COSE BENEFIT PLAN

Employer Group Enrollment Application and Participation Agreement
COSE Benefit Plan

☐ initial enrollment ☐ change

1. Group/Company Information

Business Name				Requested Effective Date
Has this business ever been known by another name? ☐ Yes ☐ No If yes, what name(s)?				Chamber Membership #
Business Address (No P.O. Boxes)			Billing Address	
City	County	State	Zip Code	Business Phone Number
Chief Executive Officer	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			Employer/Federal Tax ID #

Your TIN number must match your registered business name – failure to do so may result in a delayed 1094B filing.

Is the plan subject to ERISA ☐ Yes ☐ No (Check the applicable box below)

- ☐ Government entity (i.e., city, county, township, public school district)
- ☐ Church plan
- ☐ Group of one (self employed)
- ☐ Other: _____

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.

_____

_____

_____

_____

2. Enrollment Criteria

Minimum Hour Requirement: What is the minimum # of hours to be worked per week for employees to be considered eligible for benefits*_____

* Hours must be between 20-30 hours per week, for full time eligibility.

Probationary Period: Per ACA guidelines, your group probationary period may not exceed 90 calendar days. Therefore, eligible members electing coverage shall be effective no later than their 91st calendar day of employment.

- ☐ 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
- ☐ 90 calendar days following Date of Hire
- ☐ Other (not to exceed 90 calendar days from Date of Hire) _____

Probationary Period for Rehire ☐ Same as Above ☐ Other _____

* If not noted, the rehire probationary period will be same as new hire probationary period.

Waive probationary period for initial enrollment? ☐ Yes ☐ No

Are there any other employer imposed eligibility requirements? ☐ Yes ☐ No

If "yes", explain: _____

_____

Please supply your percentages of total premium for your next renewal period that will be paid by the employer and paid by the employee. The employer and employee percentage should add up to 100%.

Please include all plan options into the one response. The percentages should represent a weighted average of all plan options and employee classifications.

_____ _____ employer %. _____ employee %

(insert your renewal period)

Participation

(Total number of employees applying and waivers must equal total number of full-time employees)

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

	Active**	COBRA/state continuation	Retired**
Total number of current employees (part time & full time)			
Total number of full-time equivalents			
Total number of eligible employees			
Number of eligible employees applying for coverage			
Total number of ineligible employees			
Total number of waivers			
Total number of Medicare primary retirees:			
Total number of Medicare non-primary retirees:			

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

Name	Social Security #	Beginning Date	Expiration Date	Qualifying Event

COSE BENEFIT PLAN

2. Enrollment Criteria (cont.)

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

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

3. Recent Health Changes

Are you aware of any medical conditions present for enrolling members that may not yet have been disclosed to Medical Mutual during the past 90 days? ☐ Yes ☐ No

If yes, please describe_____

4. Products

Medical benefits

COPAY PLANS:

0% coinsurance plans:

- ☐ 30-1000 Rx
- ☐ 30-2000 Rx
- ☐ 30-2500 Rx
- ☐ 30-3500 Rx
- ☐ 30-5000 Rx
- ☐ 30-8000 Rx
- ☐ 20-3000 Rx

20% coinsurance plans:

- ☐ 3020-250 Rx
- ☐ 3020-500 Rx
- ☐ 3020-1000 Rx
- ☐ 3020-1500 Rx
- ☐ 3020-2000 Rx
- ☐ 3020-3000 Rx
- ☐ 3020-6000 Rx

30% coinsurance plans:

- ☐ 3030-0 PD Rx
- ☐ 3030-1000 MMRx
- ☐ 3030-1500 MMRx
- ☐ 3030-2000 MMRx
- ☐ 3030-5000 MMRx

HSA OPTIONS:

0% coinsurance plans:

- ☐ HSA 2500 Agg MMRx
- ☐ HSA 3500 PD Rx
- ☐ HSA 4000 PD Rx
- ☐ HSA 5000 PD Rx
- ☐ HSA 6550 MMRx
- ☐ HSA 7500 MMRx

20% coinsurance plans:

- ☐ HSA 3500/20% MMRx
- ☐ HSA 4000/20% MMRx
- ☐ HSA 5000/20% MMRx

HRA OPTIONS:

- ☐ HRA 30-2000 Rx
- ☐ HRA 30-3500 Rx
- ☐ HRA 6550 MMRx

Max plan:

- ☐ 9200 MMRx (no dual or triple option)

MEDFLEX OPTIONS:

- ☐ 3020-250 Rx
- ☐ 3020-1000 Rx
- ☐ 3020-2000 Rx
- ☐ HSA 5000 PD Rx

CLE-CARE OPTIONS:

- ☐ 3020-250 Rx
- ☐ 3020-1000 Rx
- ☐ 3020-2000 Rx
- ☐ HSA 5000 PD Rx

SHARE OPTIONS*:

- ☐ SHARE 3020-1000 Rx
- ☐ SHARE 3030-1000 MMRx
- ☐ SHARE 3020-1500 Rx
- ☐ SHARE 3030-1500 MMRx
- ☐ SHARE 3020-2000 Rx
- ☐ SHARE 3030-2000 MMRx
- ☐ SHARE 3020-3000 Rx
- ☐ SHARE 20-3000 Rx
- ☐ SHARE HSA 3500 PD Rx
- ☐ SHARE HSA 3500/20% MMRx
- ☐ SHARE HSA 5000 PD Rx
- ☒ SHARE HSA 5000/20% MMRx

*These products are only available to groups in the SM+ network and must have 10 or more enrolled employees.

COSE BENEFIT PLAN

4. Products (continued)

Dental Plans:	ER Spon MAC	ER Spon UCR	Vol MAC	Vol UCR
☐ SDC #390 $1500 Cal Yr Max No Ortho	☐	☐	☐	☐
☐ SDC #1314 $1000 Cal Yr Max No Ortho	☐	☐	☐	☐
☐ SDC #1315 $1500 Cal Yr Max No Ortho	☐	☐	☐	☐
☐ SDC #1316 $1000 Cal Yr Max W/Ortho	☐	☐	☐	☐
☐ SDC #1317 $1500 Cal Yr Max W/Ortho	☐	☐	☐	☐
☐ SDC #1388 $1000 Cal Yr Max No Ortho	☐	☐	☐	☐

Vision Plan Options:

☐ VSP 1 (Employer Paid)
☐ VSP 2 (Voluntary)

5. Medical Mutual's Integrated HSA Administration (Included with qualified plans)

Medical Mutual provides a free, integrated health savings account (HSA) administration platform for employers selecting a Medical Mutual qualified high-deductible health plan. When the company opts into our HSA administration, employees who enroll in our qualified high deductible plan will have access to a no-cost HSA that is integrated with their health benefits through My Health Plan, our secure member website. Do you want to provide your company and its employees access to our free HSA? ☐ **Yes** ☐ **No** If Yes, your Medical Mutual Sales Rep will provide further information and additional paperwork that is required.

6. Employer Funding

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

7. Life, AD&D, Dependent Life and Short-Term Disability

☐ Yes I am electing life and/or short-term disability coverage in accordance with proposal number _____, incorporated by reference in and made part of this application for all purposes.
If multiple plans are indicated on the proposal, indicate plan option elected _____.

The requested effective date will be as stated in the above-mentioned proposal, unless indicated below:

_____.

If the Company approves this application, a policy will be issued. The applicant agrees that acceptance of the Policy will be approval of the Policy terms.

☐ **Voluntary Life Insurance**
Increments of $10,000 to a maximum of $300,000

☐ **Voluntary Short-Term Disability**
Increments of $50; minimum of $100 to a maximum of $500, not to exceed 70% of employee's Basic Weekly Wage.

Select One:
☐ Voluntary STD benefits payable: 1st day of Accident; 8th day of Sickness for a maximum benefit period of 26 weeks.
☐ Voluntary STD benefits payable: 15th day of Accident; 15th day of Sickness for a maximum benefit period of 26 weeks.

Waiting period is identical to medical probationary period, unless indicated below:
☐ None
☐ First of month following completion of _____ days
☐ Other _____

Employees working less than 20 hours per week are not eligible for coverage. If different than 20 hours, please indicate number of hours:_____

Employer contribution percentages (%) for all products are stated in the proposal, unless indicated below:

Product	%	Product	%

☐ **Group Long-Term Disability**
*Employees must work a minimum of 30 hours per week

Select One Plan:
☐ 90 day elimination ☐ 180 day elimination ☐ Other _____

8. Current and Prior Carrier History

List your current or most recent carrier for all product lines of insurance offered to your employees. If no coverage is or was recently in effect, indicate "NONE".

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

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

Renewal Rates** Employee	Spouse	Child	Family

9. Terms and Conditions

I, as the undersigned Participating Employer and member of the Council of Smaller Enterprises (COSE), and the Greater Cleveland Partnership (GCP), hereby apply to obtain health benefits from the COSE Benefit Plan ["MEWA"]. I acknowledge that I am applying for an employee health benefit offered collectively through the MEWA 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 in the applicable documents, as amended from time to time.

I agree to comply with the requirements applicable to Participating Employers described in the COSE MEWA Administration & Compliance Guide, which is incorporated herein by reference, and may be amended from time to time. In addition, I understand, acknowledge and agree to the following:

1. The MEWA for which I am applying is a self-insured plan, and benefits are not guaranteed by a licensed insurer. The MEWA is not covered by the Ohio Life and Health Guaranty Association. This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, Participating Employers shall be required to contribute the funds necessary to meet any unpaid obligations. Any such assessment will be determined using a reasonable proportionate methodology. The Plan does provide certain protections to Plan Sponsors regarding this assessment. Please see the Plan Document and Administrative & Compliance Guide for details. Certain other major protections offered to Ohio residents under the Ohio Insurance Code and Rules and Regulations, such as certain mandated or required benefits, may not be available through the multiple employer self-insured plan.
2. I acknowledge and agree that the Funding Rate and any other amounts I contribute to the MEWA may be commingled with contributions made by all other Participating Employers in the MEWA and that all amounts once contributed by a Participating Employer, may be used to pay any benefit of any Participant in the MEWA, including benefits attributable to Participants of other Participating Employers.
3. Vision benefits are being made available on a fully insured basis through the Alliance Agreement between Medical Mutual and COSE/GCP. Life, AD&D and disability benefits are being made available through COSE/GCP under a fully insured arrangement with MedMutual Life. Dental benefits are being made available through COSE/GCP under a fully insured arrangement with Superior Dental Care.
4. This Employer Group Application and Participation Agreement ("Application") is not a contract for benefits. Neither this Application, nor the payment of any moneys to be applied towards contributions for coverage, shall cause coverage to become effective on any of my employees. In order for coverage to go into effect, I must be accepted as a Participating Employer, and my employees must satisfy the applicable eligibility requirements. I should continue my current coverage until I am notified in writing the MEWA has accepted this Application.
5. I have seen a copy of the benefits proposed and agree to pay the required contributions (funding rates), including the additional $25 fee due for non-electronic invoice payment by check or the $39 fee for late payments, to the MEWA 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 to the MEWA the funding rate billed to me by the MEWA and to pay other charges or expenses assessed against me under this agreement or the terms of the MEWA. The MEWA'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.
6. To be eligible for coverage through the MEWA, I must: 1) meet the eligibility requirements set forth in the plan documents of the MEWA; 2) meet the COSE membership or chamber requirements; 3) be and remain a member in good standing with such chamber in order for coverage to stay in effect; and 4) comply with all applicable laws of the State of Ohio.
7. To be eligible for coverage through the MEWA, my employees must be actively working on a full-time basis and drawing a regular paycheck, whose compensation is reported on IRS Form W-2 (if applicable); and for life, AD&D, disability, dental and/or vision coverage, my employees must also meet the eligibility requirements of Medical Mutual/MedMutual Life/Superior Dental Care.
8. I agree to maintain at least 75% enrollment level of eligible employees for coverage through the MEWA. I understand that in determining the number of eligible employees, I may exclude an employee who waives coverage because he or she is: 1) covered in his or her spouse's employer-sponsored health plan; 2) an active eligible or retiree in another health plan sponsored by a second employer; 3) covered under a parent's plan; 4) covered by Medicare and/or a Medicare supplement plan; 5) covered under a government-sponsored plan, such as TRICARE, Medicaid or Veteran's Administration (VA) coverage; or 6) enrolled in an individual plan that was purchased through an Exchange and was approved for a federal subsidy.
9. By applying for coverage, I agree that the MEWA 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 MEWA or Medical Mutual/MedMutual Life.

continued on page 7

9. Terms and Conditions (cont.)

10. 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 MEWA. 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.
11. 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 MEWA must approve this Application for health coverage, and Medical Mutual/MedMutual Life/Superior Dental Care must approve this Application for life, AD&D, disability, dental and vision coverage. The coverage is subject at all times to the benefit plan applied for, which alone constitutes the contract under which benefits become payable. 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.
12. Acceptance of this request is subject to all MEWA requirements, including the provisions of any Administrative Services Agreement between the MEWA and any third party administrator, but only to the extent such provisions apply to rights and/or obligations applicable to employers accepted as Participating Employers in the MEWA, and the terms of the applicable benefit plan. The Participating Employer responsibilities can be found in the Benefit Plan Administration & Compliance Guide. The MEWA Administrator or its designee will notify the applicant of the approval or disapproval of this request. A notice of approval will specify the effective date of the applicant's participation in the MEWA. If the applicant is accepted as a Participating Employer, it will receive the appropriate material for enrolling its employees.
13. To the extent a Participating Employer is subject to ERISA, that Participating Employer is considered the "Plan Sponsor" and "Plan Administrator" of its Plan, within the meaning of ERISA, and, as such, is responsible for complying with the duties of those roles, and any other applicable obligations under ERISA.
14. 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 MEWA identification card, can result in denial of a claim or rescission of coverage for me or any group member, prospective or retrospective funding rate adjustments, and may subject me or any group member to legal action by the MEWA. I have a duty to notify the MEWA of any changes to the information contained in this Application.
15. 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 denies due to the illness, injury or condition being treated as a preexisting condition.
16. If this Application is accepted by the MEWA, the actual benefits will be specified in the Benefit Book or other plan material provided to each enrolled employee, and said benefits will take effect on the date specified in the communication from a representative of the MEWA. If the Application for dental, vision and/or life insurance is accepted by Medical Mutual/MedMutual Life/Superior Dental Care, the actual benefits will be set forth in the group policies and other documentation.
17. No agent or broker has the authority to: (1) bind the MEWA by making promises regarding eligibility, benefits, or the issuance of coverage; (2) waive any answer or any portion of any answer to any questions on this Application or any information the MEWA requests; (3) approve coverage; (4) make or alter any contract on behalf of the MEWA; or (5) waive or alter any of the MEWA rights or requirements.

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BENEFIT PLAN

10. Authorized Signature (Please print)

Business Name	Name (print)		Title
Authorized Signature	Date	Agency Name	
Agency Address			Agency Tax ID
Broker Name (print) (if applicable)		Broker Signature (if applicable)	
Broker NPN (National Producer Number)	Broker Email Address		
Broker Phone Number	Broker Fax Number		

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a 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)