



**Association of Washington Cities /
Standard Insurance Company
Participation Agreement**



The Association of Washington Cities Employee Benefit Trust contracts with Standard Insurance Company for its Life, Accidental Death & Dismemberment, Additional Life, Dependent Life and Long-Term Disability coverages. This form must be used when enrolling a new employer, enrolling a new group of employees or when an employer changes its existing level of coverage. Standard requires the following information be provided by the participating employer and kept on file as a Participation Agreement between said participating employer and the AWC Employee Benefit Trust/Standard Insurance.

Employer – Please complete the entire following section														
Legal Name of Employer:	Segment Number:													
Address:														
Name of Subsidiaries, Divisions or Affiliates to be covered (if applicable):														
Name of Contact:	Phone:													
	Fax:													
	email:													
Proposed Effective Date:	Nature of Business:													
Eligibility: All regular Full-time Employees working a minimum of 20 hours per week. Is any class of employees excluded from coverage? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please define: _____ _____	Number of Employees: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">Life</th> <th style="width: 20%; text-align: center;">LTD</th> </tr> </thead> <tbody> <tr> <td>Eligible</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Enrolled</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td></td> <td style="text-align: center;">(100%)</td> <td style="text-align: center;">(varies)</td> </tr> </tbody> </table>			Life	LTD	Eligible	_____	_____	Enrolled	_____	_____		(100%)	(varies)
		Life	LTD											
Eligible	_____	_____												
Enrolled	_____	_____												
	(100%)	(varies)												
Eligibility Waiting Period for New Employees: <input type="checkbox"/> LEOFF 1 Employees: The date of employment. <input type="checkbox"/> All Other Employees: The first of the calendar month following the date they become a member. <input type="checkbox"/> All Other Employees: Other, please define: _____ _____														
Other Insurance: Is there any other group insurance in force, being applied for or being issued at this time? Life: <input type="checkbox"/> yes <input type="checkbox"/> no LTD: <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please provide details: _____ _____														
Does this new coverage <i>replace</i> or <i>change</i> any existing group coverage? Life: <input type="checkbox"/> yes <input type="checkbox"/> no LTD: <input type="checkbox"/> yes <input type="checkbox"/> no If yes, Name of Prior Carrier: _____ Date of Termination: _____ Please describe the change: _____														
Active Work Requirement: Is any employee disabled at this time? <input type="checkbox"/> yes <input type="checkbox"/> no. If yes, please provide names & details: _____														

Employer – Please complete the following section if you are enrolling on or making changes to Life Insurance.

Basic Life: The maximum potential benefit is \$300,000. Employers must pay 100% of the premium cost of the Basic Life. For participating employer's with 10 or less employees, Evidence of Insurability must be submitted for amounts over \$10,000.

Plan A: Flat Amount for all Employees \$_____ (minimum \$5,000)

Plan B: Benefit Amount by Class of Employee

Class I definition: _____ Amount \$ _____

Class II definition: _____ Amount \$ _____

Class III definition: _____ Amount \$ _____

Plan C: Benefit Amount as Multiple of Annual Salary (minimum \$10,000)

.5 x Salary 1 x Salary 1.5 x Salary 2 x Salary

Plan D: Requires prior approval from Standard: _____

Accidental Death & Dismemberment: yes no

Available in the amount equal to the Basic Life Insurance Plan you selected above.

Dependent Life Insurance: yes no If yes, select one plan below:

Plan I: Spouse: \$1,000 Child age 181 days to age 23: \$1,000 Child birth to 180 days: \$100

Plan II: Spouse: \$2,000 Child age 181 days to age 23: \$2,000 Child birth to 180 days: \$200

Additional Life Insurance: yes no

Available in increments of \$10,000 to \$100,000 as selected by each employee on the enrollment form. Satisfactory Evidence Of Insurability is required for amounts exceeding \$20,000.

Spouse Additional Life Insurance: yes no

Available in increments of \$5,000 to \$50,000 not to exceed 50% of the employee Additional Life amount selected; employee must be enrolled in order for spouse to enroll. Satisfactory Evidence Of Insurability is required for all amounts.

Benefit Reduction: Basic Life, AD&D and Additional Life benefits reduce to 65% of the original amount at age 65, reduce to 50% of the original amount at age 70, reduce to 30% of the original amount at age 75, and further reduce to 20% of the original amount at age 80, and terminate at retirement.

Employer – Please complete the entire following section if you are enrolling on or making changes to Long Term Disability.

Long Term Disability:

Benefit Waiting Period: 90 day 180 day

Benefit Level %: 60% 67%

Note: If LTD coverage has been negotiated into a collective bargaining agreement, please forward the page from the labor contract indicating the coverage.

Premium Contributions: Do employees pay toward their LTD coverage? yes no

If yes, amount city pays: _____%

amount employee pays: _____ %

All statements made herein are true and complete to the best of my knowledge.

Signature: _____ **Date:** _____

Please return this completed form with the AWC Combined Insurance Enrollment Forms to:
AWC Employee Benefit Trust
1076 Franklin Street SE
Olympia, WA 98501-1346