

**GMEBS LIFE & HEALTH PROGRAM  
EMPLOYER DECLARATION & APPLICATION  
EMPLOYEE HEALTH, DENTAL & VISION BENEFITS  
LOGANVILLE**

**NOTE TO EMPLOYER:** THIS FORM DESIGNATES GMEBS HEALTH AND DENTAL BENEFITS THAT YOU REQUEST BE MADE AVAILABLE, THE POSITIONS THAT ARE ELIGIBLE FOR SUCH BENEFITS, AND THE EXTENT THE BENEFITS ARE AVAILABLE TO DEPENDENTS. TO BECOME EFFECTIVE, THIS DECLARATION MUST BE APPROVED BY YOUR GOVERNING AUTHORITY, AND BY THE GMEBS LIFE & HEALTH PROGRAM ADMINISTRATOR. UPON SUCH APPROVAL, THIS DECLARATION WILL REPLACE AND SUPERSEDE ANY PRIOR EMPLOYER DECLARATION ON FILE WITH THE GMEBS LIFE & HEALTH PROGRAM ADMINISTRATOR. IF YOU WISH TO OFFER HEALTH / DENTAL COVERAGE FOR RETIREES, YOU MUST APPROVE A SEPARATE RETIREE DECLARATION.

ELECTIONS MADE IN THIS DOCUMENT MAY OR MAY NOT RESULT IN PENALTIES IF YOU ARE AN APPLICABLE LARGE EMPLOYER (“ALE”) UNDER THE AFFORDABLE CARE ACT (“ACA”). IT IS YOUR RESPONSIBILITY TO CONSULT WITH YOUR ATTORNEY ABOUT WHETHER YOU ARE AN APPLICABLE LARGE EMPLOYER AND THE CONSEQUENCES OF YOUR ELECTIONS. REGARDLESS OF YOUR SIZE, BY EXECUTING THIS DECLARATION, YOU CERTIFY THAT YOU WILL NOT IMPOSE ELIGIBILITY CONDITIONS THAT ARE NOT SET FORTH IN THIS DOCUMENT, OR IMPOSE A LONGER WAITING PERIOD THAN IS SET FORTH IN THIS DOCUMENT. EFFECTIVE JANUARY 1, 2015, IF YOU ARE AN APPLICABLE LARGE EMPLOYER, YOU MAY INCUR ACA PENALTIES IF: 1) YOU DO NOT IDENTIFY ALL “FULL TIME EMPLOYEES” AS DEFINED BY THE ACA AND OFFER THEM HEALTH COVERAGE; 2) YOU DO NOT OFFER HEALTH COVERAGE TO DEPENDENT CHILDREN; OR 3) YOU DO NOT SUBSIDIZE HEALTH COVERAGE ENOUGH TO MAKE THE COST OF EMPLOYEE-ONLY HEALTH COVERAGE AFFORDABLE (AS DEFINED BY THE ACA).

**SECTION 1. ELIGIBLE POSITIONS; TYPE OF BENEFITS REQUESTED**

**1A. Regular Employees**– The Employer requests the following benefits for all Regular Employees (as defined below).

**Regular Employees:** A Regular Employee who resides in the United States, and is employed in a salaried or hourly rated position that requires 30 Hours of Service per week or more and is expected to last at least 48 weeks. An Hour of Service is an hour for which an employee is paid, or is entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Health       Dental       Vision

**1B. Elected or Appointed Members of the Governing Authority** – The Employer requests the following benefits for all active elected or appointed members of the Employer’s Governing Authority. This would include the Chief Legal Officer, Associate Legal Officer and Municipal Judges unless identified as being excluded by Employer below.

Health       Dental       Vision

**Exclude from Benefits: (EMPLOYER FILL IN BOX WITH "X")**

Chief Legal Officer       Associate Legal Officer       Municipal Judges

**1C. [For ALE’s only** - Participating Employers that are ALE’s may determine that certain workers who do not meet the definition of a Regular Employee above are “ACA Full-Time Employees.” For example, an Employer might determine that a newly hired employee in a nine-month position that requires 30 Hours of Service per week is an ACA Full-Time Employee. For coverage in calendar years 2015 and later, Participating Employers that are ALE’s may offer the coverage elected in 1A to anyone it determines to be an ACA Full-Time Employee.]

**SECTION 2. EMPLOYEE ELIGIBILITY WAITING PERIOD**

Individuals who are hired or take office into an Eligible position after the Employer’s effective date of group health/dental coverage are eligible to enroll for such coverage on the first day of the calendar month following or coinciding with the date that they complete the following number of days of continuous, active service in an Eligible position.

0       30       45       60

Those rehired into an Eligible position are not subject to a waiting period unless rehired after 13 consecutive weeks without an Hour of Service.

[For ALE’s only - The waiting period elected above applies for any newly hired workers the Employer identifies as being “ACA Full-Time Employees” pursuant to Section 1.C. If the Employer determines a worker to be an ACA Full-Time Employee based on Hours of Service during an initial measurement period, the waiting period: 1) starts at the end of the initial measurement period, and 2) must be shortened as needed for coverage to be effective no later than 13 months from the date of hire (or the first day of the following month if the worker did not start on the first day of the month.)]

Note: The Employer’s waiting period must be the same for all GMEBS Life & Health Program coverages offered by the Employer (i.e., health, dental, life, short term disability, etc.) There will be no exceptions to waiting period unless Employer submits documentation waiving the stated waiting period.

**SECTION 3. EMPLOYER HEALTH PLAN ELECTION**

If the “Health” box for any Employee position in Section 1A or 1B above is checked, the boxes checked below indicate the Health Plan option(s) and deductibles requested and coverage for dependents:

	Plan Name/Deductible	Employee	Employee + Spouse	Employee + Child	Family
<input checked="" type="checkbox"/>	HMO 90%	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	PPO 90/70 500	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	POS 90/70 1000	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**SECTION 4. EMPLOYER DENTAL PLAN ELECTION** If the “Dental” box for any Employee position in Section 1A or 1B above is checked, the box checked below indicates whether coverage is requested for eligible dependents.

Employee Only       Employee + Dependents (spouse and children)

**SECTION 5. EMPLOYER VISION PLAN ELECTION**

If the “Vision” box for any Employee position in Section 1A or 1B above is checked, the boxes checked below indicates whether coverage is requested for eligible dependents:

	Employee	Employee + Spouse	Employee + Child	Family

**SECTION 6. EMPLOYER REPRESENTATIVE** – Please list by title or position the person designated by the Employer to represent the Employer in all communications with GMEBS and the Program Administrator concerning the GMEBS Life & Health Program: Human Resources Director

The Employer may identify in writing to the Program Administrator an additional agent or authorized representative (such as an insurance broker) as being authorized to receive communications, including enrollment information for billing purposes.

**SECTION 7. EMPLOYER ADOPTION** - The Employer acknowledges that this Employer Declaration and Application will not become effective unless and until it is approved by the GMEBS Life & Health Program Administrator, and that upon such approval this Employer Declaration and Application will replace and supersede any prior Employer Declaration and Application concerning health and dental coverage for employees that is on file with the GMEBS Life & Health Program Administrator. The Employer further acknowledges that GMEBS’ approval of this Employer Declaration and Application is contingent upon the Employer having adopted the GMEBS Life and Health Program Participation Agreement, as amended. If the Employer has elected Vision Coverage, the Employer also agrees to the following Vision Participation Agreement required by Anthem, the insurer of the Vision Coverage:

VISION PARTICIPATION AGREEMENT

- By electing Vision Coverage, Employer is electing to participate in the Master Policy for Anthem Vision Coverage held by GMEBS (the Policyholder.)
- The eligibility and waiting period provisions elected above are incorporated by reference in this Vision Participation Agreement.
- Employer shall fulfill the obligations of the “group” or the “employer” set forth in the Vision Coverage Certificate.
- The Employer affirms that it will not offer any other vision coverage while offering Vision Coverage through GMEBS.
- If the Employer engages in fraudulent conduct or misrepresentations when requesting or offering Vision Coverage, Anthem has the right to rescind, cancel or terminate the Employer’s participation in the Anthem Vision Coverage effective on the date of the fraudulent conduct or misrepresentation, regardless of the date of Anthem’s discovery of such conduct. The Employer shall be liable to Anthem for any and all payments made or losses or damages sustained by Anthem arising as a result of such conduct.
- In the event the Employer has failed to provide to Anthem’s satisfaction, any information requested by Anthem, Anthem may terminate the Employer’s participation in Vision Coverage upon thirty (30) days written notice.
- If the Employer fails to timely notify the Life & Health Program Administrator of an employee or dependent’s loss of eligibility, and Anthem is unable to recover claim amounts paid to an ineligible individual, the Employer shall be liable to reimburse Anthem for all unrecovered claim amounts paid.
- Employer agrees not to impede any individual enrolled in Employer’s Vision Coverage from performing his or her obligations under the Certificate of Coverage, and agrees to assist such individuals in performing their obligations.

Approved by the Mayor and Council/Commission of the City of Loganville, Georgia this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Attest:

CITY OF \_\_\_\_\_, GEORGIA

\_\_\_\_\_  
Signature of City Clerk

\_\_\_\_\_  
Signature of Mayor

\_\_\_\_\_  
Print Name of City Clerk  
(SEAL)

\_\_\_\_\_  
Print Name of Mayor

**Please do not write below this line (for GMEBS USE ONLY)**

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The terms of the foregoing Employer Declaration and Application are approved by the GMEBS Life & Health Program Administrator this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.  
Subject to the applicable terms of the GMEBS Life and Health Program Participation Agreement and the Plan(s), the effective date of the coverages (or any change in coverage) as reflected in this Employer Declaration and Application will be the date shown under "Declaration Effective Date" on the first page of this form.

GMEBS LIFE & HEALTH PROGRAM ADMINISTRATOR  
By: \_\_\_\_\_