Capital Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association

Employee Group Health Benefit Proposal

Group Name: ASSOCIATION OF FLORIDA COLLEGES
Renewal Date: 10/1/2018
Agency Name: Legacy Insurance Solutions, LLC
Agent Name: Howard Shapiro
CHP Group Number: S3059

Subscriber ...Dependents	Age At Renewal	3101-Platinum	3102-Platinum	3104-Gold
BRAWER, MICHAEL P	62	$1,107.53	$1,096.83	$967.87
Subtotal:		$1,107.53	$1,096.83	$967.87
FISHBURNE, LUCIA M	63	$1,137.98	$1,126.99	$994.48
Subtotal:		$1,137.98	$1,126.99	$994.48
JOHNSON, EILEEN M	43	$523.12	$518.06	$457.15
... JOHNSON, KEVIN L	42	$510.78	$505.85	$446.37
... JOHNSON, ABIGAIL G	12	$294.90	$292.05	$257.72
... JOHNSON, AUDREY L	9	$294.90	$292.05	$257.72
... JOHNSON, TANNER	3	$294.90	$292.05	$257.72
Subtotal:		$1,918.60	$1,900.06	$1,676.68
KINER, MARSHA E	49	$657.66	$651.30	$574.72
Subtotal:		$657.66	$651.30	$574.72
~~WHEATCROFT, BELINDA K~~ (No longer Employed)	~~29~~	~~$431.37~~	~~$427.20~~	~~$376.97~~
Subtotal:		$431.37	$427.20	$376.97
WHIDDON, SHARLEE L	33	$461.82	$457.36	$403.59
... WHIDDON, CORY R	36	$474.16	$469.58	$414.37
... WHIDDON, JEB R	7	$294.90	$292.05	$257.72
... WHIDDON, COOPER B	2	$294.90	$292.05	$257.72
Subtotal:		$1,525.78	$1,511.04	$1,333.40
Total:		**~~$6,778.92~~**	**$6,713.42**	**$5,924.12**

$6,347.55

Rate quotes are based on the current census data at the time the renewal is generated. Actual costs are based on the final enrollment data of employees and dependents insured on the plan's renewal date. Please check your premium rate option and sign below:

Date	Signature of Applicant	Print/Type Name and Title
8/7/18		Michael Brawer, CEO
Date	**Signature of Florida Agent/License ID#**	**CHP Licensed Agent (Print/Type Name)**

Rate Comparison

Capital Health PLAN℠
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☒ Renewal ☐ New_____

Small Employer Application

Group Name (full and legal name is required)
ASSOCIATION OF FLORIDA COLLEGES

Doing Business As (if applicable)

Nature of Business/NAIC Code

Employer Classification
☐ Corporation ☐ Partnership ☐ Sole Proprietor
☐ Non-Profit ☐ Other

Group Physical Address
1725 MAHAN DRIVE

ERISA Classification
(Employee Retirement Income Security Act as defined by the U.S. Department of Labor)
☐ ERISA ☐ Non-ERISA

City TALLAHASSEE **State** FL **Zip** 32308

Group Mailing Address (if different from above)

City **State** **Zip**

Decision Maker Name and Title
Michael Brauer, CEO

Contact Person Name and Title
Eileen Johnson Dir of Admin

Worker's Compensation Carrier
Zenith Insurance

Phone 222-3222 **Fax** 222-3327

Prior Health Insurance Carrier
CHP

e-Mail
ejohnson@myafchome.org

Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Capital Health Plan (CHP). Upon acceptance of this application by CHP, it will become part of the Policy issued to the applicant named above.

The original effective date of this Policy shall be: 10/1/2018

This Policy may be terminated by the applicant or CHP by giving at least 45 days prior written notice to the other party except in the case of nonpayment of Premium.

Employer Contribution: Employee _____ % Dependent _____ %
or $_____ or $_____

Waiting Period
☐ Immediately on date of hire ☒ 1st of the month following date of hire

Add New Eligible Employees:
☐ 1st day of the month following 30 Days ☐ 1st of the month following 60 days

Do you impose a probationary or an orientation period prior to the wait period starting?
☐ Yes: How long is the period? (maximum one month) _____
☐ No: Wait period begins immediately upon employment.

Coverage for new eligible employees may be effective as selected above as long as the eligible employee submits an application to CHP within 30 days of the date the individual meets the applicable eligibility requirements.

Average Total Number of Employees

Please provide your "average total number of employees" during the preceding calendar year, in the space below.

NOTE: For purposes of calculation, the term "employee" is defined by ERISA and means any individual employed ***(including full-time, part-time and seasonal employees).***

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average
Full-Time	6	6	6	6	6	6	6	6	6	6	6	6	6
Part-Time													
Seasonal													
TOTAL	6	6	6	6	6	6	6	6	6	6	6	6	6

6	Total # of employees (including owners and partners, etc.) currently employed by your business
0	# of new full-time employees still in waiting period
0	# of Part-time/Seasonal Employees
0	# of COBRA/FHICCA Continuants
1	# of employees waiving CHP health benefits but are covered on another group health benefit plan
	# of employees waiving CHP health benefits without group coverage elsewhere

☐ Yes ☐ No Is your company a member of a Controlled Group of Corporations as referenced in section 414 of Internal Revenue Code of 1986 (26 U.S.C. §414(b), (c), (m), or (o))?

If yes, please give the legal names, addresses, and employer identification numbers of all other legal entities within the Controlled Group of Corporations (use separate sheet if necessary):

COBRA COMPLIANCE (CHECK APPROPRIATE BOX)

☐ Our company employed at least 20 employees* on more than 50% of our typical business days in the previous calendar year and is subject to federal COBRA. (Under Federal Law, you must provide employees with COBRA Continuation.)

☒ Our company employed fewer than 20 employees* during the previous calendar year and is subject to the Florida Health Insurance Coverage Continuation Act ("FHICCA"). (Your employees are eligible for coverage under "FHICCS".)

*Both full and part-time employees are considered in determining COBRA compliance. All full-time employees are counted as one employee and each part-time employee is counted as a fraction of an employee. For COBRA and FHICCA purposes, self-employed individuals, independent contractors and non-employee directors are not included. Owners, partners, and others paid by the employer(s) are included.

MEDICARE SECONDARY PAYER COMPLIANCE (CHECK APPROPRIATE BOX)

Under federal law, it is the employer's responsibility to inform its insurer of proper employee counts for the purpose of determining payment priority between Medicare and another insurer. Employer size, not group health insurance plan size, is used in determining whether the group health insurance plan or Medicare is the primary payer. "Employees" includes all full and/or part time employees. Multiple employer plan: a plan sponsored by more than one employer. Multi-employer plan: a plan jointly sponsored by employers and unions

If you are a single employer plan:

☐ Yes ☒ No Our company employed 20 or more full and/or part-time employees each working day for 20 or more calendar weeks (does not have to be consecutive weeks) during the current or preceding calendar year.

If you are a single employer, multiple employer or a multi-employer plan:

☐ Yes ☒ No Our company employed 50 or more full and/or part-time employees on 50 percent more of the business days during the preceding calendar year.

If you are a multiple employer or a multi-employer plan:

☐ Yes ☐ No All employers in our Group Health Plan (GHP) employed 20 or more employees.*

☐ Yes ☐ No At least one of the employers in our GHP employed 20 or more employees.*

☐ Yes ☐ No All employers in our GHP employed fewer than 20 employees.*

*The employees must be employed for 20 or more consecutive weeks in either the current or preceding calendar year.

CHP shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage; applicant agrees to furnish documents as requested. Only eligible employees who have met the applicable waiting period and who work a minimum of 25 hours each week and their eligible dependents shall be eligible for coverage on the Effective Date of this Policy.

Rate Information

Premiums/Prepayment fees are payable on or before the due date. Regular Billing - Employee applications should be submitted 30 days before the proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination. The Rates established for this Policy will not be changed for the first 12 months following the original Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, CHP may change the Rates that are to be effective after this initial 12 month period of coverage by providing notice to the employer of such changed Rates 60 days before their Effective Date. The amount of premium may be modified by CHP at any time with at least 30 days written notice to the employer of any such change.

Contribution Requirements

Minimum Employer Contribution Table
This is a requirement and not a guideline.

Group Size	Employees	Dependents
1 - 3	100%*	0%
4 - 50	50%	0%

*When an employer contribution is 100%, all employees are required to enroll in the health plan (excluding those with other coverage).

Does the applicant meet the minimum employer contribution requirements to be considered for Small Group Coverage?

☐ Yes ☐ No If a new Small Group Employer fails to meet the contribution requirements, Capital Health Plan will only accept the application from 11/15 to 12/15 for a January 1 effective date in accordance with 45 C.F.R. § 147.104.

Participation Requirements

Minimum Employer Participation Table
This is a requirement and not a guideline.

Group Size	Employees
1 - 3	100%*
4 - 50	75%*

*When an employer contribution is 100%, all employees are required to enroll in the health plan (excluding those with other coverage).

Does the applicant meet the minimum employer participation requirements to be considered for Small Group Coverage?

☐ Yes ☐ No If a new Small Group Employer fails to meet the participation requirements, Capital Health Plan will only accept the application from 11/15 to 12/15 for a January 1 effective date in accordance with 45 C.F.R. § 147.104.

Benefit Plan Selection

I acknowledge that I have reviewed the Benefit Plan offerings and the associated rates for those plans. As the authorized group representative, the following Benefit Plan is selected (choose one only):

☒ 3101 - Platinum ☐ 3102 - Platinum ☐ 3104 - Gold

See the Group Master Policy and Member Handbook for a complete description of benefits

Applicant Responsibilities

The applicant shall:

1. Notify each enrollee of the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of CHP for this or any other purpose, nor shall CHP be responsible for such notification to retirees).
2. Deliver to covered enrollees Member Handbooks and the Summary of Benefits and Coverage (SBC).
3. Notify CHP promptly of any changes in eligibility of enrollees covered under this Agreement.
4. List any absentees at the time of initial enrollment on the appropriate CHP form. Applications from absentees will be accepted at CHP's Enrollment Department no later than 30 days from the group's original Effective Date.
5. Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to CHP as specified in this application. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
6. Applicant hereby acknowledges receipt and review of the CHP Confidentiality Notice and agrees to abide by said notice. Applicant acknowledges that it may be liable to CHP and/or others should it fail to comply with the requirements of said notice.

The Patient Protection and Affordable Care Act (ACA) requires health plans offered in the small group market include Essential Health Benefits (EHBs) as defined in sections 1302(a) and (b). EHBs include pediatric dental care, which must be offered to children younger than 19. Pediatric dental benefits may be provided through a mix of comprehensive coverage plans or bundled coverage (45 CFR 156.150 and 1311(d)(2)(B)(ii) of PPACA) separate from the major medical coverage. Capital Health Plan provides pediatric dental benefits through the bundled coverage model through our alliance dental plan or through the insurance market as a stand-alone product. Capital Health Plan must be reasonably assured that your organization has the required level of coverage for pediatric dental services. This policy will not be issued without reasonable assurance that pediatric dental coverage is offered to all your eligible employees.

Do you want to purchase or renew stand-alone pediatric (children up to age 19) dental coverage through Capital Health Plan's alliance with Delta Dental Insurance Company to provide the required coverage?

☐ **Yes, we want to purchase or renew pediatric (children up to age 19) dental coverage through Capital Health Plan's alliance with Delta Dental Insurance Company.** Your employees and their dependents' information will be provided via secure transmission to Delta Dental for enrollment. You will receive your Dental Plan Coverage Documents from Delta Dental. Monthly premiums will be billed separately by Delta Dental and paid directly to Delta Dental by you, the employer. There are no contribution level requirements for dental coverage, thus the employer may collect the full dental care premium from the employee to pay Delta Dental.

☒ **No, we do not want to purchase or renew pediatric dental coverage through Capital Health Plan's alliance with Delta Dental Insurance Company,** as we already offer ACA-compliant pediatric dental coverage through a stand-alone dental plan. If you have coverage through Delta Dental via CHP and do not wish to renew it, you must term the employer group in Delta Dental's online system and list your replacement coverage here.

Please provide the following information on your dental plan coverage:

Company Name: Principal

Name of Benefit Plan: Dental

☐ **No, we do not want to purchase pediatric dental coverage through Capital Health Plan's alliance with Delta Dental Insurance Company,** and we do NOT currently offer ACA-compliant pediatric dental coverage through a stand-alone dental plan. *Since we will not be in compliance with the ACA, we understand the group health care coverage with Capital Health Plan will be terminated at the end of the current contract year.*

I also certify that the information included in this application is correct to the best of my knowledge. I understand that this information will be used to determine my group's compliance with CHP eligibility and Underwriting Guidelines, as well as the applicability of state and federal laws relating to my group and plan. CHP reserves the right to request an RT-6 (formerly UCT-6) or other documentation as evidence of business activity at any time to validate my compliance with eligibility and Underwriting Guidelines, as well as validate the applicability of state and federal laws. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Final premiums, benefits, and effective date are subject to approval by Capital Health Plan.

This application must be filled out completely. Questions left unanswered or information not provided will result in return of the application. This could affect your coverage effective date.

Date	Signature of Applicant	Print/Type Name and Title
8/7/18		Michael Brawer CEO
Date	**Signature of Florida Agent**	**CHP Licensed Agent (Print/Type Name)**
	FL Agent License Identification Number	