laws, and to act in accordance with the direction of any plan so that such plan may fulfill its obligations under the HIPAA Privacy Laws.

DOL Form 5500 Requirement: Employer firms of 100 or more employees agree to provide proof of Form 5500 filing to the Plan Administrator.
All carrier contracts with the CBX are guaranteed coverage as of the proper effective date (with the exception of Voluntary Life) as long as the qualifications and participation requirements stated on this agreement are met.

As the legally authorized representative, I certify that I have read and understand the above and that all information provided is accurate and complete to the best of my knowledge and belief. I certify and understand that this is a legally binding agreement.

18. _____ _____
Print Name **Date**

19. _____ _____
Signature of Owner/Officer only **Title**