



Legal Name: IGA Group Employee Benefit Trust
Version: IGA / PAgree / 0409

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PARTICIPATION AGREEMENT

Please complete this fillable form and click the Submit button. Then save it, print it, sign it and fax it to the number shown above.

SECTION I. GENERAL INFORMATION

Company Name: \_\_\_\_\_ Federal ID# \_\_\_\_\_
Street Address: \_\_\_\_\_
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Administrative Contact: \_\_\_\_\_ Title: \_\_\_\_\_
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_
Nature of Business: \_\_\_\_\_

SECTION II. GROUP INFORMATION

Employer Information:

\_\_\_\_\_ Total Number of Employees
\_\_\_\_\_ Total number of employees working more than 30 hours per week
\_\_\_\_\_ Total number of employees working less than 30 hours per week
\_\_\_\_\_ Number of COBRA Participants (also include those within their election period)

Enrollment Information: (Please read carefully)

Full-Time: Each Participating Employer determines the minimum number of hours each week that an employee must work to be considered Full-Time and therefore eligible for coverage under the Plan. However, such requirement should be consistent with employer's normal and usual business practices and may not be less than 30 hours per week under the Plan.

Required Participation: Minimum 75% of eligible Full-Time employees.

\_\_\_\_\_ Number of hours per week employees must work to be considered Full-Time
\_\_\_\_\_ Number of Full-Time employees enrolling for coverage
\_\_\_\_\_ Number of Full-Time employees declining coverage (a signed Waiver of Coverage is required to preserve Special Enrollment Period rights)
\_\_\_\_\_ How many are declining due to other coverage
\_\_\_\_\_ How many are declining, but not due to other coverage

Group Selections:

Requested Effective Date: First day of \_\_\_\_\_ 20\_\_\_\_
(Month) (Year)

Waiting Period: First day of the month following 30 Days 60 Days 90 Days 120 Days \_\_\_\_ Days.

Employer Level of Contributions for Medical Coverage:

\_\_\_\_\_ % of Employee contribution (minimum 50% is required. If 100%, ALL Full-Time employees are required to enroll)
\_\_\_\_\_ % of Dependent contribution

### SECTION III. BENEFIT PLAN SELECTION

**Benefits Elected:** (Please attach a signed copy of Proposal with selection circled or noted)

**Benefits Effective Date:** \_\_\_\_\_ mm/dd/yyyy)

#### Plan Options

**Option 1**

**Option 2**

**Option 3**

\* 20% to \$200 on injectables applies

PPO Network Selection:

**Optional Addendum Benefits:** (Applies to all employees & dependents enrolled in the medical Plan)

**Group Dental:** Yes No **Group Vision:** Yes No **Other:** \_\_\_\_\_

**Anniversary Date:** First day of \_\_\_\_\_  
(Month)

The Annual Anniversary Date is the original date/month in which a Group as a whole actually/initially enrolls into the Plan. The Annual Anniversary Date (the first day of the original coverage month), under the Special Enrollment Period, is the only time in which employees can elect to change their individual coverage plan (if group has a multi tier plan). An individual may also elect to terminate their coverage or enroll late in the Plan without the occurrence of a qualifying event as specified in the Summary Plan Description. An individual is deemed a Late Enrollee if he/she is enrolling in the Plan later than 31 days after they first become eligible for coverage under the Plan and may be subject to the Plan's Preexisting Conditions Exclusion for 18 consecutive months as opposed to 12 consecutive months under Timely Enrollment.

### SECTION IV. ATTACHMENTS CHECK LIST

1. Signed Request For Quote.
2. **Evidence of Creditable Coverage.** Will this Plan replace an existing employer-sponsored healthplan? Yes No  
(If yes, please attach Evidence of Creditable Coverage to ensure your employees get appropriate credit toward the Preexisting Limitations of the Plan. Or you may **attach the first and last month's bill from prior carrier**)
3. Signed copy of proposal with selection circled or noted.
4. Updated Quarterly Detailed Wage & Tax Statement indicating (Full Time) F.T., (Part Time) P.T., or (Waived) W.
5. Employee Enrollment / Waiver Form for **ALL** Full Time Eligible Employees.

### SECTION V. ACKNOWLEDGEMENTS

**WE HEREBY CERTIFY** that our company is a subscriber member employer in good standing with the Plan Sponsor. **WE ACKNOWLEDGE** that we have selected the benefit plan we wish to provide for the employees and dependents of our organization. As a member employer, we hereby subscribe to the terms and conditions of the sponsored Plan and the benefits as provided and described in the Summary Plan Description.

**AS THE UNDERSIGNED PARTICIPATING EMPLOYER, WE UNDERSTAND** that our elected Trustees, and the Plan Administrator (as defined within the Summary Plan Description) engaged by the Trustees, may amend the Plan from time to time. We understand that the employer / employee contribution rates may change. While the rate tables, which were in effect on the effective date of our Participating Employer's Plan's coverage, are those projected for the first year of our plan, changes may be made the first day of any month following the sixth month of our participation under the Plan.

**WE FURTHER UNDERSTAND** that if we are transitioning coverage from any prior Trust Plan administered by the current Plan Administrator, our rate review schedule will remain unchanged and the timing of such review will be as if no transition took place.

Any change in contribution rates however, will only be made after written notice has been sent to us 30 days in advance. Once the change has been made, the Plan cannot make another change for six months. However, and notwithstanding the above, a change may be made anytime if:

1. the benefit provisions are changed at our request; or
2. there is a change in the benefits required by state or federal law; or
3. there is a change in the number of employees in our employer group which exceeds:
  - a) 10% in any benefit month when compared to the previous coverage month; or
  - b) 20% at any time within the benefit year when compared with the number of employees covered in the first month of the benefit plan year; except that, no increase in employer / employee contributions will take effect before 30 days after the date of written notice of such increase given to us as a participating employer under the Plan.

**WE ACKNOWLEDGE** that the first contribution payment is due on or before the date of issue. It is acknowledged and understood that our subsequent contributions are due on or before the 1st day of each coverage month. Monthly contributions for coverage shall be made payable to the **IGA Group Employee Benefit Trust** and shall be mailed to **PO BOX 456, Forest Hill, MD 21050**.

**WE UNDERSTAND payments must be for the full invoiced amount.** Any adjustments or credits will be reflected on the following month's invoice. All payments are due on the last day of the month prior to the month for which coverage and service are to be effective. Any contributions received after the last day of the preceding month for which coverage and services are to be effective will be considered late and the claims administrator (Medical Benefits Administrators of MD, Inc.) reserves the right to hold all benefits payments and authorizations for care until such payments are received. A Grace Period of 30 days may (at the Plan Administrator's discretion) be allowed for the payment of any Contributions due after the initial Contribution. During any grace period, claims/ benefits payments may be held by the claims administrator. If the Participating Employer group's contributions are not paid as billed and the grace-period (if any) has elapsed, coverage will terminate automatically as of the last day of the month in which the required contributions were paid in full. Temporary waiver of this provision shall not constitute a change in the provision with regard to future late payments. Contributions for all covered periods prior to the date of termination under the Plan remain due and payable.

**WE ALSO AGREE** to give 30 days advance written notice in the event we wish to terminate coverage under the Plan. Notice of Termination must be made in writing and submitted to the Plan Administrator (as defined within the Summary Plan Description).

**WE UNDERSTAND** that our benefits under this plan begin with a specific effective date of coverage applicable to all plan participants and coverage ends at the end of a month in which Contributions have been paid. We understand if anyone attempts to utilize the benefit plan or prescription drug card when coverage is no longer effective under the plan, the Participating Employer and the Employee(s) will be responsible for repayment of any benefits wrongfully disbursed.

**WE HEREBY CERTIFY** that we have personally reviewed all of the answers to the questions on this Participation Agreement (including attachments) and represent that all of the information we have provided is true and complete. We understand that it is our responsibility to provide truthful, complete and accurate information and we fully understood all questions asked. We understand and agree that the Plan relies on the statements, answers and information contained in the Participation Agreement and attachments and that any statement, answer or information that is determined to be false, incomplete or inaccurate by the Plan Administrator may be used for the basis of rescission or termination of coverage on our group collectively, or our Employees and their dependent(s) individually.

**WE AGREE** to advise the Plan or the Plan Administrator of any change in health or habits on a proposed Employee or dependent(s) that occurs after completion of this Participation Agreement, Employee Application or Statement of Health but before the Employee or dependent(s) becomes covered under the Plan. We understand that under no circumstances is anyone allowed to (a) waive, alter or modify any questions; or (b) permit us to inaccurately answer any questions. We understand that no one other than the Plan Administrator or the Trustees (in consultation with the Plan Administrator) is authorized or has authority to alter the terms of the Plan.

**WE UNDERSTAND** that acceptance of the check submitted with the Participation Agreement does not constitute approval or guarantee coverage. We agree and understand the coverage which is to be placed in force is subject to all of the provisions of the Trust including, without limitation to the foregoing, the right of the Trust to periodically request and inspect payroll and personnel records which may have a bearing on or be the basis for any coverage requested, placed in force, or maintained. We understand that final rates are based on final enrollment.

**WE HEREBY CERTIFY** that we have read and agree to the above and understand that the **IGA Group Employee Benefit Trust** will rely on this statement and all the information provided as a part of our application as a basis for approval as a participating employer under the Plan.

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**WE UNDERSTAND that any person who, with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, submits an Enrollment, Participation, or other required form or files a claim containing a false or deceptive statement, material misrepresentation or material omission commits a fraudulent insurance act, which is a crime, and subjects the person to civil and criminal penalties.**

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**WE ACKNOWLEDGE that we are advised not to terminate any existing health coverage plans for our Employees until we receive notification this Plan has been approved by the Plan Administrator (as defined within the Summary Plan Description).**

This form must be signed by a duly authorized Officer or Director who has the authority to bind the Participating Employer to the proposed plan.

Today's Date: \_\_\_\_\_ (mm/dd/yyyy)

Officer / Director Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Officer / Director Signature: \_\_\_\_\_