



EMPLOYER'S REQUEST FOR PARTICIPATION AGREEMENT (PA) & EMPLOYER'S STATEMENT WITH BUILDERS' EXCHANGE OF STOCKTON (BES)

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. STREET ADDRESS

3. CITY	4. STATE	5. ZIP
6. PHONE () ()	7. FAX () ()	8. FEDERAL TAX ID# (FEIN) <small>Required</small>
		9. SIC/NAICS CODE <small>Required</small>

10. LIST ALL CONTACTS TO WHOM ADMINISTRATOR IS AUTHORIZED TO SPEAK TO (later updates to this list must be in writing)

CONTACT NAME	TITLE	EMAIL

11. EMPLOYER IS A: (Check one box in each column and follow the Proof of Eligibility reference list on page 6)

- 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-6) 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-6.*
- PARTNERSHIP**
Attach a copy of your most recent CA State EDD Quarterly Wage Report (DE-6) and K-1 or Business License *showing any partner not listed on the DE-6.*
- CORPORATION**
Attach a copy of your most recent CA State EDD Quarterly Wage Report (DE-6) and Articles of Incorporation *showing any owner if not listed on the DE-6.*

- ACTIVE LICENSED CONTRACTOR**
- CONSTRUCTION SUPPLIER/VENDOR**
- OTHER**
Please define:

12. EFFECTIVE DATES

- EXISTING MEMBER FIRMS**

2010 Renewal Effective Date: 4/1/2010
- NEW MEMBER FIRMS WITH MEDICAL COVERAGE**

New Firm Effective Date: _____
BX/Assoc Membership Activation Date: _____

REQUESTED PARTICIPATION:

Firms of 1 or 2 owners and employees enrolling

 - During the first 60 days after meeting a 365-day (1 year) waiting period from the membership effective date
 - During Open Enrollment (February/March) for an April 1 effective date if the 365-day waiting period has been met

Firms of 3 or more owners and employees enrolling

 - During the first 60 days after your membership effective date
 - During Open Enrollment (February/March) for an April 1 effective date
 - During the first 60 days after a current Group Health Insurance contract cancellation
 - Within 60 days of no longer being subject to a collective bargaining agreement

Firms of 6 or more owners and employees enrolling

 - During the first 60 days of changing carriers
 - Offering Group coverage for the first time
- NEW MEMBER FIRMS WITH ANCILLARY COVERAGE ONLY (DENTAL, VISION, AND/OR LIFE)**

REQUESTED PARTICIPATION FOR GROUPS OF ALL SIZES:

 - During the first 60 days after your membership effective date
 - During Open Enrollment for an April 1 effective date

13. EMPLOYEE WAITING PERIOD

Continuous, full-time employment is required for eligibility. Eligible employees must all be active and working full-time, a minimum of 20 hours per week. The employee's coverage will be effective the first of the month following: (choose one)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Date of hire
(1st of month following) | <input type="checkbox"/> 30 days of employment | <input type="checkbox"/> 60 days of employment | <input type="checkbox"/> 90 days of employment |
| | <input type="checkbox"/> 120 days of employment | <input type="checkbox"/> 180 days of employment | <input type="checkbox"/> 365 days of employment |

14. EMPLOYER'S CONTRIBUTION TOWARD MEDICAL

For Employees: _____ % (Minimum 50% to be paid by employer)

For Dependents: _____ % (no minimum required)

Toward the cost of any Plan OR Towards the cost of the base Plan. Base Plan: _____

15. PLAN SELECTION(S):

- Place an "X" by the plan(s) you have elected for your owners/employees (firms of 3 or more, 75% must enroll in a medical plan).
- ▶ Firms with (2) two or fewer enrolling owners/employees may only elect one medical carrier (100% must enroll in a medical plan)
- ▶ Plans marked with an "◀" are not available to firms with 1 or 2 enrollees.
- ▶ Plans marked with an "▼" are not available to firms with 1 or 2 enrollees in medical; however existing subscribers currently enrolled may remain.

KAISER HMO PLANS

- Copayment Plan 15◀
- Copayment Plan 20▼
- Copayment Plan 30
- Copayment Plan 50

HSA COMPATIBLE PLANS

- Plan \$0/\$2,000
- Plan \$0/\$2,700

HIGH DEDUCTIBLE PLANS

- Plan \$30/\$1,000
- Plan \$40/\$2,000

If both Health Net AND Kaiser Permanente are selected, participation requirements apply (please see rules for Participation with HealthNet, page 4).

HEALTH NET HMO PLANS**

- Value HMO 30◀
- Value HMO 40◀

PPO & HSA COMPATIBLE PLANS**

- Value PPO 30◀
- Value PPO 40◀
- Value HSA 4500

▶ New member firms enrolling 10 or more in Health Net should complete the Health Net Employer Health Statement on page 27. New member firms enrolling 6-9 in Health Net should have each employee complete the Health Net Individual Health Questionnaire on page 28.

** IMPORTANT: The total number of employees on payroll will be submitted to the carriers and CMS to determine compliance under Federal Legislation related to Medicare as a Primary vs. Secondary Payor and related to the Mental Health Parity Act.

Additional premiums will apply for HealthNet groups with over 50 Total Employees, regardless of the number enrolling.

ADDITIONAL COVERAGE OPTIONS

Choose one benefit level for each Carrier choice (please see Eligibility and Enrollment on page 5 for participation rules).

METLIFE GROUP DENTAL

- Premier + Ortho (\$2,000)*
- Premier (\$2,000)
- Standard (\$1,500)
- Savings Plus (\$1,000)

* Available to firms with 6 or more enrolling

METLIFE VOLUNTARY DENTAL

- EE paid voluntary High Option (\$1,000)

BASIC GROUP LIFE - 100% Employer paid

- \$5,000
- \$10,000
- \$25,000
- \$50,000 #
- 10/25/50K Scheduled#

#Available to firms with 6 or more eligible owners/employees

BLUE VIEW VISION

- Enrollment matches medical
- 100% eligible enrollment (Stand alone)
- Employee paid voluntary plan

VISION SERVICE PLAN

- Enrollment matches medical
- 100% eligible enrollment (Stand alone)

AMERICAN SPECIALTY HEALTH

- Available to firms with 2 or more enrollees & must match medical
- Chiropractic \$15/20
- Chiropractic/Acupuncture \$15/20

OPTIONAL TERM LIFE

- 100% Employee paid individual plan
- Optional Term Life

16. MEDICAL ELIGIBILITY

The following questions should be answered using your attached DE-6 and/or owner/officer paperwork.

- a. Total number of **employees on payroll** regardless of hours worked (on DE-6 + new hires): a) _____ **
- b. Total number of **ineligible employees** in each of the following categories:
 - Union: _____ Part-time: _____ Seasonal: _____ Temporary: _____ Terminated: _____ Waiting Period: _____
- c. Total of all categories in question b: c) - _____
- d. Total number of **active, eligible employees** on payroll (a minus c): d) = _____
- e. Number of **employees declining** due to other group coverage (valid waiver): e) - _____
- f. **TOTAL ELIGIBLE** (d minus e): f) = _____
- g. Number of **employees enrolling** in:
 - Health Net: _____ Kaiser: _____ Total: _____
- h. percentage of eligible employees enrolling in:
 - Health Net: _____ % Kaiser: _____ % Total: _____ %
- i. Number of **Invalid Waivers**: _____

75% Global Participation Required & 75% Participation if HN is the sole carrier
 60% Health Net if 1HMO plan is offered alongside Kaiser. (.60 x 4 = 2.4, so 3 enrollees must have HN)
 70% Health Net if PPO/HSAs are offered or if 2 or more HN Plans are offered.
 (70 x 4 = 2.8, so 3 of the enrollees must have HN if any PPO or HSA plans are offered)

** IMPORTANT: Additional premiums will apply for HealthNet groups with over 51 or more Total Employees, regardless of the number enrolling.

17. ADDITIONAL COVERAGE ELIGIBILITY - OWNERS/EMPLOYEES ENROLLING

- a. **METLIFE DENTAL:** How many are currently enrolling in a MetLife Dental plan? None 1 - 5 6 - 19 20+
- b. **NEW DENTAL:** Have you had 12 prior months of group dental? Yes No
- (Proof of prior group coverage required to waive all waiting periods. Voluntary Plans may not be waived)
- c. **CHIRO/ACUPUNCTURE:** How many are currently enrolling in a chiropractic/acupuncture plan? None 2 - 9 10+

18. FOR INTERNAL USE ONLY

COBRA STATUS: Submitted 2010 COBRA Questionnaire Federal Cal No COBRA

RATE TIER

- DESIGNATION: HN: Tier 1
- Tier 2
- Tier 3

- KP: Tier 1
- Tier 2 Tier 4
- Tier 3 Tier 5

MHPAEA STATUS

- (51+ Total Employees on DE6 more than 1/2 the year)
- Yes: No:



EMPLOYER'S REQUEST FOR PARTICIPATION AGREEMENT (PA) & EMPLOYER'S STATEMENT WITH BUILDERS' EXCHANGE OF STOCKTON (BES)

As a member in good standing of the Builders' Exchange of Stockton (BES), 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 North Bay Builders Exchanges (NBBE) and the Builders' Exchange of Stockton.

To maintain a current membership in good standing in the Builders' Exchange of Stockton 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:

Table with 2 columns: ADDITIONS* and TERMINATIONS*. Rows include New hire, Increased hours to full-time employment status, Marriage, Birth of a child, Legal adoption of a child, Loss of coverage due to a qualifying event, End of employment, Reduced hours to part-time status, Death of an employee, Employee's Medicare entitlement, Legal start of bankruptcy proceedings, Divorce or legal separation from employee, Loss 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 include a \$15 monthly billing fee, 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 fifteenth (15th) day of the month prior to the month of coverage. Upon enrolling in the Health Program a participating employer must prepay a minimum of one month's premium plus fees. Please note, all premiums include a 5% Administration fee.

To hold harmless the NBBE Insurance Program Board of Directors for any action taken or omitted by them in good faith. The NBBE 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 NBBE 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 NBBE are guaranteed coverage as of the proper effective date (with the exception of Optional 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.

19. Print Name Date

20. Signature of Owner/Officer only Title

All enrollment documents, complete and accurate, must be received by the 15th of the month prior to the requested effective date.

Federal COBRA/Cal-COBRA 2010 Status Questionnaire

As your Insurance Administrator, it is very important that we identify your COBRA status for each year. To establish Federal COBRA or Cal-COBRA status for the 2010 calendar year, please read the statement below, choose one of the COBRA options listed, and then return it to us. Your company's COBRA status is based on the total number of employees on payroll at your company, not on the total number of employees enrolled in the insurance plan.

Do not count Owners or Officers of the company unless they appear on the DE6.

To calculate part-time employee hours to full-time employee hours: add all part-time hours, divide by full-time hours and add this number to your full-time employee count.

Please complete and return this form to your administrator.

2010 COBRA/Cal-COBRA Status

(You Must Choose One)

- _____ Federal COBRA: 20 or more employees on payroll (including union, part time & temporary) for at least 50% of the working days of 2009.
- _____ Cal-COBRA: 2 to 19 employees on payroll (including union, part time & temporary) for at least 50% of the working days of 2009.
- _____ Not COBRA Eligible: Sole Proprietor with no employees on payroll (including union, part time & temporary) for at least 50% of the working days of 2009.

Name of Company

Firm #

Date

Print Name of Owner/Officer

Exchange / Association

Signature of Owner/Officer

Title

Please complete and return this form even if you have no employees. Thank you.

A new Cobra Status Questionnaire is required to be on file with us annually in order to enroll or re-enroll.

Important Information you should know

Whether your company is deemed Federal or Cal-COBRA, it is your responsibility as the employer, to notify your employees and their dependents of their rights to continuation of coverage. When an employee experiences a Qualifying Event, (i.e., termination of employment) and you had a minimum of 2 employees on payroll (including union, part time, and temporary employees) for at least 50% of the previous working year, that employee is eligible for COBRA continuation. This questionnaire helps us administer that COBRA with required notices and reporting to the appropriate carrier the type of COBRA to be offered.

If the owner(s) of your company have ownership in multiple companies the COBRA/Cal-COBRA status for all companies may be affected. Federal law in many instances regarding multiple/common ownership is very complex. If your company falls into a multiple/common ownership category legal counsel is strongly advised. While each administrator endeavors to provide a simple guideline, we make no representation as to legal status of your company with regard to COBRA/Cal-COBRA.