BEX Benefit Plan
The Future of Health Benefits

Employer Group Enrollment/Change Form

1. Group/Company Information

Business Name				
Has this business ever been known by another name? ☐ Yes ☐ No If yes, what name(s)?				Membership # (if applicable)
Business Address (No P.O. Boxes)			Billing Address	
City	County	State	Zip Code	Business Phone Number
Office Manager	Billing Contact			Business Fax Number
Business E-Mail	Number of years in business (If less than one year specify the date the business started.)			
Type of Business (be specific)	SIC Code/NAICS Code			Employer/Federal Tax ID #

Is the employer contribution at least 25% of each contract? ☐ Yes ☐ No

Do you have any affiliations with other companies or unions (include parent, subsidiary, joint venture, etc...) ?

☐ Yes ☐ No If yes, please describe. _____

If yes, do any of these affiliates qualify as a single employer under subsection (b), (c), (m), or (o) of the Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID# and number of employees.

_____

_____

_____

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2. Enrollment Criteria

Eligible Employee Definition: What is the minimum # of hours to be worked per week for employees to be considered eligible for benefits*_____

Probationary Period for New Hire Benefits

- ☐ Date of Hire
- ☐ First of month following Date of Hire
- ☐ 30 calendar days following Date of Hire
- ☐ First of month following 30 calendar days
- ☐ 60 calendar days following Date of Hire
- ☐ First of month following 60 calendar days

Probationary Period for Rehire ☐ same as above ☐ other_____

Waive probationary period for initial enrollment? ☐ Yes ☐ No

* Minimum must be within 20 – 30 hours per week, for full time eligibility for groups with 50 or fewer eligible employees.

Participation	Active**	COBRA	Retired**
Total number of current employees (part time & full time)			
Total number of eligible employees			
Number of eligible employees applying for coverage			
Total number of ineligible employees			
Total number of waivers			

**Including owners, officers and partners who receive compensation from the company, reported on a tax form other than a 1099.

Provide details below for anyone currently eligible or enrolled in COBRA.

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

Provide details below for any retirees who meet the eligibility requirements AND are members of a formal retirement program?

Name	Social Security #	Age at Retirement	Date of Retirement	Date of Hire	Avg. Hrs. Worked Per Week Prior to Retirement

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3. Products

Employers of more than twenty-five (25) employees may select up to three options.
Employers of more than ten (10) and fewer than twenty-five (25) employees may select up to two options.
Employers of fewer than ten (10) employees may make one health plan election.

Health Plan Options

☐ $500/80% ☐ $1000/80% ☐ $2250/80% ☐ $5000/80% ☐ $4000/100% ☐ $7000/100%
☐ HSA 2500 MMRx ☐ HSA 3000 MMRx ☐ HSA 3000 PD Rx ☐ HSA 4000 MMRx
☐ HSA 4000 PD Rx ☐ HSA 5000 MMRx ☐ HSA 5000 PD Rx ☐ HSA 6750 MMRx ☐ HSA 7000 MMRx

Dental Plan Options — **Ortho Rider**

☐ Dental PPO 1 $1000 CY Max (Employer Sponsored)..... ☐
☐ Dental PPO 1 $1000 CY Max (Voluntary)

☐ Dental Value PPO 1 $1000 CY Max (Employer Sponsored)..... ☐
☐ Dental Value PPO 1 $1000 CY Max (Voluntary)
☐ Dental Value PPO 1 $1000 CY Max (Open Access)

☐ Dental PPO 2 $1000 CY Max (Employer Sponsored)..... ☐
☐ Dental PPO 2 $1000 CY Max (Voluntary)

☐ Dental Value PPO 2 $1000 CY Max (Employer Sponsored)..... ☐
☐ Dental Value PPO 2 $1000 CY Max (Voluntary)
☐ Dental Value PPO 2 $1000 CY Max (Open Access)

☐ Dental Value PPO 3 $1000 CY Max (Employer Sponsored)..... ☐
☐ Dental Value PPO 3 $1000 CY Max (Voluntary)
☐ Dental Value PPO 3 $1000 CY Max (Open Access)

Ortho Rider

☐ Dental PPO 1 $1500 CY Max (Employer Sponsored)..... ☐
☐ Dental PPO 1 $1500 CY Max (Voluntary)

☐ Dental PPO 2 $1500 CY Max (Employer Sponsored)..... ☐
☐ Dental PPO 2 $1500 CY Max (Voluntary)

☐ Dental Value PPO 1 $1500 CY Max (Employer Sponsored)..... ☐
☐ Dental Value PPO 1 $1500 CY Max (Voluntary)

☐ Dental Value PPO 2 $1500 CY Max (Employer Sponsored)..... ☐
☐ Dental Value PPO 2 $1500 CY Max (Voluntary)

Vision Plan Options

☐ EyeMed Vision

4. Employer Funding

Is any part of the employee's or dependent's deductible being funded by the employer or from an employer-established account? ☐ Yes ☐ No If so, how much? Single: _____ Family: _____
Does the employer fund first? ☐ Yes ☐ No

5. Current and Prior Carrier History

List all carriers used for all product lines of insurance offered to the employees for the past 5 years. If there are no carriers, indicate NONE. (list current carrier first)

Carrier Name	Continuing Coverage	Benefits*	Dates From	Dates To	Current Rates** Emplye	Spouse	Child	Family	Renewal Rates** Emplye	Spouse	Child	Family
	☐											
	☐											
	☐											

*Examples: Traditional, PPO, HMO, Self Insured, etc...
**If you're age banded with current carrier, please provide most recent billing statement.

6. Validations

Has anyone within the past 24 months been hospitalized, institutionalized or missed work due to any disability or work related injury? ☐ Yes ☐ No If yes, provide details below.

Patient Name	Describe Illness or Condition

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7. Terms and Conditions

I, as the undersigned employer and eligible organization duly organized under the laws of the state of Ohio, hereby apply to the Builders Exchange Benefit Plan. I acknowledge that I am applying for an employee health benefit offered collectively through the Builders Exchange Benefit Plan under a certificate of authority issued by the Ohio Department of Insurance and that this benefit may be subject to special terms and conditions outlined by the Builders Exchange Benefit Plan Summary Plan Description and Plan Document as amended from time to time by the Board of Trustees of the Builders Exchange Benefit Plan.

I understand, acknowledge and agree to the following:

- This Employer Group Enrollment/Change Form ("Application") is not a contract for benefits. I should continue my current coverage until I am notified in writing that the Builders Exchange Benefit Plan has accepted this Application.
- If this Application is accepted by the Builders Exchange Benefit Plan, the actual benefits will be specified in the group participation agreement and that said benefits will take effect on the date specified in a communication from a representative of the Builders Exchange Benefit Plan.
- For all groups, each employee not enrolling must complete the waiver section of the applicable employee application and each employee enrolling must complete all sections of the applicable employee application.
- To be eligible for coverage through the Builders Exchange Benefit Plan, all participants must meet the eligibility requirements set forth in the plan documents of the Builders Exchange Benefit Plan and: 1) for employee coverage, all employees must be active, full-time employees drawing a regular paycheck, whose compensation is reported on IRS Form W-2.
- To be eligible for coverage, I must comply with all applicable laws of the State of Ohio. By applying for coverage, I agree that the Builders Exchange Benefit Plan may, from time to time, verify my compliance with the underwriting, eligibility or participation standards of the pertinent program. I agree to provide payroll records if requested by a representative authorized by the Builders Exchange Benefit Plan or Medical Mutual.
- Any untrue or incomplete information, statements or answers on this Application or engaging in any fraudulent conduct, deceptions or intentional and material misrepresentation relating to any application, coverage, claim or usage of a Builders Exchange Benefit Plan identification card, can result in denial of a claim or rescission of coverage for me or any group member, and may subject me or any group member to legal action by the Builders Exchange Benefit Plan. I have a duty to notify the Builders Exchange Benefit Plan of any changes to the information contained in this application.
- Approval and acceptance of this Application and individual employee applications are subject to underwriting guidelines as permitted by law. Checking boxes does not cause automatic enrollment. The Builders Exchange Benefit Plan must approve this Application for health coverage.
- By signing this Application, I represent that this group or company is not an entity that has been formed primarily to obtain benefits, and it does not permit membership in this group or company solely for the purpose of obtaining benefits.
- No agent or broker has the authority to: (1) bind the Builders Exchange Benefit Plan by making promises regarding eligibility, benefits, or the issuance of coverage; (2) waive any answer or any portion of any answer to any question on this Application or any information the Builders Exchange Benefit Plan requests; (3) approve coverage; (4) make or alter any contract on behalf of the Builders Exchange Benefit Plan; or (5) waive or alter any of the Builders Exchange Benefit Plan rights or requirements.
- All contract terms must be in writing and signed or accepted in writing by an authorized representative of the Builders Exchange Benefit Plan.
- I have seen a copy of the benefits proposal and agree to pay the required contributions (funding rates), including the $39 fee for late payments, to the Builders Exchange Benefit Plan when due and in accordance with the guidelines pertaining to billing and collections. I further agree to give all eligible employees an opportunity to enroll for coverage if contributions from employees are required. I agree to pay the Builders Exchange Benefit Plan the funding rate billed to me by the Builders Exchange Benefit Plan and to pay other charges or expenses assessed against me under this agreement or the terms of the Builders Exchange Benefit Plan. The Builders Exchange Benefit Plan's Board of Trustees (Board) will provide written notice to me of any changes in the funding rate. I acknowledge that the funding rate may be changed at any time, without prior notice, as deemed necessary by the Board in its sole discretion.
- By applying for coverage, I agree that the Builders Exchange Benefit Plan may, from time to time, verify my compliance with the underwriting, eligibility, or participation standards of the pertinent program. I agree to provide payroll records, if requested by a representative authorized by the Builders Exchange Benefit Plan or Medical Mutual.

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7. Terms and Conditions (cont'd.)

- Underwriting guidelines are in force from the effective date of this contract and remain in effect for each subsequent renewal contract period unless written notification is provided by the Builders Exchange Benefit Plan. By signing this Application, I agree to such underwriting guidelines and qualifications and understand that should I provide false information or fail to meet the requirements for eligibility, that it will result in the termination or recission of this coverage for all covered persons.
- I understand that I must notify Medical Mutual, in writing, immediately if I (the applicant) or any other person for whom coverage is sought receives medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage approval date. I understand that in this situation, Medical Mutual has the right to underwrite my application again, using the new information and that, as a result, my coverage/family member's coverage might be rescinded or delayed, or benefits denied due to the illness, injury or condition being treated as a preexisting condition.

8. Authorized Signature (Please print)

All contract terms must be in writing and signed or accepted in writing by an authorized representative of the Builders Exchange Benefit Plan.

Business Name	Name (print)	Title
Authorized Signature		Date
Broker Signature (if applicable)	Broker Name (print) (if applicable	
Broker NPN (National Producer Number)		

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21).