

Company Name		Company Phone Number ( )	
		Company Fax Number ( )	
Address (Street)	City, State ZIP Code + four		Plan Administrator
Employer Contribution Percentage	Effective date of Coverage (Subject to Approval by CBIA Health Connections)	SIC Code	Taxpayer Identification Number:
Medical _____% Life _____% Dental _____% LTD _____% STD _____%			Eligibility period: Coverage begins first of the month following ____ days of employment
Current Medical Carrier: _____ Date of policy termination: _____		Current Dental Carrier _____ Date of policy termination: _____ Attach proof of prior dental coverage	

**1 PLAN OF BENEFITS.** See marketing materials for benefit options available by group size. (check one for each coverage you are applying for)

**Medical:**  HC  HC2

**Life Insurance\*:**

Flat amount \$ \_\_\_\_\_  
 \_\_\_\_\_ times salary to max. amt: \$ \_\_\_\_\_  
 Other: \_\_\_\_\_

**Long-term Disability\*:**

90-day elim. period  180-day elim. period  
 50%  60%  66-2/3% to max of: \$ \_\_\_\_\_  
 Other: \_\_\_\_\_

**Short-term Disability\*:**

\_\_\_\_\_ %  
 1-8-13  1-8-26  
 8-8-13  8-8-26 max. amount: \$ \_\_\_\_\_  
 Other: \_\_\_\_\_

\*Attach a copy of the quote.

**Dental Insurance**

*Group Type:*            A    B    MAC

Passive Basic Lo           

Passive Basic Hi           

Passive PPO \$1000       

Passive PPO \$1000 w/ Ortho

Passive PPO \$1500       

Passive PPO \$1500 w/ Ortho

Active PPO \$1000           

Active PPO \$1000 w/ Ortho   

Active PPO \$1500           

Active PPO \$1500 w/ Ortho

Dental DMO                   

**2 Employees residing outside CT (choose one option)**

**Oxford USA:**

HC  \$10 copay or  \$20 copay  
 HC2  \$20 copay or  \$30 copay

**3 COBRA/STATE CONTINUATION ADMIN SERVICES** CBIA Service Corp. offers

COBRA/State Continuation Administration Services FREE to employers enrolled in any CBIA Health Connections program.

**I have included my signed COBRA/State Continuation Service Agreement.**  
 Yes  No

**4 RETIRED EMPLOYEES** — A retired employee is defined as a former employee retired by your company who either receives retirement income as a result of service with your company or was employed by your company for a minimum of 10 years.

Check the retiree group you are selecting coverage for:  Existing and future retired employees  Existing only  Future only  None

Check all the retiree coverages you are applying for:  Health  Dental  Life (AD&D Discontinued at Retirement)

**Life (AD&D Discontinued at Retirement)**

Life insurance will be continued in accordance with terms and conditions of the Group Life Policy. The amount to be continued is to be based on the option selected below. (Please note: active employees who are age 65 and over will already have had their insurance reduced). Continuation option:

- ADEA 1. (The life insurance amount will reduce by 35% at age 65, and again at age 70 and 75. The amount of life insurance will reduce by an additional 25% at age 80, 85, 90 and 95.)
- Other: \_\_\_\_\_

**5 PARTICIPATION QUALIFICATIONS**

The undersigned employer attests that it meets all the following Participation Qualifications:

- The undersigned employer is, or will become, a member in good standing of the Connecticut Business & Industry Association (CBIA).
- A minimum of 50% of the Eligible Employees enrolling in the Program work in Connecticut.
- The undersigned employer employs a minimum of 3 Eligible Employees and not more than 100 Eligible Employees, and is enrolling a minimum of 3 active Eligible Employees to participate in medical coverage if it elects to offer medical 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 enrolling in the Program.
- Not more than 10% of the Eligible Employees enrolling in the Program are retirees.
- The signing officer of the undersigned employer is located in Connecticut.
- The undersigned employer is domiciled 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 employer will contribute an amount equal to at least fifty percent (50%) of the lowest monthly employee-only medical rate.

Please complete reverse.  
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AGENT USE ONLY

**6** I designate Agent of Record as: \_\_\_\_\_ Agency \_\_\_\_\_

Address (Street) \_\_\_\_\_ Address (City, State, ZIP Code + four) \_\_\_\_\_

**7** 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) \_\_\_\_\_

**8 CONNECTICUT SMALL EMPLOYER HEALTH INSURANCE VERIFICATION** (For employers with 50 or fewer eligible employees)  
 In order to comply with Connecticut Public Act 90-134 effective 5/1/91, we must have current and accurate information concerning your company and your employees and their dependents.

**Company Information**

Current Medical Carrier \_\_\_\_\_ Number of years with current carrier \_\_\_\_\_  
 If not currently covered, how long have you been without coverage? \_\_\_\_\_

Is your company part of or affiliated with another company or eligible to file a combined tax return under Chapter 208?  Yes  No  
 If yes, name of affiliated company: \_\_\_\_\_ # of employees at affiliated company: \_\_\_\_\_  
 Does your company have more than one location?  Yes  No If yes, how many locations are there? \_\_\_\_\_  
 Where are the offices and/or facilities located: \_\_\_\_\_

**Employee Information**

During the preceding 12 months:

- Number of employees, including full-time, part-time and seasonal employees: \_\_\_\_\_
- Number of full-time who worked a minimum of 30 hours per week: \_\_\_\_\_
- Number of retired employees covered under your medical plan: \_\_\_\_\_

As of today:

- Number of individuals on COBRA/continuation: \_\_\_\_\_
- Number of employees not actively at work (excluding vacations): \_\_\_\_\_
- Number of full-time employees who work in Connecticut: \_\_\_\_\_

**Company's State Unemployment Compensation Number** \_\_\_\_\_

**9 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 Qualifications set forth in Section 5 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 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 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.

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

\_\_\_\_\_  
 Owner/Officer signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Witness (Broker) print name

\_\_\_\_\_  
 Witness (Broker) signature

\_\_\_\_\_  
 Date

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