ASSOCIATION MEMBERS APPLICATION FORM

Legal Name of Organization: ____

Mailing Address: ____

City: ______________________________ State: _____________ Zip: __________

Executive Officer (signer): ____

Title: ______________________________ Email Address: ____________________

Telephone: __________________________ Business Activity: _________________

Employer Fed Tax ID#: ________________ Tax Year Start Date: _______________

Date of Organization: _________________ State of Organization: ______________

Affiliated Employers *(list):* ____

____ ☐ None

Organization Type *(please check)*: ☐ Non-Profit Organization ☐ Government Agency

☐ Partnership* ☐ Sole Proprietorship* ☐ LLC *(Limited Liability Company)**

☐ Sub-chapter "C" Corporation ☐ Sub-chapter "S" Corporation* ☐ Other ________________

The undersigned applicant (hereinafter the Association Member), hereby applies for coverage under the Chamber of Commerce Dental Plan, provided by Altus Dental Insurance Company, Inc (hereinafter the Carrier). This plan will be administered by the American Benefits Insurance Corporation, Inc. of Northampton, d/b/a American Benefits Group (hereinafter ABG).

If approved for coverage under the plan, the Association Member hereby accepts the Dental Benefits and Subscription Charges set forth in this document and in the attached Riders, and agrees to adhere to the Underwriting Guidelines of the Carrier as further specified herein.

A. Association Members

In order to be eligible to purchase benefits from Altus Dental Plan, each Association Member must be an active member in good standing of a Massachusetts Chamber of Commerce, and must meet the following criteria:

1. Association Members must have a definitive employer-employee relationship. Groups formed solely for the purpose of obtaining group insurance benefits or groups comprised of two related individuals are not eligible for group coverage.

2. Association Member Groups must maintain enrollment participation with Altus Dental Plan according to the following schedule for Altus Plus Plans.

Eligible Subscribers	Participation Requirement
1 - 9	100%
10 - 49	90%
50 - 74	75%
75 and up	70%

Altus Plus Plan 1 (Basic Plan) is available to groups with one or more unrelated eligible subscribers, Altus Plus Plan 2 (Comprehensive Plan) is available to groups with ten or more eligible subscribers, and Altus Plus Plan 3 (Comprehensive Plan with Orthodontia) is available to groups with twenty or more eligible subscribers.

Eligible subscribers are active, full-time employees who work a minimum of twenty (20) hours per week. Association Members must provide a copy of their quarterly report of wages paid (WR-I) to ABG when joining the program and once each subsequent year at least ninety (90) days prior to the renewal.

3. Association Member Employers must contribute at least fifty percent (50%) of the monthly premium to be eligible for coverage. The employee portion of the monthly premium must be no more than fifty percent (50%) and must be deducted through payroll deduction.

B. Eligibility Requirements

Each Individual, depending on his / her status (subscriber or dependents), must meet the following criteria:

1. Subscribers

   A subscriber must be an active, full-time employee who works a minimum of twenty (20) hours per week.

2. Dependents

   A subscriber's spouse and unmarried dependent children, up to twenty-six (26) years of age, are eligible for coverage under a family membership. There are several situations where an individual may not meet these criteria and still be considered an eligible dependent.

   a. Divorced Spouse

      divorced or legally separated spouse is eligible under family coverage provided that:

      1. A court judgment does not provide otherwise; and
      2. Neither spouse remarries; and
      3. The subscriber remains a covered employee

   b. Handicapped Children

      Unmarried mentally or physically handicapped children who are incapable of self-support and who were covered under the subscriber's family membership at age 19 may continue coverage under the subscriber's family membership. Coverage will continue as long as the child remains incapacitated, unmarried and dependent on the subscriber's support. Verification of the child's disability may be required by Altus Dental.

   c. Adopted Children

      Adopted children and foster children who are under your legal guardianship are eligible for benefits under a family membership from the date the adopted / foster child is placed

in the home or in your care. A written attestation from the adoption or other appropriate agency is required.

d. Domestic Partners

Dependent coverage is available to qualified domestic partners.

e. Child Dependents and Students

Altus Dental extends coverage for dependents to age 26, or for two years past the loss of dependent status under the Internal Revenue Code, whichever comes first. Verification of student status may be required by Altus Dental for student dependents.

C. Responsibilities of Association Members

1. Association Members will be solely responsible for complying with all applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. In particular, Association Members will be responsible for fulfilling the obligation of a plan sponsor under ERISA, including, without limitation, providing its employees with copies of certificates and riders and with copies of a summary brochure describing benefits, limitations, exclusions, and waiting periods.

2. Association Members will be solely responsible for complying with all applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

3. Association Members will be solely responsible for any dental coverage which they may be required to provide under any applicable employer's liability or indemnification law or under any workers' compensation act.

4. Association Members will be responsible for deducting the employee portion of the dental premium through payroll deduction.

5. Association Members must annually provide a copy of their quarterly report of wages paid (WR1) to ABG ninety (90) days prior to the renewal.

6. Association Members must adhere to the Underwriting Guidelines as set forth herein, and as may be reasonably amended from time to time. Failure to adhere to Underwriting Guidelines may result in termination of coverage.

D. Term of Coverage and Payment of Subscription Charges

1. The initial term of coverage shall be two years. Coverage may subsequently be extended from year to year at the option of the Association Member subject to subscription charges and Underwriting Guidelines applicable at the time of renewal.

2. Association Members shall authorize monthly direct bank draft payment of subscription charges to ABG for remittance to the Carrier along with a $20 per month administration fee. If subscription charges have not been paid within 30 days after the date on which payment is due, the Carrier and/or ABG, upon written notice to the Association Member, may terminate this Agreement as of the date to which subscription charges have been paid.

E. Other Provisions

1. This Agreement may be modified or amended by written agreement of the parties.

2. Carrier reserves the final right to approval of any applicant under the plan.

3. The dental benefits offered under this Agreement may be amended from time to time by the Carrier to reflect current standards of good dental practice within the dental community or general standards of practice within the insurance industry. ABG will provide written notification to Association Members regarding such changes and will provide Association Members an opportunity to object to these amendments within three (3) business days.

4. In the event that the Carrier is subject to federal or state laws or regulations mandating any changes or modifications in the benefits specified, or in the eligibility criteria of employees and their covered dependents, the Carrier shall implement such mandatory change or modification, together with a reasonable adjustment in the subscription charges, if necessary. The Carrier will provide prior notification of changes when reasonably possible.

5. This Agreement may be terminated immediately, upon written notice, for material breach, fraud, misrepresentation or for failure to adhere to Altus Dental Plan's Underwriting Guidelines.

F. Subscription Charges

1. **Altus Plus Plan 6730-0001 –** Basic Plan

From the effective date coverage through March 31, 2017 the following shall apply:

Dental Benefits provided shall be those included in Altus Dental Plan 1.

The monthly subscription charges shall be:

$33.55	for each individual
$67.09	for each individual plus one
$122.20	for each family

2. **Altus Plus Plan 6730-0002** – Comprehensive Plan

From the effective date coverage through March 31, 2017 the following shall apply:

Dental Benefits provided shall be those included in Altus Dental Plan 2.

The monthly subscription charges shall be:

$45.80	for each individual
$91.62	for each individual plus one
$143.69	for each family

3. **Altus Plus Plan 6730-0003** – Comprehensive Plan with Orthodontia

From the effective date coverage through March 31, 2017 the following shall apply:

Dental Benefits provided shall be those included in Altus Dental Plan 3.

The monthly subscription charges shall be:

$45.86	for each individual
$93.23	for each individual plus one
$151.07	for each family

Participation Requirement Verification

A copy of most recent Quarterly Report of Wages filed (WR-1) ***must*** be provided.

Total number of employee's _________

Number of employees eligible for dental benefits _________

Number of employees waiving benefits due to coverage through spouse _________

Applicant hereby applies for coverage under the following Plan:

(**Note:** Plan 2 is available only to applicants with 10 or more covered employees. Plan 3 is available only to applicants with 20 or more covered employees.)

Plan 1 ________ Plan 2 ________ Plan 3 ________

(Applicable Riders are attached and form part of this agreement.)

Applicant:

____
Signature

____
Company Name

____
Title

____
Date

Administrator:

____
Signature

American Benefits Group

____
Date

Please Return To: American Benefits Group, PO Box 1209, Northampton, MA 01061-1209
Fax: 413-727-7232, Attention: Diane Reynolds