Employer's Request for Participation Agreement & Employer's Statement

The undersigned Employer requests participation in the North Bay Builders Exchanges Insurance Trust, elects the Plan of Benefits shown, and hereby adopts and agrees to be bound by the terms and provisions of the Restated Trust Agreement of the North Bay Builders Exchanges Insurance Trust and the Administration Agreement between the Insurance Trust and its designated Administrator.

Full Legal Name of Firm (including DBA, Name must match company's membership name):			
Street Address:			
City:	State:	Zip Code:	Federal Tax ID # (FEIN) Required:
Phone:	Fax:	Email Address:	SIC/NAICS Code:

List all contacts below to whom administrator is authorized to speak *(later updates to this list must be in writing)*:

Name	Title	Email	Phone

Employer is a *(check one box in each column below and follow the Proof of Eligibility Reference List on Page 3)*:

❑ Sole Proprietor without Employees
Attach a copy of your most recent IRS 1040S Schedule C, Fictitious Business Name Filing, or current CA Business License.

❑ Sole Proprietor with Employees
Attach a copy of your most recent CA State EDD Quarterly Wage Report (DE-9C), CA business license or fictitious business name filing; and if employee is a spouse/domestic partner submit jointly filed current IRS 1040 with separate Schedule C/F.

❑ 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), California Secretary of State "active" web confirmation (kepler.sos.ca.gov), and if an officer is not on a DE-9C submit: Articles of Incorporation, Election by a Small Business Corporation, Tax Form 1120 (pages 1 & 2) with Schedule 1125E (for C Corp), or Schedule K-1 1120S (for S Corp)

❑ Active License Contractor

❑ Construction Supplier Vendor

❑ Other — please define:

For Sole Proprietors without employees and for Owners/Partners/Officers who are not listed on the DE-9C who are enrolling in Kaiser Permanente medical plans: By initialing in this box below, you attest that although your name does not appear on the DE-9C the following are all true:

- I am a sole proprietor, partner, or LLC manager/member at the named company
- I work at this company on a permanent basis with a normal work week of: ❑ 20-29 hours/week ❑ 30 hours or more/week
- I draw wages, dividends, or other distributions for this company on a regular basis
- I do not derive substantial earned income from any other employer and am not eligible for other employer-sponsored coverage as a subscriber
- I will have satisfied the designed waiting period before coverage becomes effective

Initial: ______________________ Date: ______________________

Employer's Request for Participation Agreement & Employer's Statement

Effective Dates: ❑ Existing Member Firm ❑ New Member Firm Renewal Date: ___________________________

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:

❑ Date of Hire ❑ 30 Days ❑ 60 Days

Employer's Contribution Toward Medical:

For Employees: ____________________ % (Minimum 50%)

For Dependents: ___________________ % (No minimum required)

❑ Toward the cost of any plan — or —

❑ Toward the cost of the Base Plan

Base Plan ____

Medical Plan Selection:

- Sole Proprietors and Companies with only one enrollee who is listed on the DE9-C: May elect any Kaiser plan
- Employer Groups with 2 or more enrolling employees who are listed on the DE9-C: May select any combination of plans

Note: Owners and spouses or legal domestic partners do not constitute as an employee and do not accrue toward the employee count even if they are listed on the DE9-C.

Anthem Blue Cross:

❑ Premier PPO 500($500 ded)

❑ Standard PPO 1000 ($1,000 ded)

❑ Value PPO 1500 ($1,500 ded)

❑ HSA 3000 ($3,000 ded)

❑ EPO 1000 ($1,000 ded)

Kaiser Permanente:

❑ Platinum HMO 0/15

❑ Gold HMO 0/30

❑ Gold DHMO 500/30

❑ Silver DHMO 1000/55

❑ Bronze DHMO 6300/75

❑ Bronze HSA 6000/40

Dental Plan Selection:

Groups may elect any single Anthem Blue Cross Dental plan:

Groups with no current Dental Plan must select the Value Plan for a minimum of one year and may change to other plans at first Open Enrollment after 12 months.

❑ Premier

❑ Standard

❑ Value

❑ Voluntary *(100% Employee Paid)*

Current Dental Coverage?

❑ Yes ❑ No

Life and AD&D Plan Selection:

Groups may elect any single Anthem Blue Cross Life/AD&D Plan *(100% Employer Paid)*:

[1] Only available for member firms with 6 or more enrolled owners/employees.

[2] "Scheduled" allows for different amounts based on position, title, salary or other non-discriminatory elections. When offering the scheduled plan, at least one owner/employee must be in each of the three levels.

Groups may also select Optional *(100% Employee Paid)*

❑ $5,000 Flat Amount

❑ $10,000 Flat Amount

❑ $25,000 Flat Amount

❑ $50,000 Flat Amount[1]

❑ $10k/$25k/$50k Scheduled Amtount[1,2]

❑ Optional Plan *(100% Employee Paid)*

Vision Plan Selection:

Groups may elect either Anthem Blue View Vision or Vision Service Plan (VSP):

❑ **Anthem Blue View Vision**

❑ Stand Alone *(100% participation required)*

❑ Match Medical Enrollment

❑ Voluntary *(100% Employee Paid)*

❑ **VSP**

❑ Stand Alone *(100% participation required)*

❑ Match Medical Enrollment

Medical Eligibility: The following questions should be answered using your attached DE-9C and/or owner/officer paperwork:

a) Total number of employees on payroll regardless of hours worked *(on DE-9C + 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 from Line 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:

Anthem Blue Cross _____________ Kaiser ______________ Total ______________

h) Percentage of eligible employees enrolling in:

Anthem Blue Cross _____________ Kaiser ______________ Total ______________

i) Number of invalid waivers ______________________________

Employer's Request for Participation Agreement & Employer's Statement

As a member in good standing of the Bay Area Builders Exchange, 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:

1. **To abide by** the Participation Agreement and the By-Laws of the North Bay Builders Exchanges (NBBE) Insurance Trust and the above-named Builders Exchange.
2. **To maintain** a current membership in good standing in the above-named Builders Exchange and to assume liability for any changes incurred in said membership during the time this firm is a participant in the Insurance Trust.
3. **To abide by** the Group Participation Requirements as stated in the Proof of Eligibility.
4. **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 1) the employee date of eligibility as stated on the current Participation Agreement, or 2) 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%.
5. **To notify** the Plan Administrator of all employee changes and terminations of employment or other qualifying event in writing within 30 days of the change, termination or other qualifying event on the appropriate form. It is understood that failure to submit such notification in writing within 30 days will not reduce the employer's liability for any premiums incurred prior to the date of notification. No changes or terminations will be accepted on a retroactive basis. Terminations will not be processed further back than the first day of the current month of coverage.
   A qualifying event means any of the following:

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	Employee's Medicare entitlement
Legal adoption of a child	Legal start of bankruptcy proceedings
Loss of coverage due to a qualifying event	Divorce or legal separation from employee
	Loss of dependent child status

6. **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 fifteenth (15th) day of the month prior to the month of coverage. Upon enrolling in the Insurance Trust, a participating employer must prepay a minimum of one month's premium. Please note all premiums include a 2% Administration Fee.
7. **To hold** harmless the Board of Trustees of the NBBE Insurance Trust for any action taken or omitted by it in good faith. The Board of Trustees of the NBBE Insurance Trust reserves the right to make policy, plan and carrier changes at any time.
8. **To participate** in elected insurance programs and to be bound by and entitled to all rights as set forth in the Restated Trust Agreement of the NBBE Insurance Trust and policies as well as the sponsored carrier contracts.
9. **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.

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.

I understand that the plan year is from April 1st through March 31st.

As the legally authorized representative of the Employer hereby requesting participation in the NBBE Insurance Trust, 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.

Print Name _______________ Date _______________

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.