RESOLUTION NO. 70-44
CITY OF CENTERVILLE, OHIO

SPONSORED BY COUNCILMEMBER Sally Beals ON THE 19th DAY OF December, 1994.

A RESOLUTION CAUSING THE CITY TO BECOME A MEMBER OF THE OHIO BENEFITS COOPERATIVE, INCORPORATED, AND AUTHORIZING THE CITY MANAGER TO EXECUTE SUCH DOCUMENTS AS ARE NECESSARY TO EFFECTUATE THIS RESOLUTION.

NOW THEREFORE, THE MUNICIPALITY OF CENTERVILLE HEREBY RESOLVES:

SECTION 1. That the City shall become a member of the Ohio Benefits Cooperative, Incorporated, ("Cooperative"). shall abide by all provisions of the Articles of Incorporation, Code of Regulations and other rules and regulations of such Cooperative, and shall pay to the Cooperative any and all dues and assessments charged against members of the Cooperative.

SECTION 2. That the City shall purchase through the Cooperative the insurance/benefits provided by the City for its employees in accordance with the rules and regulations of the Cooperative, and shall pay to the Cooperative the premiums for such insurance/benefits.

SECTION 3. That the City Manager is hereby authorized to execute on behalf of the City any and all agreements, contracts, resolutions, instruments, certificates, forms and other documents, and take any and all action required for the City to become a member of the Cooperative, to procure insurance/benefits for the City's employees through the Cooperative, or to otherwise effectuate these Resolutions.

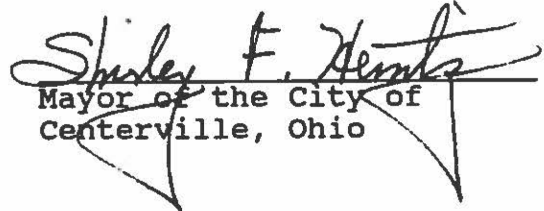
SECTION 4. That the City Manager is hereby authorized to execute on behalf of the City of Centerville an Agreement with Community Mutual Insurance Company and Community National Assurance Company, a copy of which is attached hereto as Exhibit "A" and incorporated herein, to provide insurance coverage to eligible employees of the City of Centerville.

SECTION 5. It is hereby bound and determined that all formal actions of this Council concerning and relating to the passage of this Resolution were taken in an open meeting of this

Council, and that all deliberations of this Council and of any committees that resulted in those formal actions were in meetings open to the public, in compliance with all legal requirements.

SECTION 6. This Resolution shall take effect on the earliest date allowed by law.

PASSED this 19th day of December, 1994.



Mayor of the City of Centerville, Ohio

ATTEST:

Clerk of the Council of the City of Centerville, Ohio

CERTIFICATE

The undersigned, Clerk of the Council of the City of Centerville, Ohio, hereby certifies that the foregoing is a true and correct copy of Resolution Number 70-94, passed by the Council of the City of Centerville, Ohio, on the 19th day of December, 1994.

Clerk of Council

Approved as to form, consistency with the Charter and Constitutional Provisions.
Department of Law
Robert N. Farquhar
Municipal Attorney

Preliminary Application And Conditional Receipt For Group Insurance

EXHIBIT "A"

HOME OFFICE USE ONLY	GID	EFFECTIVE DATE	PACKAGE NO.

1. Legal Name of Group
   CITY OF CENTERVILLE

2. Address of Group
   100 W. SPRING VALLEY
   CENTERVILLE OH 45458
   County: MONTGOMERY

3. Affiliates, Subsidiaries or Divisions to be included (names and addresses)
   If none, check box X

4. Billing Address (if different than above)

5. Type of Organization
   ☐ Corporation ☐ Sole Proprietorship ☐ Partnership ☐ Labor Union
   ☒ Government Unit ☐ Trust ☐ Other:

6. Is coverage subject to Bargaining Agreement? ☐ Yes ☒ No
   Union Number ______
   Union Name ______
   Contract Expiration Date ______
   (Attach a copy of the Agreement)

7. Requested Group Effective Date
   1 | 1 | 95

7a. Initial Rate Guarantee
   ☐ 12-month ☒ Other

8. Head of Firm/Title
   GREGORY B. HORN/CITY MANAGER

8a. Telephone
   (513) 433-7151

9. Group Administrator/Correspondent
   JUDY GILLELAND

9a. Telephone
   (513) 433-7151

Schedule A — Eligibility

10. Eligible employees must work at least 30 hours per week; must be actively at work, must have satisfied the eligibility waiting period, and must meet the following additional criteria (if any):

11. Total Number of Eligible Employees: ______ (including COBRA eligibles)
   Total number of employees residing outside of Ohio ______
   Total number of COBRA enrollees ______
   (Please attach copy of COBRA Election Form.)
   Number *Enrolling*: Community Choice ______ Gold Share ______ HMP ______ Community Preferred ______ Other Health ______ Life ______
   Number *Waiving Coverage*: Health ______ Health & Life ______

12. Effective Date of Coverage
   Initial Eligible Persons:
   ☐ Covered on the Group Effective Date
   ☐ Covered after the same waiting period that applies to new persons or on the Group Effective Date, whichever is later.

   New Eligible Persons:
   ☐ Covered on the first Billing Date following ______ days of employment
   ☐ Other ______

Schedule B — Proposed Health Premiums

(Not for use in Alternate Funding Arrangements)

13. Following are the proposed monthly premiums for the health care benefits. **These premiums are subject to change based on application cards received and Final Underwriting approval.** If group is age/sex rated, please attach rate schedule.

   Employer's Deposit Toward Health Premium: $______

Health Coverage(s)	IND	FAM	MED ELIG
PNP			
PPO			
TOTAL			
Employer Contribution	%	%	%

2160 Rev 4/93

See Schedule C (Attachment)

Schedule D — COMMUNITY NATIONAL

14. LIFE Eligible Classes	Amount of Insurance or Principal Sum					
	Term Life*	AD&D*	STD*	Dependent Life		Supplemental Life*
				Spouse	Child	
I						
II						
III						
IV						
V						

Employer Contribution Term Life/AD&D _____ % Dependent Life _____ % Supplemental Life _____ % STD _____%

Employer's Deposit Toward Life Premium $ ____________

* Benefits may be fixed dollar amounts or a multiple or percentage of earnings. Benefits above the guaranteed issue limit set by Community National are subject to evidence of insurability.

15. Term Life Coverage Options

15a. If life amount is based on annual earnings, exclude overtime pay, bonuses and commissions, EXCEPT:

☐ Include bonuses ☐ Include commissions averaged over ☐ 12 months ☐ 24 months ☐ Other ____________

15b. If life amount is based on annual earnings, round benefits to the ☐ nearest ☐ next higher ☐ next lower $ ____________ , if not already an even multiple, subject to a maximum benefit amount of $ ____________

15c. Reduction/Termination:

☐ Reduces by the following percentages of the under age 65 benefit: 35% at age 65, an additional 25% at age 70, an additional 12% at age 75; and an additional 8% at age 80; terminates at retirement.

☐ Other ____________

15d. Continuation of life insurance during disability. All plans include a six-month continuation during disability, subject to premium payment. All continued coverage will reduce as stated above. In addition, the following applies.

☐ Extension of benefits with waiver of premium after ☐ six months or ☐ Other____________ of total disability.

Total disability must begin before ☐ age 60 ☐ Other ____________

Terminates at ☐ age 70 ☐ Other ____________

☐ Extension of Benefits subject to continued premium payment for ☐ One Year ☐ Other ____________

Total disability must begin before ☐ age 60 ☐ Other ____________

Terminates when group's coverage ends under group policy.

☐ Other (please explain in Additions or Exceptions)

16. Accidental Death and Dismemberment Coverage Options

16a. If AD&D amount is based on annual earnings, calculation will be same as stated in Term Life Option, unless otherwise noted in Additions or Exceptions.

16b. Coverage is ☐ 24-hour ☐ non-occupational

16c. Reduction/Termination: ☐ Same as Term Life Option ☐ Other ____________

17. Short-Term Disability Income Coverage Options

17a. Maximum Weekly Benefit:

☐ ____________ % (66⅔% is standard) of weekly earnings, subject to the maximum benefit stated above.

☐ Benefit amount stated above, subject to a maximum benefit of 66⅔% of weekly earnings

17b. Weekly earnings exclude overtime pay, bonuses and commissions EXCEPT:

☐ Include commissions averaged over ☐ 12 months ☐ 24 months ☐ Other____________

17c. Plan: ☐ 1 - 8 - 26 ☐ 1 - 8 - 13 ☐ 15 - 15 - 13 ☐ Other ____________

17d. Termination: ☐ Terminates at retirement ☐ Other____________

18. Dependent Life Insurance Coverage Options

18a. Spouse covered until ☐ age 65 ☐ Other ____________

Child covered ☐ from age 15 days to age 19, extended if child qualifies as a federal tax exemption, subject to a maximum age of 25.

☐ Other ____________

18b. Termination: Terminates when covered employee's term life insurance terminates.

19. Supplemental Term Life Coverage Options

19a. Same as Term Life Options ☐ Yes ☐ No If No, describe ____________

19b. Maximum Supplemental Life Amount: ☐ $ ____________ Supplemental Term Life

☐ $ ____________ Supplemental Term Life and Term Life Combined

19c. Is Supplemental AD&D included? ☐ Yes ☐ No If Yes, describe in Additions or Exceptions.

RISK EVALUATION QUESTIONNAIRE

This information is required by Community Mutual Blue Cross & Blue Shield to help evaluate your request for a group insurance quotation. It is not an application for coverage.

General Information

Company Name CITY OF CENTERVILLE

Address 100 W. SPRING VALLEY

City, State, Zip CENTERVILLE, OH 45458

Type of Business GOVERNMENT UNION SIC ______ Telephone (513) 433-7151

1. Has this company been previously insured with Community Mutual Blue Cross & Blue Shield? [ ] Yes [ ] No
2. Current Carrier ______ 3. Number of years with carrier ______
4. Is there plans or are there plans to offer a Health Maintenance Organization (HMO) type plan (including IPA and PPO plans)? [ ] Yes [ ] No If yes, please describe plan and give current rates.
   5. Plan Name ______ 6. Individual ______ 7. Family ______
   8. Current number of employees covered in the HMO, PPO or IPA plan ______
9. What was the total amount of medical claims paid for your group in the past 12 months? $______
10. What was the total amount of medical premium paid for your group in the past 12 months? $______
    Current monthly medical rates: 11. Individual $______ 12. Family $______
    13. Effective Date ______ *(Please attach a copy of the latest billing.)*
14. Are there any employees in locations other than the address listed above?
    [ ] Yes [X] No If "yes," please give the number of employees at each location, the city and state.
15. Has this company been declined a quote or is its current carrier not renewing its health plan?
    [ ] Yes [X] No If "Yes," please explain below or attach another sheet.

Eligibility and Participation Information

1. Total number of employees ______ 2. Total number of eligible employees ______
2. Total retirees covered ______ 4. Total covered eligible due to COBRA and/or TEFRA ______
3. Are there any employees not actively at work or likely not to be as of the intended effective date of coverage?
   [ ] Yes [ ] No If "Yes," please explain below.

Name	Date last worked	Reason not actively at work	Insured prior carrier? (Y/N)

PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM

A-2055-IP (10/91)

Medical Information

1. Are there any employees or dependents with scheduled hospitalizations or surgery pending or receiving disability benefits? [ ] Yes [ ] No (If yes, please explain below or attach an additional sheet.)

____

____

2. Are there any employees or dependents with any of the following health conditions? Please check the box if applicable to any employees or dependents. If more than one of the same conditions exist, please indicate the number.

- [ ] AIDS
- [ ] Arthritis (Rheumatoid)
- [ ] Cancer (Present)
- [ ] Cancer (Recovered over 10 years)
- [ ] Cancer (Recovered over 5 years)
- [ ] Cancer (Recovered over 3 years)
- [ ] Cerebral Palsy
- [ ] Collagen Diseases
- [ ] Coronary Artery Disease (last 5 Years.)
- [ ] Crohn's Disease (present)
- [ ] Cystic Fibrosis
- [ ] Diabetes (Diet Control)
- [ ] Diabetes (Oral Meds)
- [ ] Diabetes (insulin)
- [ ] Drug/Alcohol Abuse (treated in 3 yrs.)
- [ ] Emphysema (uncomplicated)
- [ ] Epilepsy (Grand Mal)
- [ ] Epilepsy (Others non-febrile)
- [ ] Heart Attack (Coronary bypass)
- [ ] Kidney Dialysis
- [ ] Kidney (pending transplant)
- [ ] Liver (Cirrhosis)
- [ ] Liver (Hepatitis, non alcoholic)
- [ ] Liver (pending transplant)
- [ ] Lung abscess present
- [ ] Lupus
- Mental disorders (Present)
  - [ ] Major Depression
  - [ ] Anxiety disorders
  - [ ] Psychotic disorders
- [ ] Muscular Dystrophy/Sclerosis
- [ ] Myasthenia Gravis
- [ ] Paralysis (paraplegia)
- [ ] Paralysis (others)
- [ ] Pericarditis
- [ ] Pregnancy
- [ ] Spinal Bifida
- [ ] Stroke (within last 5 years)
- [ ] Transplants (not listed elsewhere)
- [ ] Tuberculosis (pulmonary)

The medical conditions listed above are considered to be of a serious nature by Community Mutual Blue Cross & Blue Shield. This list has attempted to identify the most serious illnesses that preclude risk taking on this specific company. Every medical condition is not exactly the same. To appeal the decision in the event of a declination to quote, Attending Physician Statements (or a similar physician's statement describing the illness) may be necessary for the listed illness.

Additional Information

Is there any additional information to be provided to help in the consideration of this group?

____

____

Any questions asked concerning this form will be answered by the end of the next work day.

I agree that the information furnished above is complete, true and correct to the best of my knowledge and belief. Any person who, with the intent to defraud or knowing that he or she 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.

Owner/Officer Signature ______________________________

Title ______________________________ Date __________

Agent/Broker Signature ______________________________ Date __________

Community Mutual sales representative signature ______________________________ Date __________

Schedule C
(Community Choice)

DO NOT WRITE IN THIS SPACE

CODE ____________

GID ____________

Please complete the following information.

Group Name CITY OF CENTERVILLE

Requested Effective Date of Coverage 1 / 1 / 95

Section I. Product – *Please select from one of the following Community Choice plan options:*

☒ **Network Option** ☐ **PNP Option** ☐ **EPO Option**

NETWORK AND PNP OPTIONS – *Please select from each of the following categories:*

Individual Deductible *(Network)*	Individual Deductible *(Non-Network)*	Co-Insurance *(Network/Non-Network)*	Annual Co-Insurance Individual Maximums *(Network/Non-Network)*
☐ None (100+)	☒ 1 x Network*	☐ 100% / 80%(100+)	☒ $2,000 / $4,000
☐ $100	☐ 2 x Network	☐ 90% / 80%*	☐ $4,000 / $4,000*
☒ $200	☐ 3 x Network	☒ 90% / 70%	☐ $4,000 / $8,000
☐ $300	☐ Other______*	☐ 90% / 60%	☐ $5,000 / $5,000*
☐ $500		☐ 80% / 70%*	☐ $5,000 / $10,000
☐ Other______*		☐ 80% / 60%	☐ $10,000 / $10,000*
		☐ 80% / 50%	☐ $10,000 / $20,000
		☐ 70% / 50%	☐ Other__________*

Family Maximum Factor *(Deductible & Co-Insurance)* ☒ 2 x Individual ☐ 3 x Individual ☐ None ☐ Other____________

**Non-standard benefit option in some regions. This may require a Benefit Exception.*

EPO OPTION – *Please select from one of the following plan options:*

☐ **Plan 1:** No Deductible – 100% Coverage with $10 office visit and Community Rx

☐ **Plan 2:** $100 / $200 Deductible – 90% Coverage to $2,000 / $4,000

☐ **Plan 3:** $200 / $400 Deductible – 80% Coverage to $4,000 / $8,000

OTHER OPTIONS

☐ Pre-existing Conditions Waived

☒ Office Visit Co-pay $10

☒ Preventive Care
- ☒ 9-18 years
- ☐ 9+ years

Section II. Riders – *Please select the rider(s) desired:*

☐ Prescription Drug Exclusion ☐ Oral Contraceptives ☐ Nicotine Replacement Therapy *(smoking cessation program required, but not payable)**

☐ Abortion Exclusion ☐ Other____________

☐ 50% Co-insurance for infertility/growth hormones and immunosuppressants *(for co-payment option under Community Rx)*

**Benefit Exception required for groups enrolled in Community Rx drug program.*

Section III. Prescription Drug – *Please select one co-payment or select from the appropriate deductible and co-insurance options.*

Co-payment

- ☐ $3 (100+)
- ☐ $5
- ☐ $7
- ☐ $10
- ☐ $15
- ☐ $______

(20-49) – Please select from one of the following options:

Deductible	Co-insurance	Co-insurance Maximum
☐ $0	70% generic	$1,000 / $2,000
☐ $25 / $50	70% generic	None
☐ $25 / $50	50% generic	$1,000 / $2,000
☐ $50 / $100	70% generic	$1,000 / $2,000
☐ Other______	Other______	Other______

(50+) – Please select from one of each of the following options:

Individual Deductible

☐ $0 ☒ $25 ☐ $50 ☐ $75 ☐ $_____

Co-insurance

☒ 80% generic ☐ 70% generic ☐ 50% generic ☐ other_____

Individual Co-insurance Maximum

☐ $1,000 ☐ $2,000 ☐ None ☐ $_____

Family Deductible and Co-insurance Maximum: ☐ 2 x Individual ☐ None

Section IV. Dental – *Please select from the following product and plan options:*

☐ **Community Choice Dental** ☐ **Comprehensive Open-Access Dental**

☐ *DHP option* ☐ *POS option*

	Community Choice (POS)**			**Comprehensive Open-Access**		
	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**
Diagnostic & Preventive	100% / 75%	100% / 75%	100% / 75%	100%	100%	80%
Primary Services	50% / 40%	80% / 60%	80% / 60%	80%	50%	80%
Prosthetic & Complex Restor.	50% / 40%	50% / 40%	80% / 60%	50%	50%	50%
Orthodontia	n/c*	50% / n/c*	50% / n/c*	option	option	option
Ortho Lifetime Maximum	n/a+	$2,000 / n/a+	$2,000 / n/a+	option	option	option
Annual Maximum	$1,000 / $500	$1,500 / $750	$1,500 / $750	$1,000	$750	$750

***All plans have a $25 / $50 Deductible*

Options for Comprehensive Open-Access: ☐ $25 / $50 Deductible ☐ 60% Ortho

☐ $50 / $100 Deductible ☐ $750 Ortho Lifetime Max

☐ $1,000 Ortho Lifetime Max

☐ $1,500 Ortho Lifetime Max

Community Choice (DHP): ☐ Plan 1 ☐ Plan 2 ☐ Plan 3

☐ Other *(please specify)* ________________________________

**not covered + not applicable*

Section V. Vision Coverage – *Please select the coverage desired.*

☐ Vision Plus (Vision Plus schedule no. ________________)

Section VI. Misc. Notes

____

____

____

____

Authorized Group Signature **Date** **Authorized CMIC Signature** **Date**

Schedule C
(Community Choice)

DO NOT WRITE IN THIS SPACE
CODE ______
GID ______

Please complete the following information.

Group Name CITY OF CENTERVILLE

Requested Effective Date of Coverage 1 / 1 / 95

Section I. Product – *Please select from one of the following Community Choice plan options:*

☐ **Network Option** ☒ **PNP Option** ☐ **EPO Option**

NETWORK AND PNP OPTIONS – *Please select from each of the following categories:*

Individual Deductible *(Network)*	Individual Deductible *(Non-Network)*	Co-Insurance *(Network/Non-Network)*	Annual Co-Insurance Individual Maximums *(Network/Non-Network)*
☒ None (100+)	☐ 1 x Network*	☒ 100% / 80%(100+)	☐ $2,000 / $4,000
☐ $100	☐ 2 x Network	☐ 90% / 80%*	☐ $4,000 / $4,000*
☐ $200	☐ 3 x Network	☐ 90% / 70%	☐ $4,000 / $8,000
☐ $300	☒ Other $150/300	☐ 90% / 60%	☐ $5,000 / $5,000*
☐ $500		☐ 80% / 70%*	☐ $5,000 / $10,000
☐ Other_____*		☐ 80% / 60%	☐ $10,000 / $10,000*
		☐ 80% / 50%	☐ $10,000 / $20,000
		☐ 70% / 50%	☒ Other $650/$850

Family Maximum Factor *(Deductible & Co-Insurance)* ☒ 2 x Individual ☐ 3 x Individual ☐ None ☐ Other______

Non-standard benefit option in some regions. This may require a Benefit Exception.

EPO OPTION – *Please select from one of the following plan options:*

☐ **Plan 1:** No Deductible – 100% Coverage with $10 office visit and Community Rx

☐ **Plan 2:** $100 / $200 Deductible – 90% Coverage to $2,000 / $4,000

☐ **Plan 3:** $200 / $400 Deductible – 80% Coverage to $4,000 / $8,000

OTHER OPTIONS

☐ Pre-existing Conditions Waived

☒ Office Visit Co-pay $5

☒ Preventive Care
- ☐ 9-18 years
- ☒ 9+ years

Section II. Riders – *Please select the rider(s) desired:*

☐ Prescription Drug Exclusion ☐ Oral Contraceptives ☐ Nicotine Replacement Therapy *(smoking cessation program required, but not payable)**

☐ Abortion Exclusion ☐ Other______

☐ 50% Co-insurance for infertility/growth hormones and immunosuppressants *(for co-payment option under Community Rx)*

**Benefit Exception required for groups enrolled in Community Rx drug program.*

Section III. Prescription Drug – *Please select one co-payment or select from the appropriate deductible and co-insurance options.*

Co-payment	*(20-49) – Please select from one of the following options:* Deductible	Co-insurance	Co-insurance Maximum
☐ $3 (100+)			
☐ $5	☐ $0	70% generic	$1,000 / $2,000
☐ $7	☐ $25 / $50	70% generic	None
☐ $10	☐ $25 / $50	50% generic	$1,000 / $2,000
☐ $15	☐ $50 / $100	70% generic	$1,000 / $2,000
☐ $______	☐ Other______	Other______	Other______

(50+) – Please select from one of each of the following options:

Individual Deductible	Co-insurance	Individual Co-insurance Maximum
☐ $0 ☒ $25 ☐ $50	☒ 80% generic ☐ 70% generic	☐ $1,000 ☐ $2,000
☐ $75 ☐ $_____	☐ 50% generic ☐ other_____	☐ None ☐ $_____

Family Deductible and Co-insurance Maximum: ☐ 2 x Individual ☐ None

Section IV. Dental – *Please select from the following product and plan options:*

☐ **Community Choice Dental** ☐ **Comprehensive Open-Access Dental**

☐ *DHP option* ☐ *POS option*

	Community Choice (POS)**			**Comprehensive Open-Access**		
	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**	☐ **Plan 1**	☐ **Plan 2**	☐ **Plan 3**
Diagnostic & Preventive	100% / 75%	100% / 75%	100% / 75%	100%	100%	80%
Primary Services	50% / 40%	80% / 60%	80% / 60%	80%	50%	80%
Prosthetic & Complex Restor.	50% / 40%	50% / 40%	80% / 60%	50%	50%	50%
Orthodontia	n/c*	50% / n/c*	50% / n/c*	option	option	option
Ortho Lifetime Maximum	n/a+	$2,000 / n/a+	$2,000 / n/a+	option	option	option
Annual Maximum	$1,000 / $500	$1,500 / $750	$1,500 / $750	$1,000	$750	$750

***All plans have a $25 / $50 Deductible*

Options for Comprehensive Open-Access: ☐ $25 / $50 Deductible ☐ 60% Ortho

☐ $50 / $100 Deductible ☐ $750 Ortho Lifetime Max

☐ $1,000 Ortho Lifetime Max

☐ $1,500 Ortho Lifetime Max

Community Choice (DHP): ☐ Plan 1 ☐ Plan 2 ☐ Plan 3

☐ Other *(please specify)* ______

**not covered* *+ not applicable*

Section V. Vision Coverage – *Please select the coverage desired.*

☐ Vision Plus (Vision Plus schedule no. ______)

Section VI. Misc. Notes

______

______

______

______

______ ______ ______ ______

Authorized Group Signature **Date** **Authorized CMIC Signature** **Date**

20. The employer, by paying the required premiums, may continue coverage beyond the last day of active work as described below:

If not actively at work due to:	the following coverage may be continued:	for a maximum of:
layoff	term life	3 months
leave of absence	term life	3 months
disability	all life and disability coverages	6 months

☐ Other ______________________________

21. **Additions Or Exceptions.** (Describe fully. If needed, attach an additional sheet. Each sheet must be signed and dated by the applicant.)

EMPLOYER AGREEMENT:

The undersigned employer hereby requests that it be approved for insurance coverage through Community Mutual Insurance Company ("CMIC") and Community National Assurance Company ("CNAC").

If approved for coverage, the employer agrees, by payment of the required premiums:

1. to be bound by CMIC and CNAC's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time;
2. to make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. to maintain records and furnish to CMIC and CNAC, or their designated agent, any information required in connection with administration of the insurance coverage;
4. to provide notice of conversion rights and rights to continue health care coverage under COBRA to eligible employees and eligible dependents;
5. that evidence of insurability may be required of employees and dependents initially and/or when applying for coverage outside the time frames or amount of insurance limits established by CMIC and CNAC; and
6. that approval for this insurance shall automatically cancel any prior contracts and/or coverage with CMIC and CNAC effective immediately preceding the effective date of the employer's coverage.

The employer acknowledges that if the health care coverage issued contains Cost Management features, all of those features have been explained to the employer's satisfaction. Cost management features may include, but are not limited to, Pre-Admission Review and Length of Stay and Second Opinion Programs.

The employer hereby acknowledges that the advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on CMIC's and CNAC's determination that the group is an acceptable risk based on their current underwriting, medical and actuarial rules, practices and procedures. Unless these conditions are met, there shall be no liability on the part of CMIC or CNAC except to refund the payment. The employe: will be responsible for returning to individual employees any part of the payment contributed by those employees.

The employer understands that, in order for CMIC and CNAC to accept or decline this application, all the information requested on this application must be completed. **In the event the application is not complete, CMIC and/or CNAC, or their designated agent, is authorized to obtain the necessary information and to complete that information on this application.** The employer understands that the coverage issued by CMIC and CNAC may be different than the coverage applied for herein. In that event, CMIC and/or CNAC shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.

By his/her signature on this form, the employer's authorized representative certifies on behalf of the employer that:

1. he/she has read the entire Preliminary Application and Conditional Receipt for Group Insurance, and that all answers contained herein are true and complete to the best of his/her knowledge and belief;
2. all employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work 30 or more hours per week (unless otherwise approved by us in writing), and meet any other eligibility requirements for coverage;
3. he/she understands that the insurance requested may not duplicate previous coverage;
4. he/she understands that the requested coverage is not in effect unless and until this application is approved by CMIC and CNAC, and that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer;
5. he/she understands that an employee's coverage is not in effect unless and until the employee makes application and is approved for coverage by CMIC and CNAC; and
6. he/she understands that any person who, with intent to defraud or knowing that he/she 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.

Has your group been turned down for coverage in the last 12 months? ☐ Yes ☐ No

If so, by whom and when? ______________________________

NOTE: Please attach a company check for the first month's premium.

____
SIGNATURE OF AUTHORIZED COMPANY REPRESENTATIVE

______________________________ ______________ ______________
NAME OF AUTHORIZED COMPANY REPRESENTATIVE (PLEASE PRINT) TITLE DATE

______________________________ ______________
SIGNATURE OF BROKER DATE

______________________________ (______)______________
BROKER NAME (PLEASE PRINT) BROKER TELEPHONE NO. (AREA CODE)

______________________________ ______________ ______________
AGENCY NAME (IF APPLICABLE) TAX ID TO BE PAID COUNTY

______________________________ ______________
STREET ADDRESS SALES REPRESENTATIVE

______________________________ ______________ ______________
SIGNATURE OF MEGA BROKER TAX ID NO.

Enrollment Requirements

Once an employee is determined eligible and is enrolled under the terms of this Contract, the employer guarantees the employee's continued enrollment, as long as eligible, for the term of this Contract.

IN WITNESS WHEREOF, the parties have caused their duly authorized representative to execute this Contract on the dates listed below.

CITY OF CENTERVILLE	SUPERIOR DENTAL CARE, INC.
By______________________	By Thomas G. Raney DMD
Title____________________	Title President
Date____________________	Date 12-9-94