ARBA Account # _____

Participation Agreement & Employer's Statement

Plan Year 12/01/2023-11/30/2024

Association Affiliation: (must be a current member)

□ACRE □AGC □BEAR □CAMP □LAR □EDCAR □CBIA □BIAGV □BIASD
□NSBIA □NSCAR □NORBAR □PCAR □PCOC □SAR

Effective Date: _____ □Existing Member □New Firm Member

****

Full Legal Name: (Must match membership name) _____ _____

Street Address: _____
City: _____ State: _____ Zip: _____ FEIN: _____
Phone : (____) _____ Fax: (____) _____ Email: _____

Contacts Authorized to Speak to:
Name: _____ Title:_____ Email: _____
Name: _____ Title:_____ Email: _____

Employer is a:
□ **Sole Proprietor (with employees) OR □ Sole Proprietor (without employees, go to section 3)**

□ **Partnership Type_____**

□ **Corporation □ C-Corp OR □S-Corp**

Attach a copy of your most recent CA State EDD Quarterly Wage Report (DE-9C)

1. **Medical Eligibility**

The following questions should be answered using your attached DE-9C and/or owner/officer paperwork. Continuous full-time employment is required for eligibility. Eligible employees must all be active and working full-time, a minimum of 30 hours per week.

a. Total Number of Employees on payroll regardless of hours worked (on DE-9C + new hires)	
b. Total number of ineligible employees in each of the following categories: Union _____ Part-time _____ Temporary _____ Terminated _____ Seasonal _____ Waiting Period _____	
c. Total of all categories from Line b:	
d. Total number of active, eligible employees on payroll (a minus c):	
e. Number of employees declining due to other group coverage (valid waiver):	
f. TOTAL ELIGIBLE (d minus e) (participation must be 50% of this number)	

g. number enrolling in:		
Western Health _____	Kaiser _____	Total _____

2. **Plan Selection**

Employee Waiting Period, effective 1st of month following: □ Date of Hire □ 30 Days □60 Days

Employer Contribution: ____% or $_____ Employee (Must be min 50%) ___% or $_____ Dependent

Plan Selection: (Check all that apply)

Western Health Advantage: □ Gateway 30 □ Gateway 70□ Gateway 2400 □ Gateway 4010 □ Gateway 5020 □ Gateway 7000

Kaiser: □ Platinum 90 0/10 □Platinum 90 0/20 □ Gold 80 0/30 □ Gold 80 250/35 □ Gold 80 1000/40 □ Silver 70 1900/65 □ Silver 70 2500/55 □ Silver 70 HDHP **2700/25% □ Bronze 60** HDHP 7000**/0% □ Bronze 60 6300/65**

Delta Dental: □ HMO □ PPO Cypress Dental: □ HMO □ MAC □ UCR
VSP Vision Care: □ Yes □ No

3. **Attestation**

For Sole Proprietors without employees and for Owners/Partners/Officers who are not listed on the DE-9C who are enrolling in the medical plans - by initialing in this box below you attest that although your name does not appear on the DE-9C that the following is true:[_____] Initial

- **I am a sole proprietor, partner, or LLC manager/member at named company.**
- **I work at this company on a permanent basis with a normal work week of: □ 20-29 hours/week □ 30 hours or more/week.**
- **I draw wages, dividends, or other distributions for this company on a regular basis.**
- **I do not derive substantial earned income from any other employer and am not eligible for other employer-sponsored coverage as a subscriber.**
- **I will have satisfied the designed waiting period before coverage becomes effective**

All carrier contracts are guaranteed coverage as of the proper effective date and the qualifications and participation requirements stated on page three of this agreement are met.
I understand that the plan year is from December 1st to November 30th and acknowledge receipt of eligibility and enrollment rules.
As the legally authorized representative of the Employer hereby requesting participation in the Association Insurance Benefit Program, I certify that I have read and understand the above and that all information provided is accurate and complete to the best of my knowledge and belief. I certify and understand that this is a legally binding agreement.

_____

Print Name **Date**

_____

Signature of Owner/Officer only **Title**

Office Use Only: Membership Verified by: _____ On _____
Member # _____ Representative Signature _____

Cobra Eligible: □ Federal □ Cal Cobra □ Not eligible

Participation Agreement & Employer's Statement Rules

The following statements must comply with all the rules and regulations of the program, Eligibility and Enrollee Requirements

1. To abide by the Participation Agreement.
2. To maintain a current membership in good standing in the above-named Association.
3. To abide by the Group Participation Requirements as stated in the Proof of Eligibility.
4. To enroll the required percentage of all eligible (full-time) owners, partners, officers and employees not covered by a collective bargaining agreement within 30 days of 1) the employee date of eligibility as stated on the current Participation Agreement or 2) a qualifying event, and to pay at least 50% of the employee-only premium for coverage.
5. To notify the Plan Administrator of all employee changes and terminations of employment or other qualifying event in writing within 30 days of the change, termination or other qualifying event. It is understood that failure to submit such notification in writing within 30 days will not reduce the employer's liability for any premiums incurred prior to the date of notification. A qualifying event means any of the following:

ADDITIONS	TERMINATIONS
New hire	End of employment
Increased hours to full-time employment status Marriage	Reduced hours to part-time status Death of an employee
Birth of a child	Employee's Medicare entitlement
Legal adoption of a child	Legal start of bankruptcy proceedings
Loss of coverage due to a qualifying event	Divorce or legal separation from employee Loss of dependent child status

6. To pay premiums and fees as billed upon written demand of amounts due and to furnish the Plan Administrator with any statements or reports required to carry out the program. Fees may include a late payment penalty. Upon enrolling in the Insurance Benefit Plan, a participating employer must prepay a minimum of one month's premium. Please note all premiums include an Administration Fee.
7. To hold harmless the Association referenced above for any action taken or omitted by it in good faith. The Association Board of Trustees reserves the right to make policy, plan and carrier changes at any time.
8. To participate in elected insurance programs and to be bound by and entitled to all rights as set forth in the Association Insurance Benefit Program of the Association referenced above and policies as well as the sponsored carrier contracts.
9. To respect and protect the confidentiality of health information of employees and other participants; and to acknowledge that the group insurance plan(s) are subject to the HIPAA Privacy Laws, and to act in accordance with the direction of any plan so that such plan may fulfill its obligations under the HIPAA Privacy Laws.

Broker Contact:
USI Insurance Services, LLC
3435 American River Drive Suite C Sacramento, CA 95864 | Ph: 916-486-2900 | F: 916-486-4936
Administrator Contact:
American River Benefit Administrators
3435 American River Drive Suite B Sacramento, CA 95864 | Ph: 916-486-1292 | F: 916-751-7113

(Keep this page for your records)