# CHECK LIST & GUIDELINES
## NEW FIRMS & OPEN ENROLLMENT RENEWAL

FOR NEW FIRMS

We have included this list to help you prepare your enrollment documents. In order for your company's benefits to be effective on the date you have elected, we must have all of these items in the "New Firms" column on or before the 15th of the month prior to that date. Thank you.

OPEN ENROLLMENT RENEWAL

In order to renew your current coverage April 1, 2011, we must have all of the following renewal documents by 3/15/2011 (earlier is better). Please use the checklist below to ensure you have completed all of the required paperwork (renewing firms column) for renewing firms. Thank you.

### ALL OF THE FORMS LISTED BELOW CAN BE VIEWED AND PRINTED FROM WWW.QAIM.COM

| NEW FIRMS | RENEWING FIRMS | If you are a new firm enrolling in our program, please submit the items in the first column. If you are a firm renewing coverage at Open Enrollment, please submit the items in the second column. |
|---|---|---|
| ☐ | ☐ | **PARTICIPATION AGREEMENT (PA) & EMPLOYER'S STATEMENT**<br>A new Employer's Request for Participation Agreement and Employer's Statement must be completed and signed, by the member firms Owner/Officer, upon initial enrollment and with every renewal. |
| ☐ | ☐ | **LATEST DE-6 / PROOF OF CORPORATE OFFICERS OR OWNERSHIP / OTHER PROOF OF ELIGIBILITY**<br>See the information on Proof of Eligibility and how to reconcile the DE-6 for a detailed explanation and sample of the required paperwork. |
| ☐ | ☐ | **2011 COBRA/CAL-COBRA QUESTIONNAIRE**<br>Required by all new and renewing firms annually. If you have not already submitted your 2011 COBRA Questionnaire, you must do so in order to renew for 4/1/11. |
| ☐ | ☐ | **2011 EMPLOYEE BENEFIT DETERMINATION QUESTIONNAIRES (CMS/MHP)**<br>This is a new form this year that is included in your Open Enrollment Packet. |
| ☐ | | **ORIGINAL APPLICATIONS FOR NEW ENROLLMENTS**<br>Completed and signed applications for each eligible owner/employee to be enrolled are required for enrollment in the medical, dental, vision and chiropractic/acupuncture plans. For applications to enroll in the life insurance please contact your Benefits Consultant or Plan Administrator. Incomplete applications may cause a delay in the entire firm's enrollment.<br>**FOR HEALTH NET APPLICANTS ONLY**<br>**HMO ENROLLEES** - The elected Primary Care Physician (PCP) ID# and name must be listed clearly for each person enrolling. If a PCP is not chosen, Health Net will choose one for the enrollee and all dependents.<br>**PPO/HSA ENROLLEES** - Please complete the "Other Health Insurance" information on the application. The benefits for the enrollee and dependents may be affected unless completed. |
| ☐ | | **FOR HEALTH NET APPLICANTS ONLY**<br>**NEW FIRMS ENROLLING 10 OR MORE** - A completed Employer's Health Statement is required to apply for a lower rate tier. If any questions are answered "yes" please have that employee(s) complete the Health Questionnaire. The final rate tier will be determined by Health Net Underwriting.<br>**New firms enrolling 6-9 with Health Net** - Each applicant is required to complete the Individual Health Questionnaire to apply for a lower rate tier, otherwise Tier I will be assigned.<br>**IMPORTANT**: The total number of employees on payroll will be submitted to the HealthNet to determine compliance under Federal Legislation related to the Mental Health Parity Act. ***Additional premiums will apply for HealthNet groups with over 50 Total Employees.*** |
| | ☐ | **TRANSFER FORMS**<br>At Open Enrollment you may transfer any employees from one like coverage to another by completing a Transfer Form which can be requested from your administrator. A transfer form can be used to move elected coverage from one HMO to another HMO or one PPO to another PPO. |
| | ☐ | **ORIGINAL APPLICATIONS FOR EXISTING FIRMS ENROLLING NEW EMPLOYEES / NEW PLANS**<br>Completed and signed applications for new enrollments, firms adding new plans and existing owners/employees adding new dependents. |
| ☐ | ☐ | **COVERAGE DECLINATIONS**<br>Every eligible owner/employee must either enroll or provide a signed declination. Owners/employees with eligible dependents must either enroll their dependents or provide a signed declination for each dependent. One combined declination can be used and must be provided for each coverage that applies. Proof of other Group Coverage must be attached, if applicable. |
| ☐ | | **INITIAL PREMIUM PAYMENT**<br>Upon enrolling in the NCBE Health Insurance Program a participating employer must prepay a minimum of one month's premium and reserve deposit for all coverages selected. The "Reserve Deposit" must be equal to the amount of the current monthly premium at all times.<br>**Make check payable to: North Coast Builders Exchange Insurance Trust** (NCBEIT). |

**PLEASE SEND ALL MATERIALS TO:**

North Coast Builders Exchange
PO Box 8070
Santa Rosa, CA 95407
Phone: (707) 542-9502
Fax: (707) 542-6529
E-mail: cindy@ncbeonline.com or kelly@ncbeonline.com

**ADMINISTRATION AND BILLING INFORMATION**

North Coast Builders Exchange Insurance Trust
PO Box 8070
Santa Rosa, CA 95407
Phone: (707) 542-9502
Fax: (707) 542-6529
E-mail: cindy@ncbeonline.com

ALL completed enrollment materials must be received in order to process your company's request for coverage.
Prior to receipt of ID cards, please call the North Coast Builders Exchange Insurance Administration staff to assist with access to coverage.

# EMPLOYER'S REQUEST FOR PARTICIPATION AGREEMENT (PA) & EMPLOYER'S STATEMENT WITH NORTH COAST BUILDERS EXCHANGE (NCBE)



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)** Required | 9. **SIC/NAICS CODE** Required |
|---|---|---|---|
| | | | |

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** — 2011 Renewal Effective Date: 4/1/2011

☐ **NEW MEMBER FIRMS WITH MEDICAL COVERAGE** — New Firm Effective Date: ______

**REQUESTED PARTICIPATION:** — BX/Assoc Membership Activation Date: ______

**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)*

| | | | |
|---|---|---|---|
| ☐ Date of hire (1st of month following) | ☐ 30 days of employment | ☐ 60 days of employment | ☐ 90 days of employment |
| | ☐ 120 days of employment | ☐ 180 days of employment | ☐ 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: ______



Continued

## 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 $30/$1,500
- ☐ Plan $40/$2,000

*If both Health Net AND Kaiser Permanente are selected, participation requirements apply.*

**HEALTH NET HMO PLANS****
- ☐ Value HMO 30◄
- ☐ Value HMO 40◄

**HEALTH NET ADVANTAGE HMOS**
- ☐ Advantage HMO 25◄
- ☐ Advantage HMO 35◄
- ☐ Advantage HMO 45◄

**PPO & HSA COMPATIBLE PLANS****
- ☐ Value PPO 30◄
- ☐ Value PPO 40◄
- ☐ Value HSA 4500

If Health Net HMO plans are chosen, are you offering the ☐ **FULL Network** or the ☐ **SILVER Network**?
- New member firms enrolling 10 or more in Health Net should complete the Health Net Employer Health Statement. New member firms enrolling 6-9 in Health Net should have each employee complete the Health Net Individual Health Questionnaire.

** 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 Paricipation 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

**HMO NETWORK?** ☐ Full ☐ Silver

**RATE TIER DESIGNATION:**
**HN:** ☐ Tier 1 ☐ Tier 2 ☐ Tier 3
**KP:** ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Tier 4 ☐ Tier 5

**MHPAEA STATUS**
(51+ Total Employees on DE6 more than 1/2 the year)
Yes: ☐ No: ☐



Continued

**As a member in good standing** of the North Coast Builders Exchange (NCBE), 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 North Coast Builders Exchange.

**To maintain** a current membership in good standing in the North Coast Builders Exchange 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:

| **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 |

* 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 reserve deposit 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. Premiums are due and payable in advance by the first (1st) of the month of coverage. Upon enrolling in the Health Program a participating employer must prepay a minimum of one month's premium and reserve deposit. Please note, all premiums include a 5% Administration fee.

**To hold** harmless the NBBE Insurance Program Board of Directors and the NCBE Insurance Trust Trustees for any action taken or omitted by them in good faith. The NBBE Insurance Program Board of Directors and the NCBE Insurance Trust Trustees 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.

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 1 to December 31, 2011. Rates and benefits will change January 1, 2012.**

**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.