

**ADOPTION & PARTICIPATION
REQUEST FOR PARTICIPATION IN:**

GettHealth USE ONLY
GROUP # _____
PLANCODE _____
CHECK \$ _____
ASSOCIATION _____
MARKETING REP. INITIALS _____

- INSURANCE SERVICES INDUSTRY TRUST-Pennsylvania (ISIT- PA), established under a Trust Agreement dated January 1, 1991 insured for the benefits provided under group insurance policies issued to the Trustee(s) by:
- Delta Dental of Pennsylvania (the "Insurance Company") For 2-4 lives only. Delta Dental 5+ lives must use Delta SBA Forms.
- Harleysville Life Insurance Company (the "Insurance Company") Policy Number G-536-01
- Inter-County Hospitalization Plan, Inc./Inter-County Health Plan, Inc. (the "Insurance Company").
- VSP.

Administrator:

Gettysburg Health Administrators, Inc. (GettHealth), 34 Locust Ave., P.O. Box 1060, Gettysburg, PA 17325-1060 (717-334-9247)

The undersigned, subject to acceptance by the Administrator, hereby makes application to become a participant in and to be bound by all of the terms, provisions, conditions and limitations of the Trust and Trust Agreement, as amended, between the Trust and Gettysburg Insurance Services, Inc. and the master insurance policy or policies (Policy) issued thereunder and providing benefits for the employees of the undersigned Participant/Employer to the same extent as if it were the Policyholder named therein. The undersigned further agrees from time to time to execute and deliver such papers and documents and to furnish such records and information to said Administrator and Insurance Company as shall be required to effect and continue coverage for the undersigned's employees under such Policy. The undersigned further agrees that if it withdraws from the Trust and cancels its insurance plan, it thereby relinquishes any claim it may then or thereafter have to any benefits provided through the Trust.

We understand and agree as follows:

1. The Trust may be amended, revised, supplemented, or terminated by the Trustee(s) as provided therein, and any such change shall be binding upon us.
2. The Policy may be amended, canceled or discontinued, according to its terms, by the Trustee(s) and the Insurance Company, and all of the terms of the Policy including such change shall be binding upon us.
3. Since premiums for said policy are payable in advance to the Administrator, we shall make in advance to the Administrator such premium payments and/or participating employer assessments as are requested of us by the Administrator to cover the cost of insuring our employees. An initial premium deposit must accompany this application for group insurance, but the remittance of this deposit does not constitute automatic acceptance of this group insurance application by the Insurance Company. We may be subject to having personal health statements for both employees and dependents completed prior to approval by the Insurance Company. Attending physician statements and other investigations may be requested by the Insurance Company through the Administrator. We understand that the submitted materials are subject to review for acceptability and that the insurance, as applied for, will not be in force until we have received formal, written notification of acceptance, and of the effective date of the coverage applied for, from the Administrator. Appropriate declinations may be made prior to acceptance. The initial premium deposit will not be credited to our account until such time as the formal notification has been released by the Administrator. We understand that this premium deposit will be returned to us in the event that the application is not approved by the Insurance Company.
4. The Insurance Company and Administrator reserve the right to adjust rates (with 30 days notice) from time to time to assure the actuarial soundness of the trust upon the recommendation of the Insurance Company.
5. All disclosures and declarations on Plan of Coverage and Coverage Requested (pages 2 and 3) and Field Underwriting Information (page 4) shall become a part of the coverage issued pursuant to this application.
6. It is critical that eligibility and coverage terminations be reported to Gettysburg Health Administrators, Inc. immediately upon termination of employment. If we fail to promptly terminate an employee's coverage, the Insurance Company reserves the right to recoup repayment of any claims incurred and paid beyond the employee's date of termination or expiration of eligibility.
7. Conversion Notice: It is the employer's responsibility under the terms of the Policy and Trust Agreement to present the employee with notification of his right to convert medical insurance to a non-group type of insurance, under certain conditions, after termination of employment. The insurance benefits, eligibility requirements and effective date of the insurance are requested herein. I certify, as the employer, that to the best of my knowledge and belief all statements and answers in this Application are true. I have read and understand the Notice Regarding Limitations on Health Insurance Coverage (page 4). Advance payment, herewith, of _____ is to be applied toward the payment of premiums under the group insurance coverage hereby requested. **PLEASE MAKE CHECK PAYABLE TO: GETTHealth PREMIUM ACCOUNT.**

EMPLOYER NAME: _____

BY: _____ TITLE: _____ Date: _____
SIGNATURE

The above named Employer is eligible to participate in the above described Trust and is approved as a participant therein.

EFFECTIVE DATE: ____/____/____

Gettysburg Health Administrators, Inc. By: _____ ____/____/____

PLAN OF COVERAGE

NAME OF FIRM _____ TAX ID # (E.I.N.) _____

CORRESPONDING PERSON & TITLE _____ TEL. # (____) _____

PRESIDENT/CEO _____

STREET ADDRESS _____ FAX # (____) _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

(1) Effective Date: The requested effective date for this plan is _____, 20_____

(2) Type Of Business Corporation Partnership Sole Proprietor

(3) Nature Of Business _____ SIC Code _____

(4) How long has this particular business been in operation? _____

(5) Subsidiary or affiliated companies to be covered (if trusteeship or association list contributing employers or employer-members on a separate sheet and attach with this application):

Name & Address

Relationship to Policyholder (Subsidiary or Affiliate)

a) Are any employees outside coverage area quoted by Gettysburg Health Administrators? # of employees _____
Location _____

(6) Total Number Of Employees: A) INSURED: Full-Time _____ COBRA _____
B) DIS-ELECTION: PartTime/Seasonal _____ Waivers _____

a) List classes of employees to be covered: _____

All full-time employees who devote a minimum of 30 hours each week to the service of the applicant at their regular and customary place of employment are considered eligible. It is agreed that the insurance applied for shall not become effective unless the number of persons insured is no less than the minimum number of lives required by law. It is also agreed that if contributions are required, at least 75% of the persons eligible for insurance must make written request for the insurance. It is further agreed that if contributions are not required, 100% of the persons eligible for insurance must make written request for the insurance. In addition to part-time and temporary employees, the following classes of employees or employees by name are NOT to be considered eligible: _____

b) Are 50% of the employees to be insured of the same immediate family? YES NO Proof of full-time employment is attached.

c) Individuals to be covered receiving extended benefits under COBRA? NO YES Identify individuals, effective date and termination date of COBRA: _____

(7) Waiting Period For Eligible Full-Time Employees:

a) Initial employees employed ON or BEFORE effective date: No Waiting Period _____ Months

b) Subsequent employees employed AFTER the effective date: 3 Months

c) New hire waiting period for current plan: 3 Months

d) Are any employees currently absent due to illness or injury or receiving disability benefits? YES* NO

*If YES, provide an explanation on separate sheet (without any identifying information).

NOTE: For non-medical coverage, eligible employees who are disabled on the date their insurance would otherwise become effective shall become insured on the date they return to active work. For non-medical coverage, if a dependent of an insured employee is hospital confined on the effective date, he or she shall be covered under this plan when discharged from the hospital.

(8) Does your company have a policy for Continuation of Coverage for disabled employees or those on leave of absence? YES* NO

*If YES, attach copy of policy.

(9) Does your company provide health benefits for laid off employees? NO YES, # of Days: 30 60 90 _____

(10) Does your company provide health benefits for dependents to age 30 (PA Act 4 of 2009)? NO YES

(11) Are all employees and owner/partners covered by Workers' Compensation? YES NO Name of Carrier _____
Name of owner/employee not covered by Workers' Compensation: _____

(12) Is HMO currently offered? YES* NO *Specify HMO: _____
*Specify HMO Enrollment Period: _____

(13) Insurance coverage hereby applied for is to replace insurance in force as stated below: **(Attach copy of previous carrier's bill.)**

a) Coverage applied for is is not in addition to coverage below:

TYPE OF INSURANCE	DATE DISCONTINUED	INSURANCE COMPANY	YEARS WITH CURRENT CARRIER
_____	_____	_____	_____

(14) EMPLOYEE CONTRIBUTIONS:

Insurance is non-contributory Insurance is contributory: If contributory: Premium is Pre-Tax Post Tax

The Applicant Employer agrees to make the payroll deduction authorized in writing by each employee.

EMPLOYEE'S CONTRIBUTION TOWARD COST

VSP vision	DENTAL
_____ %	_____ %
EE/Dependent	EE/Dependent

DELTA DENTAL COVERAGE REQUESTED (For 2-9 lives; 5+ lives must use Delta SBA Forms):

Waiting period for subsequent employees (eligible full-time) employed after the effective date is 90 days.

Network:

PPO Plus Premiere Network PPO Network

Basic Plan - \$25 DED - \$1000 MAX (2-4 EE's)

Traditional Plan - \$50 DED - \$1250 MAX (2-4 EE's)

High Plan - \$50 DED - \$1500 MAX (2-4 EE's)

Rates require that the employer will contribute a minimum of 50 percent of the cost of the plan and that there will be no less than 50 percent enrollment of all eligible employees and no less than 50 percent enrollment of their dependents if dependent coverage is elected by the employer. **Employees covered through a spouse's dental plan, and employees and/or dependents with dentures will be counted toward meeting the participation requirement. Minimum enrollment of two (2) lives.**

Administration Fee

\$10.00 per group per month

VSP COVERAGE REQUESTED

For 2-99 Employees – Employer Contribution Required

VSP Exam Plan - Benefits Include: Exam Plus Program - \$10 Copayment; Exam 1 per twelve (12) months

2 options (100% or 50% based on contribution level)

0% Employer Paid / 100% Employee Participation ; voluntary program

50% Employer Paid / 75% Employee Participation;

VSP Signature Plan – 2 options (100% or 50% based on contribution level)

0% Employer Paid / 100% Employee Participation - Full Service Program ; voluntary program

Plan B - Benefits Include:

Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment

Plan C - Benefits Include:

Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment

50% Employer Paid / 75% Employee Participation - Full Service Program

Plan B - Benefits Include:

Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment

Plan C - Benefits Include:

Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment

PRODUCER SECTION

PRODUCER OF RECORD: The below signed producing agent is hereby recognized as the Agent of Record to receive credit for this application according to the Insurance Company rules and regulations on coverages issued in accordance with this application, provided he or she is duly licensed as required by law.

PRODUCER CERTIFICATION: I certify, as primary agent, that to the best of my knowledge and belief all of the statements and answers on this Adoption & Participation Agreement are true. I also certify that I have no knowledge or information regarding the applicant group which is not fully set forth herein.

Independent Producer/Solicitor _____ SIGNATURE _____ / _____ % Date _____ / _____ / _____

Independent Producer/Solicitor _____ PRINT NAME _____ Phone#(_____) _____ GettHealth Agent ID# _____

Agency (If Applicable) _____ Phone#(_____) _____ GettHealth Agency ID# _____

Super Producer (If Applicable) _____ SIGNATURE _____ GettHealth Agency ID# _____

Super Producer _____ PRINT NAME _____

Independent Producer/Solicitor _____ SIGNATURE _____ / _____ % Date _____ / _____ / _____

Independent Producer/Solicitor _____ PRINT NAME _____ Phone#(_____) _____ GettHealth Agent ID# _____

Agency (If Applicable) _____ Phone#(_____) _____ GettHealth Agency ID# _____

Super Producer (If Applicable) _____ SIGNATURE _____ GettHealth Agency ID# _____

Super Producer _____ PRINT NAME _____

Mail Commissions

To _____
(Street) (City) (State) (Zip)

Commission payable to Independent Producer/Solicitor Agency Super Producer

NOTICE REGARDING LIMITATIONS ON HEALTH INSURANCE COVERAGE

While we believe that the insurance coverage you are purchasing is among the finest obtainable, you should be aware of certain limitations in the coverage being offered. In particular, please note the following:

- There may be a "waiting period" which would delay the insurance coverage effective date (see page 2 of this form);
- Certain exclusions from coverage are contained in the Policy (see the Policy);
- Some "pre-existing conditions" may not be covered for up to 12 months (see the Policy);
- The Policy discusses the various optional coverages and limitations upon some of these benefits.

*** IMPORTANT NOTE FOR EMPLOYERS REGARDING MATERNITY COVERAGE (APPLICABLE TO MEDICAL PLANS):**

If you are required to offer maternity coverage by state or federal law, based upon the number of employees that you employ, you should request to add such coverage to your medical plan. The addition of maternity coverage may be subject to underwriting review and approval. The Pennsylvania Human Relations Act generally applies to employers with 4 or more employees, and the federal Pregnancy Discrimination Act generally applies to employers with 15 or more employees. As the employer, you are responsible to monitor the number of employees that you employ, to determine whether these laws apply to you. You are also responsible for notifying us if you want to add maternity coverage to your medical plan.