EIA SMALL GROUP EMPLOYEE BENEFITS PROGRAM

Thank you for your interest in EIA's Small Group Benefits program. We provide smaller public agencies an alternative to group health insurance plans using the concepts of pooling to reduce insurance premiums.

Our programs are designed to meet the needs of public agencies in California who are looking for competitive rates and benefits in a stable cost environment.

In order to participate in any of the EIA Small Group benefits programs, **the group must be a qualifying public entity** (or made up of all public entities): County, Municipality, or a Special District. Special conditions apply for School Districts.

To find out if you qualify and receive a proposal, please complete the following information:

GROUP INFORMATION

Group's Legal Name: _____

Street Address: _____

City: _____ State: _____ County: _____ Zip: _____

Contact name: _____ Title: _____

Email: _____ Phone Number: _____

Form of Organization: **(Enter an 'X')** Government Entity: ☐ JPA: ☐ Other (Specify) _____

Please specify the probationary period/eligibility date:
Eligibility date is always on the FIRST DAY of the month following waiting period unless otherwise specified:

- The waiting period for employees is: _____ Other: _____

Public Officials:

- **CHECK HERE** ☐ If you currently cover public officials and intend to continue providing coverage to your Public Officials/Governing Body members through the EIA Small Group Coverage.

  Total number of public officials: _____ Total number of enrolling public officials: _____

Desired Effective date:

- Requested Effective Date to join the EIA program: _____

CURRENT CARRIER(S) / AFFILIATIONS

Indicate the names of all current carriers

- Is this plan intended to replace any existing group coverage? _____(yes/no)
- If YES, name of current group carriers(s): _____
- Do you currently have any lines of coverage (medical, dental property/liability, worker's compensation, etc.) with a pool or JPA?_____(yes/no)
    - If yes, which pool/JPA and what lines of coverage? _____

Carrier Guidelines:
Medical: Groups with existing Anthem coverage will be replaced with Blue Shield. Groups with existing Blue Shield coverage will be replaced with Anthem.

The EIA small group benefits program cannot provide quotes for Dental, Vision or Life &Disability if group coverage is currently with the providers adjacent to the benefit plans identified below:

- Dental: Currently with Delta Dental - cannot quote
- Vision: Currently with VSP - cannot quote
- Life & Disability: Currently with ING - cannot quote
- EAP: Currently with MHN – cannot quote

COVERAGES REQUESTED AND CONTRIBUTIONS

The employer will contribute the following percentage or dollar amount of the subscription charge/premium on behalf of its employees and/or dependents for the coverages requested:

Select plans to quote(x)							
Employer Contributions	**Medical**	**Dental***	**Vision***	**LTD***	**Life***	**Optional Life**	**EAP***
Employee:		100%	100%	100%	100%	Employee Paid	100%
Dependent:						Employee Paid	N/A

*Employer **must** contribute 100% of the employee cost towards any ancillary coverage.

OTHER:

- Do you provide a cash-in lieu option? (yes/no):_____ If yes, indicate amount: _____
- Proof of other coverage required to waive benefits? (yes/no): _____

CENSUS INFORMATION

The following is the minimum information needed on your census. We suggest providing this information in Excel format. For each employee please provide:

- **Name or employee id**
- **Age**
- **Gender**
- **Tier** (Single, two party, Family)
- **Status** (Please note, this column should be listed as follows in the Excle file: A, R, RMC, B, C, W)
  Code definitions: **A:** Active **R:** Non-Medicare (early retiree) **RMC:** Medicare Retiree **B:** Board member/Director/Trustee/Council Member **C:** COBRA **W:** Waiving benefits
- **Current Plan Name** (Example: Healthnet HMO, Healthnet PPO, Kaiser)

Checklist:

For all products:

- Completed "Program Interest Package": This completed form
- Employee Census file in Excel, as specified in the section above

Additional information required for medical coverage:

- Completed, signed and dated Large Claimant Disclosure Statement form. Form must be completed and signed even if there are no known large claimants.
- Copies of current Plan Designs and rates