AWC Employee Benefit Trust
Employer Master Participation Agreement

❑ Initial Employer Master Participation Agreement

❑ Change to existing Employer Master Participation Agreement

The change to the existing Employer Master Participation Agreement is: ______________________

The effective date of the change is: ______________

www.awcnet.org/employeebenefits

The AWC Employee Benefit Trust is a plan sponsor for health coverage through the following insurance carriers:

Medical			Dental		Vision	EAP	Life & LTD
Regence	Asuris Northwest Health	GroupHealth	Delta Dental Washington Dental Service	Willamette Dental	VSP	ComPsych	The Standard
PO Box 21267 Seattle, WA 98111	PO Box 91130 Seattle, WA 98111	Group Health Cooperative PO Box 34750 Seattle, WA 98124	Northgate Delta Building PO Box 75983 Seattle, WA 98175	Willamette Dental of Washington, Inc. 6950 NE CampusWay Hillsboro, OR 97124	PO Box 997105 Sacramento, CA 95899	NBC Tower 455 N. Cityfront Plaza Drive Chicago, IL 60611-5322	900 SW Fifth Ave. Portland, OR 97204

Employer: ______________________

Date form completed: ______________________

Form completed by: (name, title) ______________________

Total number of full time employees **eligible** for ANY employer sponsored health coverage: _______

Total number of full time employees **eligible** for AWC sponsored medical plans: _______

Total number of full time employees **enrolled** on AWC sponsored medical plans: _______

Total number of full time employees **eligible** for AWC sponsored dental plans: _______

Total number of full time employees **enrolled** on AWC sponsored dental plans: _______

Total number of full time employees **eligible** for AWC sponsored vision plans: _______

Total number of full time employees **enrolled** on AWC sponsored vision plans: _______

Total Number of LEOFF I Actives: Fire Dept: _______ Police Dept: _______

Total Number of LEOFF I Retirees: Fire Dept: _______ Police Dept: _______

Do you provide health coverage for your elected officials? **Yes** **No**

If yes, number of eligible elected officials: _______

Number of elected officials enrolled on AWC sponsored : Medical _______ Dental _______ Vision _______

Do you provide health coverage for your part time employees? **Yes** **No**

If yes, provide your definition of minimum hours worked per week in order for part time employees to be eligible for benefits. (Must be a minimum of 20 hours/week.) _______

If yes, number of part time employees **eligible** for AWC sponsored Medical _______ Dental _______ Vision _______

Number of eligible part time employees **enrolled** on: Medical _______ Dental _______ Vision _______

A listing of Trust-sponsored medical, dental, vision, life, LTD and EAP plans, rates and the AWC Trust's underwriting rules is available in the annual employer publication *Your Guide to Administering AWC Benefit Plans*.

ELIGIBILITY CRITERIA:

EMPLOYEES:

1. Employees are covered the first day of the month after date of hire.
Yes **No** (If no, please complete #2 and #3 below.)

2. Employees have a ____________________ probationary period and then are covered the first of the month following the date probationary period is completed. (Written employer policy must be submitted to AWC.)

3. Other: ____ (Written employer policy must be submitted to AWC.)

4. If an employee's hire date is the first day or first working day of the month – is your city policy to (circle one):
A. Start the employee's insurance on the first of that month **or**
B. Start the employee's insurance on the first of the month *following date of hire*

5. Employee's insurance coverage terminates the first of the month following the date of termination/date of retirement. **Yes** **No**

If no, please explain employer policy below. (Written employer policy must be submitted to AWC.)

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DEPENDENTS:

1. Dependents are eligible to be covered on the City's plan. **Yes** **No**

2. Eligible dependents are covered when the employee becomes eligible for coverage. **Yes** **No**
If no, please explain city policy below. (Written employer policy must be submitted to AWC.)

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3. Other: ____ (Written employer policy must be submitted to AWC.)

4. Domestic Partner health care coverage is required by state law. If you have a more generous domestic partner policy than required by Washington state law (RCW 48.44.900), briefly describe this policy below & attach the policy.

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EMPLOYER/GROUP PLAN ADDITIONS OR PLAN CHANGES:

1. Written notification of change and/or addition of plan(s) should be sent to the AWC Trust office no less than 30-days prior to the change and/or addition. This will be accomplished by completing a new Master Participation Agreement.
2. AWC Combined Insurance Enrollment Forms must be submitted a minimum of 20 days prior to the change/addition. The Trust prefers the forms *prior to this* to ensure the smoothest transition.

EMPLOYER/GROUP PLAN TERMINATION:

1. Written notification of group or city coverage termination should be sent to the AWC Trust office 60 days prior to termination date.
2. Upon notification of plan termination, the AWC Trust will notify the member jurisdiction of impacted COBRA beneficiaries and retirees so that the jurisdiction may notify them of AWC coverage termination.
3. Re-entry into the AWC Trust has no restrictions at this time; however, the Board of Trustees retains the right to review jurisdictions of 250 employees or more for claims cost analysis & possible premium surcharge.

I have provided these answers as part of the procedure required by the AWC Employee Benefit Trust to provide or change any AWC Trust-sponsored insurance coverage for our employees. I certify that all information completed on this form is true, correct, and complete. I understand that the AWC Trust will rely on each answer to ensure underwriting rule compliance. For the protection of all our members, knowingly providing us with false, incomplete or misleading information may result in the Board of Trustees taking any action allowed by law, contract or Trust Document, including termination or rescission of coverage and/or denial of benefits.

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Signed Date Title

Please identify each work or bargaining unit, including the number of **eligible employees** in that unit and the number of **enrolled employees** in that unit. Please list **all groups**, including those not enrolled with a carrier offered through the AWC Trust. *If your jurisdiction has all employees on the same plans* – please write "all employees" in the name of work unit or bargaining unit column.

Name of Work Unit or Bargaining Unit (ie. Public Works, Non-Rep, Finance etc.)	**Plan Sponsor** (ie. AWC, Teamsters, Fire Commissioners etc.)	**Enrolled on what health coverage?** *Please list each health plan seperately.* (ie, Regence BlueShield Plan A, WDS Plan F, UEBT, VSP $10 etc.)	**Number of eligible employees in each work or bargaining unit.** (Please list separately by each health plan.)	**Number of employees enrolled on each health plan.** (Please list separately by each health plan.)	**Date of plan enrollment on plan** (if known).