

Employer Change Request Form

E-mail Address: groupprocessing@choicebuilder.com

• PLEASE DO NOT ALTER THIS FORM AS THIS WILL DELAY PROCESSING.
Company Name
Group #

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☐ **Change Address/Phone/Fax**
(Complete this section only if you have a change)
☐ Check here if business, billing and mailing address are the same

Group's new billing address	Street <input type="text"/>	City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/>
Group's new street address	Street <input type="text"/>	City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/>
Group's new phone and/or fax #	Phone # (XXX) XXX-XXXX <input type="text"/>	Fax # (XXX) XXX-XXXX <input type="text"/>		

☐ **Change Name of Business/Tax I.D. Number**
(Complete this section only if you have a change)

New business name <input type="text"/>	New DBA Name <input type="text"/>
New CA Federal Tax ID # <input type="text"/>	

☐ **Add/Change Contact**
(Complete this section only if you have a change)

Please add the individual(s) listed below as the primary/additional contact(s). Only authorized contacts may obtain confidential information regarding the Group. To add/change more contacts, complete Add/Change Contact section on an additional application.

☐ **ADD BROKER OF RECORD AS AUTHORIZED GROUP CONTACT**

I understand that by electing to add my Broker of Record as an Authorized Group Contact, my Broker of Record will have the ability to make changes on behalf of my group, which may result in a change of premium(s) and/or cancellation of coverage(s).

Primary Contact <input type="text"/>	Title/Position <input type="text"/>
Phone # (XXX) XXX-XXXX <input type="text"/>	E-mail Address <input type="text"/>
Additional Contact <input type="text"/>	Title/Position <input type="text"/>
Phone # (XXX) XXX-XXXX <input type="text"/>	E-mail Address <input type="text"/>

Please remove the contacts listed below as they are no longer authorized to obtain confidential information on the group:

Remove Contact <input type="text"/>	Title/Position <input type="text"/>
Remove Contact <input type="text"/>	Title/Position <input type="text"/>

▼ ▼ **THE FOLLOWING CHANGES CAN ONLY BE MADE ONCE A YEAR** *(continued on next page)* ▼ ▼

☐ **Change Pay Period**

How many pay periods per year? (will be shown on Employee Enrollment Worksheets)

☐ 12 ☐ 24 ☐ 26 ☐ 48 ☐ 52

☐ **Add/Change Chiropractic**
(Changes allowed at Renewal only)
(Complete this section only if you have a change)

Refer to the requirement section.

Step 1 - Select a benefit ☐ Chiropractic ☐ Chiropractic/Acupuncture

**If Employer Sponsored, 100% of premium is paid by the employer and 100% participation is required.*
Step 2 - Select type of contribution ☐ Employer Sponsored* ☐ Voluntary

Company Name

Group #

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THE FOLLOWING CHANGES CAN ONLY BE MADE ONCE A YEAR (continued from previous page)

☐ **Add/Change Life** (Changes allowed at Renewal only)

(Complete this section only if you have a change)

Employer is required to pay 100% of all premiums for eligible employees.

Step 1 - Select Type of Change

☐ Add Life ☐ Change Life Amount ☐ Change Carrier

Step 2 - Select Carrier

☐ **Assurity**

Guaranteed Issue Amounts are available as indicated in table below:

- ONLY flat amount available outside of Initial Enrollment
- Amounts must be in increments of \$5,000 (calculated from the minimum amount)
- Groups wishing to apply for Life amounts higher than the guaranteed issue amounts below must be medically underwritten. Please contact our Customer Service Center for more information. Refer to the requirement section.

Eligible Employees	Minimum Amount	Maximum Amount	# of Employee Classifications
2-10	\$10,000	\$10,000	N/A
11-25	\$10,000	\$25,000	N/A
26-199	\$10,000	\$50,000	N/A
200-500	\$10,000	\$150,000	N/A

☐ **MetLife**

Guaranteed Issue Amounts are available as indicated in table below:

- ONLY available at Initial Enrollment and Renewal
- Scheduled Amount:
 - o Minimum 3 Employees per classification
 - o No more than 2.5 X difference between classifications
 - o Employees must fall under specified classifications to qualify for specified amounts

Eligible Employees	Coverage Amounts Available	# of Employee Classifications
2-4	\$10,000; \$25,000	N/A
5-9	\$10,000; \$25,000; \$35,000; \$50,000	N/A
10-24	\$10,000; \$25,000; \$35,000; \$50,000; \$75,000	up to 2
25-49	\$10,000; \$25,000; \$35,000; \$50,000; \$75,000; \$100,000	up to 2
50-199	\$10,000; \$25,000; \$35,000; \$50,000; \$75,000; \$100,000; \$150,000	up to 3
200-500	\$10,000; \$25,000; \$35,000; \$50,000; \$75,000; \$100,000; \$150,000	up to 3

Step 3 - Select One Option for Employee Life Amount

☐ **Option 1 - Flat Amount**

Select a Flat amount for all employees

Amount

\$

Number of eligible employees

**Option 2 - Scheduled Amount** (select # of classifications that corresponds with the # of eligible Employees per the MetLife table in Step 2)

Life Amount	Employee Classification (i.e. management, executive, etc.)
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\$ \$ \$ ☐ **Add Section 125**

Premium Only Plan - Complete this section only if you want P.O.P. - WageWorks, a HealthEquity company.

Note: A one-time \$100 enrollment fee must be submitted.

Name of Company President, Principal, or Partners

State of Incorporation (if applicable)

Name of Corporate Secretary (if applicable)

Plan Number(usually 501)

Premium payments may be elected for ☐ Medical ☐ Dental ☐ Vision ☐ Other:Last day of first plan year
(MM/DD/YYYY)

(Usually 12 months after the effective date; subsequent plan years will be the 12 month period following this date)

Participation Limitations: P.O.P rules require that all participants in the plan be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore, are ineligible to participate in the P.O.P.

Important: Read the information provided in your ChoiceBuilder Quote pertaining to the Section 125 Premium Only Plan and tax consequences.



Company Name

Group #

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THE FOLLOWING CHANGES CAN ONLY BE MADE ONCE A YEAR (continued from previous page)

☐ **Change Dental** (Changes allowed at Renewal only)

(Complete this section only if you have a change)

Refer to the requirement section. Waiting period may apply with carrier change. Delta Dental DHMO must be offered along with one PPO.**Step 1 - Select a carrier** ☐ Ameritas ☐ Anthem Blue Cross ☐ Delta Dental PPO ☐ MetLife**Step 2 - Select type of contribution** ☐ Employer Sponsored* ☐ Voluntary

* Complete Step 3 - Employer must pay a minimum of 50% of each employees lowest cost plan

Step 3 - Select ONE option**Option 1 - Percentage of Cost**

Enter the percentage to contribute for each employee:

 % For Employees (minimum contribution is 50%) % For Dependents (no minimum)

- | | |
|--|--|
| <input type="checkbox"/> Highest - Cost Plan | <input type="checkbox"/> Lowest - Cost Plan |
| <input type="checkbox"/> Highest - Cost DHMO Plan | <input type="checkbox"/> Lowest - Cost DHMO Plan |
| <input type="checkbox"/> Highest - Cost PPO Plan | <input type="checkbox"/> Lowest - Cost PPO Plan |
| <input type="checkbox"/> Plan Selected by Employee | <input type="checkbox"/> Specific Plan _____ |

Option 2 - Fixed Dollar Amount

Enter the dollar amount to contribute for each employee:

(must be at least 50% of the lowest cost plan for each employee)

\$ for Employee\$ for Dependents (no minimum)**OR**
\$ for Employee with remainder to Dependents☐ **Orthodontia** (Changes allowed at Renewal only)

(Complete this section only if you have a change)

Waiting period may apply. Available with PPO carrier. Ameritas requires 5+ eligible to enroll. Anthem Blue Cross requires 10+ eligible employees (Employer Sponsored only). Delta Dental PPO requires 10 + eligible employees with 5 + enrolled. MetLife requires 10+ eligible employees with 5+ enrolled.☐ Add Orthodontia ☐ Cancel Orthodontia☐ **Add/Change Vision** (Changes allowed at Renewal only)

(Complete this section only if you have a change)

Refer to the requirement section.**Step 1 - Select a carrier** ☐ EyeMed (provided by Ameritas) ☐ VSP**Step 2 - Select type of contribution** ☐ Employer Sponsored* ☐ Voluntary

* Complete Step 3 - Employer must pay a minimum of 50% of each employees lowest cost plan

Step 3 - Select ONE option**Option 1 - Percentage of Cost**

Enter the percentage to contribute for each employee:

 % For Employees (minimum contribution is 50%) % For Dependents (no minimum)

- | | |
|--|--|
| <input type="checkbox"/> Highest - Cost Plan | <input type="checkbox"/> Lowest - Cost Plan |
| <input type="checkbox"/> Plan Selected by Employee | <input type="checkbox"/> Specific Plan _____ |

Option 2 - Fixed Dollar Amount

Enter the dollar amount to contribute for each employee:

(must be at least 50% of the lowest cost plan for each employee)

\$ for Employee\$ for Dependents (no minimum)**OR**
\$ for Employee with remainder to Dependents☐ **Change Hours of Eligibility** (Renewal only)

(Complete this section only if you have a change)

Coverage must be extended to all employees working the number of hours per week considered to be eligible. Refer to requirement section for additional information.Eligible employees must work the following number of hours to qualify: ☐ 20+ hours per week ☐ 30+ hours per week☐ **Change Waiting Period to First of the Month Following** (Renewal only)

(Complete this section only if you have a change)

All employees currently in the waiting period must either enroll at Renewal or be subject to the new waiting period selected.☐ Date of Hire ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

RENEWAL CHANGE REQUIREMENTS:

Change from Employer Sponsored to Voluntary Dental	<ul style="list-style-type: none"> • 2-9 Employees: Anthem Blue Cross; minimum five eligible with minimum two enrolled. MetLife; minimum 2 eligible with minimum 2 enrolled • 10-500 Employees: Anthem Blue Cross; minimum five eligible with minimum two enrolled. All other Dental Plans; minimum ten eligible with minimum five enrolled • Current quarterly/annual wage report or payroll may be requested if less than 10 enrolling • Employer contribution not applicable
Change from Voluntary to Employer Sponsored Dental or Vision	<ul style="list-style-type: none"> • Current quarterly/annual wage report or payroll may be requested • 100% participation required for employer size of 2 eligible employees or sole proprietor with 1 employee • 70% participation required for employer size of 3-500 employees (participation based on eligible employees) • Employer must pay at least 50% of the lowest cost plan for all employees • When employer contribution is 100%, employees cannot waive due to cost or individual coverage. Employees waiving due to other group coverage will be counted to determine 70% participation requirement.
Add Orthodontia Coverage	<ul style="list-style-type: none"> • Orthodontia available with PPO Carriers (Note: Ameritas Orthodontia only available to groups with 5 or more eligible employees. Anthem Blue Cross Orthodontia only available to groups with 10 or more eligible employees (Employer Sponsored only). Delta Dental Orthodontia only available to groups with 10 or more eligible employees with 5 or more enrolled. MetLife Orthodontia only available to groups with 10 or more eligible employees with 5 or more enrolled. • 12 month waiting period applies (Ameritas (Employer Sponsored and Voluntary)).
Change from Employer Sponsored to Voluntary Vision	<ul style="list-style-type: none"> • No minimum participation • Employer contribution not applicable
Change from Voluntary to Employer Sponsored Chiropractic/Acupuncture	<ul style="list-style-type: none"> • 100% participation required (based on eligible employees) • Employer must pay 100% of the premium
Change from Employer Sponsored Chiropractic/Acupuncture to Voluntary	<ul style="list-style-type: none"> • No minimum participation • Employer contribution not applicable
Add Life Coverage	<ul style="list-style-type: none"> • 100% participation required (based on eligible employees) • Employer must pay 100% of premium • Assurity: Employer may select life amounts in increments of \$5,000; MetLife: Employer may select life amounts listed in table for MetLife (available at Initial Enrollment and Renewal <u>ONLY</u>) • A reconciled quarterly/annual wage report may be requested with all employees accounted for (i.e. E=eligible, PT=part-time, T=terminated, S=seasonal, etc.)



ADDITIONAL TERMS & CONDITIONS TO THE CHOICEBUILDER® WELFARE BENEFIT INSURANCE TRUST MASTER APPLICATION

1. **Participation.** The employer or employee organization (as described in sections 3(4) or 3(5) of ERISA, respectively) named in the Master Application ("**Participating Employer**") hereby adopts as a participating employer the ChoiceBuilder Welfare Benefit Insurance Trust (the "**Trust**"), as set forth in the instrument(s) creating such Trust (the "**Trust Agreement**"). Such action shall be effective on the date shown below with respect to the sub-trust first named below that the Participating Employer is eligible to adopt in accordance with the terms of the Trust.
- (a) Master Trust
 - (b) Industry Sub-Trust
 - (c) Single Employer Sub-Trust
2. **Ratification of Trust Agreement.** Participating Employer hereby ratifies, accepts and agrees to be bound by all of the provisions of the Trust Agreement as amended from time to time, a copy of which has been made available to it.
3. **Acceptance of Trustee and Administrator.** Participating Employer hereby accepts the trustee and administrator named in the Trust Agreement as the trustee and administrator of the Trust (the "**Trustee and Administrator**") with all of the rights, powers and responsibilities set forth in the Trust Agreement and agrees to be bound by and ratifies the actions heretofore or hereafter taken by the Trustee and Administrator in accordance with the terms of the Trust Agreement.
4. **Trustee's Action.** Participating Employer acknowledges and agrees that its request to participate in the Trust pursuant to this Request for Participation shall not be effective until accepted by the Trustee in accordance with the terms of the Trust Agreement. Trustee hereby represents that, before this Request for Participation was entered into, all information described in Paragraph 9 hereof was provided to the fiduciary of the Participating Employer with the authority to enter the Participating Employer into the Trust (the "**Responsible Plan Fiduciary**").
5. **Benefits Subject to Provisions of Insurance Policies.** Participating Employer agrees to be bound by the terms and conditions of the Trust Policies (as defined in the Trust Agreement) under which its employees become covered and agrees to pay all premiums required by the provisions of the Trust Policies for the coverage's it purchases. Participating Employer understands that the insurance coverage's it elects to purchase hereunder may terminate or lapse if such premiums are not paid when required by the provisions of the Trust Policies.
6. **Assignment to Applicable Trust.** Participating Employer agrees that the Trustee may assign or cause it to be assigned to any sub-trust under the Trust for which the Participating Employer is eligible at the time of this request. The Participating Employer acknowledges that it has indicated its proper Standard Industry Classification Code below to facilitate such assignment and that the Trustee may assign or cause it to be assigned to a different sub-trust under the Trust for which it becomes eligible in the future, should the Trustee deem this advisable.
7. **Establishment of Plan; Designation of Claims Administrator.** Participating Employer agrees that, by adopting this Trust, it is establishing an employee welfare benefit plan (the "**Plan**") in accordance with the Employee Retirement Security Act of 1974, as amended ("**ERISA**") to provide its eligible employees with the insurance benefits provided by the Policies. Participating Employer further agrees that it will communicate the terms of the Plan to all eligible employees, and will maintain such Plan in full force and effect so long as any employee remains eligible for such insurance benefits. Participating Employer hereby designates, in accordance with Section 503 of ERISA, the Carrier issuing a Policy as the named fiduciary under the Plan with complete and discretionary authority to review all denied claims for insurance benefits under such Policy and to construe disputed or doubtful Policy terms with respect to such insurance benefits, and that such Carrier shall be deemed to properly exercise such authority unless it abuses its discretion by acting arbitrarily and capriciously.
8. **Disclosure of Fees and Conflicts of Interest.** Notwithstanding anything herein to the contrary, this Request for Participation shall not become effective until the Trustee, to the best of its knowledge, provides or causes to be provided to the Responsible Plan Fiduciary the following disclosures or such other disclosures as may be required by ERISA:
- (a) All services to be provided by the Trustee or any of its affiliates (collectively, the "**Service Providers**") pursuant to the Trust Agreement, this Request for Participation and any other agreements or arrangements related to the provision of benefits by the Trust or Policies (collectively, the "**Service Agreements**"), the compensation or fees (including, gifts, awards, or trips received, or to be received, from any source on account of the Service Provider's position with the Plan) for such services, and the manner of receipt of such compensation. Such disclosure shall provide a description of the manner of receipt of compensation or fees and shall state whether the Service Providers will bill the Participating Employer, deduct fees directly from the Plan accounts, or reflect a charge against the Plan investment. Such disclosure will also describe how any prepaid fees will be calculated and refunded when Participating Employer withdraws from the Plan.
 - (b) Whether any Service Provider will provide any services to the Plan as a fiduciary either within the meaning of Section 3(21) of ERISA or under the Investment Advisers Act of 1940.
 - (c) Whether any Service Provider expects to participate in, or otherwise acquire a financial or other interest in, any transaction to be entered into by the Plan and, if so, a description of the transaction and the Service Provider's participation or interest therein.
 - (d) Whether any Service Provider has any material financial, referral, or other relationship or arrangement with a money manager, broker, other client of the Service Provider, other service provider to the Plan, or any other entity that creates or may create a conflict of interest for the Service Provider in performing services to the Plan and, if so, a description of such relationship or arrangement.
 - (e) Whether any Service Provider will be able to affect its own or another Service Provider's compensation or fees, from whatever source, without the prior approval of an independent fiduciary of the Plan, in connection with the provision of services to the Plan (for example, as a result of incentive, performance-based, float, or other contingent compensation) and, if so, a description of the nature of such compensation.
 - (f) Whether any Service Provider has any policies or procedures that (i) address actual or potential conflicts of interest or (ii) are designed to prevent either compensation or fees or any other business ventures or relations that may be entered into between the Plan and a Service Provider, from adversely affecting a Service Provider's ability to provide services under the Service Agreements, and, if so, an explanation of these policies or procedures and how they address such conflicts of interest or prevent an adverse effect on the provision of services.
- The Trustee shall disclose or cause to be disclosed to the Responsible Plan Fiduciary any material change to the information disclosed above not later than 30 days from the date on which the Service Provider acquires knowledge of the material change. The Trustee shall also disclose or cause to be disclosed all information related to the Service Agreements and any compensation or fees received there under that is requested by the Responsible Plan Fiduciary or administrator of the Plan in order to comply with the reporting and disclosure requirements of Title I of ERISA and the regulations, forms, and schedules issued there under.

Acknowledgment: Person signing form must be an authorized contact on record for ChoiceBuilder.

Authorized Group Contact Signature

Print Name

Today's Date (MM/DD/YYYY)

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