

Minnesota Public Employees Insurance Program (PEIP)

GROUP APPLICATION

| Employer | INFORMATION Federal Tax ID Number | | | | Desired Effective Date | | | | |
|---|--|---|--|--------------|------------------------|------------------------------------|--|--|------------------------------|
| Employer | | Tea | ciai i ax ii | Number | | Desired Enective Date | | | |
| Name and title of person responsible for benefits deci- | sions | | 11 | Phone | | / | | | |
| tvaine and title of person responsible for benefits decisions | | | | ' \ | | | | | |
| | | | (| ,) | | | | | |
| Email Address | | | I (| ₹ax) | | | | | |
| | | | | , | | | | | |
| Address | City | | County | | State | Zip Code | | | |
| | | | | | | | | | |
| Name and title of person responsible for billing and accounting | | | ŀ | Phone | | | | | |
| 7. 11. 11 | | | () | | | | | | |
| Email address | | | Fax | | | | | | |
| Union Popracentative, if appropriate | | | Union Rep Email Address | | | | | | |
| Union Representative, if appropriate | | | Olloli Rep Ellian Address | | | | | | |
| # OF EMPLOYEES TO BE INCLUDED IN | COVERAGE | | | ELIGIBII | | | | | |
| The Public Employees Insurance Program requires that | | The Public Employees Insurance Program allows employers the opportunity | | | | | | | |
| employees participate in the Program. Those individuals who waive coverage due to coverage elsewhere are not included in the 75% calculation. | | | to determine eligibility criteria. Please attach a copy of your group's eligibility policy and | | | | | | |
| | | | Please attach a copy of your group's eligibility policy and include hours worked, new hire effective date of coverage, | | | | | | |
| T . 1 " C 1" "1 1 | | and a | ny waiting | g period. Ob | R indica | te eligibility below. | | | |
| Total # of eligible employees | | | | | | - | | | |
| # of employees who waived | | | | | | | | | |
| & have no other coverage | | | | | | | | | |
| # of employees who waived | | | | | | | | | |
| due to coverage elsewhere | | | | | | | | | |
| Total number to be included in PEIP | | | | | | | | | |
| | | DATECO | | ATTON | | | | | |
| Please attach a separate list of the following covered individuals (if any) with full names, social security numbers and effective date of coverage continuation: | | | PEIP Proposal Financial Section III signature pages attached | | | | | | |
| | | | | | | | | | ◆ Cobra individuals ◆ Disabl |
| | Cobra individuals Retirees Disabled individuals Other (explain) | | | | | | | | |
| | • | | | | | | | | |
| SELECTION OF COVERAGE Health Coverage: | | COBRA/M | N Continu | uation/Retir | ee Billi | ng | | | |
| Health Coverage: ☐ Advantage High Plan | | | ☐ Group will manage own COBRA/Retiree Administration and bill for early retirees and COBRA participants | | | | | | |
| | | | | | | | | | ☐ Advantage HSA Plan |
| | | | | r r | | | | | |
| Optional Dental Coverage: Employer Contributes: | (choose one) | | | | | | | | |
| ☐ Comprehensive Plan | | 50-89% of | amployaa | promium | | | | | |
| Comprehensive Fian | | | | ee premium. | | | | | |
| | _ | 0-100/0 | or employ | cc premium. | | | | | |
| Optional Employee Life/Accidental Death & Dismo | emberment Insurance | ee | | | | | | | |
| Minimum \$10,000, maximum \$300,000 available in \$ | 5,000 increments. An | nounts in exce | ess of the g | roup's guara | nteed is | sue amount are subject to evidence | | | |
| of insurability. Employees who waive medical coverage | ge because they are cov | | _ | | | | | | |
| providing 100% of those employees participate in life | | | | _ | | | | | |
| Choose one: \$10,000 flat amount per active | | Amount equa | _ | | Other (| please specify below) | | | |
| Eligibility: All employees | | Medical lock | | | | | | | |
| Employer agrees to pay monthly, in advance (by the | | | | | | | | | |

Employer agrees to pay monthly, in advance (by the 25th of the prior month), the entire charges due for all participating individuals. In addition, the employer bears the responsibility to collect and pay to the Minnesota Public Employees Insurance Program any and all amounts to be contributed toward such charges by employees or early retirees of the employer

TERMS AND CONDITIONS

- 1. By completing and signing this application for group coverage, you are agreeing to participate in the Minnesota Public Employees Insurance Program under all the terms and conditions contained in the proposal/renewal letter provided to you by the Minnesota Public Employees Insurance Program.
- 2. You agree that the eligibility guidelines in effect today may not be changed until the annual renewal.

A four-year commitment is required.

One of the features that ensures rate stability and affordability in the PEIP Program is a four-year membership requirement for participating employers. Premium rates are guaranteed for 12 months at a time. Although specific rates cannot be guaranteed beyond the first 12 months, the Program contains specific features to promote rate stability and to prevent excessive rate increases upon renewal. Participation is automatically renewed for an additional four-year term unless the exclusive representative, or the employer for unrepresented employees gives the commissioner notice of withdrawal at least 30 days before expiration of the participation period. The employer is liable for the full premium due within the four-year commitment in the case of an invalid termination.

Following receipt of this application, coverage selections and final rates will be confirmed in writing by the Program. Premiums are guaranteed for one year. Withdrawal from the Minnesota Public Employees Insurance Program at any time prior to the end of the two-year term may result in the state pursuing legal action against the employer. Withdrawal for any reason will result in the group's ineligibility to participate for two years.

This application constitutes an offer to purchase Minnesota Public Employees Insurance Program coverage. No contract is created until the applicant receives written confirmation of acceptance from the Minnesota Public Employees Insurance Program. No agent has the authority to waive any of the Minnesota Public Employees Insurance Program's rights or requirements or to make or alter any contract or policy. All three network carriers offered by PEIP must be offered by the group. In accepting group coverage under the Minnesota Public Employees Insurance Program, it is acknowledged that:

- 1. The applicant is the employer for purposes of ERISA (to the extent applicable), COBRA and state law regarding continuation and conversion of group health coverage. The employer will therefore be responsible for notifying the PEIP of any and all information necessary to fulfill its obligations under these laws. The employer is also responsible for receiving from employees and forwarding to the PEIP notices of events such as an employee's divorce or legal separation or cessation of a child's eligibility under this Program.
- 2. The employer bears full responsibility for ensuring that its Plan satisfies any and all requirements of state or federal law that relate to employee benefit plans, including ERISA and HIPAA. Employer's legal counsel should be consulted to ensure compliance with these laws.
- 3. The employer assumes responsibility for collecting from employees and forwarding to the Minnesota Public Employees Insurance Program in a timely and accurate manner, notices of events such as addition of new employees, changes in coverage for employees or retirees, and changes in marital or dependent status of employees and retirees.
- 4. The employer understands that the monthly premium must be received in the billing and enrollment administrator's office by the 25th of the month in which you receive your invoice. The employer understands that the PEIP may terminate the employer's insurance coverage after two premium delinquencies and that there will be a \$20 service fee for all Non-Sufficient-Fund (NSF) checks.

| EM | PLOYER SIGNATURE | EXCLUSIVE REPRESENTATIVE (if applicable) | | | | |
|--|------------------|--|--|--|--|--|
| I hereby apply for coverage stated within. I have reviewed the proposal, the terms of coverage, and the terms and conditions of participation in the Minnesota Public Employees Insurance Program. | | | I have reviewed the selections of coverages and acknowledge that the selections are in accordance with the current collective bargaining agreement. I further acknowledge that charges for selected coverages will be collected and remitted to the billing and enrollment | | | |
| Authorized Signature | Title | Date | administrator by their employer according to the procedures established by PEIP. | | | |
| Authorized Signature | Title | Date | Exclusive representative signature | | | |
| Authorized Signature | Title | Date | Title Date | | | |
| Agent of Record (if applicable) | | Date | | | | |
| Innovo Benefits Signature | | | Date | | | |