



AGC Security Plan Participating Employer Application AGC Health Plan for Washington State

OFFICE	Group Number: _____
	Med RL: _____ RX RL: _____

Medical and RX plans offered under the AGC Security Plan are underwritten and administered by Health Net Health Plan of Oregon, Inc.
Vision plans underwritten and administered by VSP®

Company Information

Effective Date Requested: _____

Company: _____ Tax ID: _____

DBA (if applicable): _____

Address: _____

City: _____ County: _____ ST: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Benefits Administrator Name: _____ Title: _____

Address (if different): _____

Phone: _____ Fax: _____ E-mail: _____

Billing Contact (if different): _____ Title: _____

Address (if different): _____

Phone: _____ Fax: _____ E-mail: _____

AGC Chapter Membership: AGC of WA AGC Inland NW Member since: _____

Type of Organization: Corporation Partnership Sole Proprietorship Other SIC Code: _____

Nature of Business: _____ Date of Inception: _____ Previous Medical Carrier: _____

Are you subject to COBRA? Yes No

A group is subject to COBRA during the current calendar year if the group employed 20 or more employees on more than 50% of its typical business days in the preceding calendar year.

If Yes, Please Choose:

AGC Trust Administration (please complete a BenefitHelp Solutions Agreement and submit with your application)

Self-Administration

Employee Information

Total employees: _____ Total working 20+ hours a week: Full-time _____ Part-time _____

Eligible Employees: Regular active full-time employees scheduled to work at least _____ hours per week (min 20 hrs)

Number of employees eligible per employer guidelines to enroll in the plan: _____

Number of employees enrolling: _____ Number of dependents enrolling: _____

Number of employees waiving for other group coverage: _____

Employees must enroll within 31 days of eligibility. Eligibility provisions may only be changed at annual contract renewal.

Newly Eligible Employees: First day of the month following _____ days from date of hire. (0, 30, 60, 90, 180)

Employees rehired within _____ (0 – 6) months are not required to complete a new probationary period.

Employer Contribution (must equal 75% or more of Employee Rate or 50% of Employee Rate and 50% of Dependent Rate)

Employee Coverage: _____% of Monthly Rate OR \$ _____ toward Monthly Rate

Dependent Coverage: _____% of Monthly Rate OR \$ _____ toward Monthly Rate

Coverage Applied For (check plans that apply):

Enrollment Packets Needed: _____

Note: If benefits differ by class or location please indicate below or add an additional sheet.

Health Net Medical Plans

- Groups under 20 choose one plan
- Groups with 20+ enrollment may choose two plans (minimum of 3 enrolled in each plan; dual choice will increase rates by approximately 5%)

<input type="checkbox"/> PPO 250 (\$15 / \$250 / 20% / \$1,000 LX) <input type="checkbox"/> PPO 300 (\$20 / \$300 / 20% / \$2500 DX) <input type="checkbox"/> PPO 500 (\$15 / \$500 / 20% / \$1,500 DX) <input type="checkbox"/> PPO 750 (\$20 / \$750 / 20% / \$2,500 DX) <input type="checkbox"/> PPO 1000 (\$25 / \$1000 / 20% / \$2,500 DX) <input type="checkbox"/> PPO 1500 (\$25 / \$1,500 / 20% / \$2,500 DX)** <input type="checkbox"/> PPO 2500 (\$30 / \$2,500 / 20% / \$2,500 DX)**	Health Net RX Plan Choose one option <input type="checkbox"/> Rx \$10 / \$20 / \$40 <input type="checkbox"/> Rx \$15 / \$30 / \$50 <input type="checkbox"/> Rx \$10 / \$50 / \$75 <input type="checkbox"/> No Rx	VSP Vision Plan Choose one option <input type="checkbox"/> VSP \$0 / \$10 <input type="checkbox"/> VSP \$10 / \$25 <input type="checkbox"/> No Vision
	Note: Pharmacy & Vision enrollment must match the medical enrollment.	
	Guardian Dental Plans	
<input type="checkbox"/> Plan 1000 (\$1,000 Max) <input type="checkbox"/> Plan 1500 (\$1,500 Max) <input type="checkbox"/> Plan 2000 (\$2,000 Max)	<input type="checkbox"/> Plan 1000 w/ Ortho* <input type="checkbox"/> Plan 1500 w/ Ortho* <input type="checkbox"/> Plan 2000 w/ Ortho*	
**See Underwriting Guidelines		
*Orthodontia coverage is only available to groups of 10+ eligible employees		

Health Net HDHP Choose one option

Optional Benefits

<input type="checkbox"/> HSA 1500 (HDHP \$1,500 / 20% / \$3,000 w/ 20% Rx) <input type="checkbox"/> HSA 2500 (HDHP \$2,500 / 20% / \$5,000 w/ 20% Rx)	<input type="checkbox"/> Domestic Partner Coverage (No Charge –Group must select product in order to add benefit) <input type="checkbox"/> Employee Assistance Program through RFL (\$0.75 per employee charge) <input type="checkbox"/> LifeBalance Card (\$1.00 per employee charge)
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Lifewise Assurance Life / AD&D Buy-up (\$10K Life / AD&D is included with each medical plan enrollment)

<input type="checkbox"/> Additional \$10K Life / AD&D	<input type="checkbox"/> Additional \$30K Life / AD&D
<input type="checkbox"/> Additional \$20K Life / AD&D	<input type="checkbox"/> Additional \$40K Life / AD&D

Participation/ Eligibility Requirements

Company must employ at least 2 eligible employees for enrollment and must meet the definition of a "business group" under Washington state law. All enrolled employees must have a bona fide employee relationship with the Employer. If the employer requires employees to contribute to the employee-only premium, a minimum of 75% of all eligible employees must enroll in the plan. A Refusal of Coverage/Waiver form must be submitted for all employees and dependents declining coverage. If employer contributes 100% of the employee premium, 100% of eligible employees must enroll in the plan. The employer must contribute at least 75% of the cost of the employee or 50% of the employee and 50% of the dependent Medical. Eligible employees must be full-time employees as defined on page 1 of the application.

Agent Designation

Agent Name: _____ Agency: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Employer Statement

- We wish to enroll our firm as a group account with the AGC Security Plan. We understand that the AGC Security Plan is the purchasing group that sponsors this plan, and that medical benefits are underwritten and administered by Health Net of Oregon, a Washington-licensed health care service contractor. Benefits and eligibility provisions are specified in the contract between the AGC Security Plan and Health Net of Oregon, of which this application forms a part. We also understand that vision benefits are provided by VSP® respectively, and are solely responsible for administration of those benefits.
- We understand the eligibility rules applicable to employee enrollment.
- We understand premiums are prepaid and are due no later than the first day of each month.
- We certify that we have received a fully completed and unaltered Enrollment and Change Application from each participating employee and that we will keep these forms on file in their original state indefinitely. They will be immediately available for use by the Plan Administrator or Carrier.
- We understand an individual's coverage terminates the last day of the month in which employee or dependent ceases to be eligible under eligibility provisions.
- There will be one open enrollment period per contract year 30 days prior to the renewal effective date.
- This Agreement consisting of the Plan Contract/Group Policy as supplemented by the Group Application has been entered into between AGC Security Plan and the Employer Group in order to provide eligible subscribers and eligible dependents electing to enroll hereunder with the health care benefit as specified in the Plan Contract/Group Policy.

Executed at _____ Date accepted _____
(City, ST)

Signature of Authorized Employer Group Representative

Print Name

Title