ORGANIZATION PARTICIPATION AGREEMENT Billing Acct# ______________

(A) ORGANIZATION INFORMATION (Must complete all sections)

Organization Name:		Region:
Contact Person:		Location:
Mailing address:		Area:
City:	State:	Zip:
Telephone number: ( )	Fax number: ( )	
Email address:	Federal tax ID number:	
Total number of actively employed individuals consistently working 30 or more hours a week: ______________		

(B) ORGANIZATION EFFECTIVE DATE OF NEW COVERAGE– Begin selected plans on ___/_01_/2023

Indicate what date you would like the above selected plans to be effective. Month Day Year

Note: Do not discontinue present coverage until you have received confirmation of your coverage effective dates.

(C) ORGANIZATION WAITING PERIOD

For the selected plans below, the following Waiting Period should apply to new applicant

- ☐ 30-Day Waiting Period–Coverage begins first day of the month following thirty (30) days of employment
- ☐ 60-Day Waiting Period–Coverage begins first day of the month following sixty (60) days of employment

(D) COVERAGE CONTRIBUTION - ORGANIZATION PAID AMOUNT and EMPLOYEE PAID AMOUNT

Medical 100% Organization paid ☐ If not 100% Organization paid, Employee Contribution _______% or $________

Dental 100% Organization paid ☐ If not 100% Organization paid, Employee Contribution _______% or $________

Vision 100% Organization paid ☐ If not 100% Organization paid, Employee Contribution _______% or $________

Basic Life 100% Organization paid ☐ If not 100% Organization paid, Employee Contribution _______% or $________

STD ☐ Employer Paid 100% – 100% of eligible employees must be enrolled
☐ Employer Contribution _______ (requires at least 50% with 75% of eligible employees enrolled)

LTD ☐ Employer Paid 100% – 100% of eligible employees must be enrolled
☐ Employer Contribution _______ (requires at least 50% with 75% of eligible employees enrolled)

(E) ORGANIZATION PLAN SELECTION(S)

Check the boxes below to indicate the plans you are offering to your employees through the BGCWA:

COMPREHENSIVE MEDICAL 75% Participation is required of All Eligible Full Time Employees

Select the Plan or Plans you will be offering to your eligible employees below:

- ☐ Club Select PPO
- ☐ Club Choice PPO
- ☐ Club Advantage
- ☐ Club Value (Health Reimbursement Account)
- ☐ Club Super Saver
- ☐ Club Basic HSA
- ☐ Club Premium HSA
- ☐ Club Select EPO
- ☐ Club Choice EPO

☐ All Plans through an IRC Section 125 Cafeteria Plan
Note: A valid Premium Only Plan Document must be in place for this selection, if assistance with this requirement is needed, please contact UMR.

☐ EAP offered to Non-Medical Employees

☐ TeleAdvocacy Package-Teledoc program

☐ DENTAL INSURANCE PLAN – (Insured by Guardian)
☐ Dental Base Plan ☐ Dental Plus Plan ☐ Offer Employees BOTH Dental Plans

☐ VISION INSURANCE PLAN – (Insured by Guardian)
☐ Vision Base Plan ☐ Vision Plus Plan ☐ Offer Employees BOTH Vision Plans

LIFE INSURANCE WITH AD&D – (Insured by Guardian – 100% Participation is required of eligible full time employees when Organization pays entire premium) - **CHOOSE ONE**

Select the Plan you will be offering to your eligible employees below:

Flat amount Life Insurance Option ☐ $10,000 ☐ $20,000

☐ Salary Based Life Insurance Option 1 ($100,000 maximum) equal to one times salary
☐ Salary Based Life Insurance Option 2 ($400,000 maximum) equal to two times salary
☐ Salary Based Life Insurance Option 3 ($400,000 maximum) equal to three times salary

Billing Acct# ________________

By choosing to offer BGCWA Trust Employer Paid Life Insurance, employees will be eligible to select additional Employee Supplemental Life coverage (Premiums will be deducted post-tax from payroll and remitted by the Organization):

Employee Supplemental Life & AD&D Insurance - in $10,000 increments up to 5 times salary not to exceed $500,000 with a guaranteed issue amount of $100,000 (Amounts over 100K require Evidence of Insurability (EOI) form submitted with this application)

If enrolled in Employee Supplemental Life, Employees may also select:

Spouse Supplemental Life Insurance & AD&D Insurance - in $5,000 increments up to $100,000; guaranteed issue amount of $30,000, but NOT to exceed 100% of enrolled employee supplemental life insurance

Child(ren) Supplemental Life Insurance & AD&D Insurance - $10,000 per child

☐ **SHORT TERM DISABILITY** (Self-funded by the BGCWA Insurance Trust – Administered by Guardian)

☐ **LONG TERM DISABILITY** – (Insured by Guardian)

Check here ☐ if your Organization has LTD with another Insurance Carrier.

TERMS OF ORGANIZATION AGREEMENT

When accepted by the Boys and Girls Club Workers Association (BGCWA) Insurance Trust, or their duly authorized representative for the purpose of participation in the Plans sponsored by the Trust, the above Club/Organization hereby agrees as follows:

1. To abide by, and be bound by, the terms and conditions of the plan(s) of benefits adopted by the BGCWA;
2. To abide by charter requirements as set forth by the Boys & Girls Clubs of America;
3. To distribute benefit materials such as benefit booklets and ID cards to insured employees and to notify insured employees and of their rights and benefits under these plans;
4. To understand the definition of "Full Time Eligible Employee" is an Employee consistently working 30 or more hours per week;
5. To include at least 75% of all eligible full time employees when participating in the BGCWA's Comprehensive Medical Plan;
6. To include at least 50% of all eligible full time employees (consistently working 30 or more hours per week) when participating in the BGCWA's Dental, Vision or Short Term Disability Plan;
7. To include 100% participation of all eligible full time employees when participating in the BGCWA's Term Life Insurance Plan; and to include 100% participation of all eligible full time employees when participating in a Long Term Disability Plan;
8. To enroll only eligible employees and dependents by submitting a completed application to UMR within 30 days from the end of the Waiting Period selected by your Organization in this agreement, (otherwise coverage may be declined or delayed);
9. To make payroll deductions for employee's portion of premium as necessary based on your Organization's policies for premium contributions and, if deducting premium from the employee's paycheck on a pre-tax basis to have an IRC Section 125 Premium Only Plan Document in effect;
10. To pay premiums and contributions to the Health Reimbursement Account (if applicable) by the due date, which is the tenth day of each month. If monthly premium billing remains unpaid by the last day of the billed month, insurance coverage will be cancelled for non-payment of premium. Organization's employees and providers of service will be informed of delinquent payments if claim payments are delayed due to non-payment of premium;
11. To pay all billed premiums by the tenth day of each billed month or be subject to Late Fee charge (1% of total billed premium or $10.00 minimum);
12. To provide an Employee Application to each newly eligible employee and inform them that their coverage will not begin until they have completed, signed and returned the application to your Club's designated insurance contact and have satisfied the Waiting Period elected by the Organization as specified in section C;
13. To report employee additions and coverage changes within 30 days of the effective date of the qualified event or change;
14. To report employee terminations, and termination of dependent eligibility within 14 days of the last day of employment or your notification that a dependent is no longer eligible for coverage under these plans;
15. To provide initial COBRA notice to all eligible employees; advising UMR as the contracted COBRA Administrator for Health, Dental and Vision plans selected with this agreement;
16. To provide annual salary updates and job titles for those employees participating in salary-based Life Insurance, Short-Term Disability and Long-Term Disability.

ORGANIZATION AUTHORIZED SIGNATURES - I certify that all information provided is correct and complete, to the best of my knowledge, and agree to the terms of this Agreement.

By Chief Executive Officer ____________________ Signature ____________________ Date ____________
Please print or type.

By Board Chairman ____________________ Signature ____________________ Date ____________
Please print or type.

By UMR Administrator ____________________ Date ____________________

Send completed Organization Participation Agreement to Plan Administrator: UMR, 333 West Vine Street, Suite 500, Lexington, KY 40507
T (888)999-7718 F (859)226-1726 e-mail bgc@umr.com

For questions about the BGCWA Insurance Trust Plans your servicing Agent is ANCO Insurance (800)749-1733 Ext 6224

Revised 10/2021