Minnesota Public Employees Insurance Program (PEIP)

GROUP APPLICATION

EMPLOYER INFORMATION

Employer:	Federal Tax ID Number:	Desired Effective Date:
INDEPENDENT SCHOOL DISTRICT NO. 709	**041-6003776**	**07/ 01 /2014**

Name and title of person responsible for benefits decisions:	Phone:
WILLIAM HANSON, EXECUTIVE DIRECTOR OF BUSINESS SERVICES/CFO	**(218) 336-8704**

Address:	City:	County:	State:	Zip Code:
215 NORTH FIRST AVENUE EAST	**DULUTH**	**ST. LOUIS**	**MN**	**55802**

Name and title of person responsible for billing and accounting:	Phone:
SHELLY ST. GERMAINE, BENEFITS COORDINATOR	**(218) 336-8723**
Email Address: **SHELLY.STGERMAINE@ISD709.ORG**	Fax: **(218) 336-8785**

OF EMPLOYEES TO BE INCLUDED IN COVERAGE

The Public Employees Insurance Program requires that 75% of all eligible employees participate in the Program. Those individuals who waive coverage due to coverage elsewhere are not included in the 75% calculation.

Total # of eligible employees: **1,074**

# of employees who waived & have no other coverage: **0**

# of employees who waived due to coverage elsewhere: **32**

# of early retirees/COBRA: **139**

Total number to be included in PEIP: 1,245

Please attach a separate list of the following covered individuals (if any) with full names, social security numbers and effective date of coverage continuation:

- Cobra individuals
- Retirees
- Disabled individuals
- Other (explain)

ELIGIBILITY CRITERIA

The Public Employees Insurance Program allows employers the opportunity to determine eligibility criteria. If you would like to use the Program's **standard eligibility criteria** (listed below) check here:

☐ Yes ☒ No If no, attach a copy of your group's eligibility policy. (Your policy must conform to the PEIP's minimum criteria guidelines. See employer manual for minimum requirements.)

Standard Eligibility Criteria:

Eligible:

- Employees working 24 hours per week or more in a Collective Bargaining Unit or an Individual Contract
- Newly eligible employees. The first day of the month following the date of hire; employees hired on the first day of their contract school year shall be covered from the date of employment
- Spouses/Dependents
- Surviving Dependents
- Retirees & early retirees as defined by ISD #709

SELECTION OF COVERAGE

Health Coverage:

☒ Advantage High Plan

COBRA/MN Continuation/Retiree Billing

☒ Group will do own COBRA/Retiree Administration
☐ PEIP will assist in COBRA/Retiree Billing and Administration

☒ Group will bill for early retirees and COBRA
☐ PEIP will bill early retirees and COBRA directly

Optional Dental Coverage:

☐ Preventive Plan
☐ Comprehensive Plan

Employer Contributes:

☐ 90-100% of employee premium.
☐ 50-89% of employee premium.

If dependent dental coverage is offered, family dental will be packaged with family medical (i.e. employees who choose family medical must choose family dental).

Employee Life/Accidental Death & Dismemberment Insurance

Minimum $10,000, maximum $300,000 available in $5,000 increments. Amounts in excess of the group's guaranteed issue amount are subject to evidence of insurability. Employees who waive medical coverage because they are covered under another plan may still participate in life/AD&D insurance coverage, providing 100% of those employees participate in life/AD&D coverage.

Choose one: ☐ $10,000 flat amount per active employee ☐ Amount equal to salary ☐ Other (please specify below)

Eligibility: ☐ All employees ☐ Medical lock _____

Advance payment of $ N/A is submitted with this application to be applied to monthly charges. This amount represents an estimate of the group's monthly premium, as calculated according to preliminary information supplied by the group to Innovo Benefits Administration. Make check payable to the Minnesota Public Employees Insurance Program.

Employer agrees to pay monthly, in advance (by the 25th of the prior month), the entire charges due for all participating individuals. In addition, the employer bears the responsibility to collect and pay to the Minnesota Public Employees Insurance Program any and all amounts to be contributed toward such charges by employees or early retirees of the employer.

TERMS AND CONDITIONS

1. By completing and signing this application for group coverage, you are agreeing to participate in the Minnesota Public Employees Insurance Program under all the terms and conditions contained in the proposal/renewal letter provided to you by the Minnesota Public Employees Insurance Program.

2. You agree that the eligibility guidelines in effect today may not be changed until the annual renewal.

You agree to participate for a two-year term. M.S. 43A.316, Subd. 5. (d) Participation in the program is for a two-year term. **Participation is automatically renewed for an additional two-year term unless the exclusive representative, or the employer for unrepresented employees, gives the commissioner notice of withdrawal at least 30 days before expiration of the participation period.** A group that withdraws must wait two years before rejoining. An exclusive representative, or employer for unrepresented employees, may also withdraw if premiums increase 50 percent or more from one insurance year to the next. The employer is liable for the full premium due within the two year commitment in the case of an invalid termination.

Following receipt of this application, coverage selections and final rates will be confirmed in writing by the Program. Premiums are guaranteed for one year. Withdrawal from the Minnesota Public Employees Insurance Program at any time prior to the end of the two-year term may result in the state pursuing legal action against the employer. Withdrawal for any reason will result in the group's ineligibility to participate for two years.

This application constitutes an offer to purchase Minnesota Public Employees Insurance Program coverage. No contract is created until the applicant receives written confirmation of acceptance from the Minnesota Public Employees Insurance Program. No agent has the authority to waive any of the Minnesota Public Employees Insurance Program's rights or requirements or to make or alter any contract or policy. In accepting group coverage under the Minnesota Public Employees Insurance Program, it is acknowledged that:

1. The applicant is the employer for purposes of ERISA (to the extent applicable), COBRA and state law regarding continuation and conversion of group health coverage. The employer will therefore be responsible for notifying the PEIP of any and all information necessary to fulfill its obligations under these laws. The employer is also responsible for receiving from employees and forwarding to the PEIP notices of events such as an employee's divorce or legal separation or cessation of a child's eligibility under this Program.

2. The employer bears full responsibility for ensuring that its Plan satisfies any and all requirements of state or federal law that relate to employee benefit plans, including ERISA and HIPAA. Employer's legal counsel should be consulted to ensure compliance with these laws.

3. The employer assumes responsibility for collecting from employees and forwarding to the Minnesota Public Employees Insurance Program in a timely and accurate manner, notices of events such as addition of new employees, changes in coverage for employees or retirees, and changes in marital or dependent status of employees and retirees.

4. The employer understands that the monthly premium must be received in the billing and enrollment administrator's office by the 25th of the month in which you receive your invoice. The employer understands that the PEIP may terminate the employer's insurance coverage after two premium delinquencies and that there will be a $20 service fee for all Non-Sufficient-Fund (NSF) checks.

EMPLOYER SIGNATURE

I hereby apply for coverage stated within. I have reviewed the proposal, the terms of coverage, and the terms and conditions of participation in the Minnesota Public Employees Insurance Program. I am submitting advance payment for the first month's estimated charges.

_____
Agent signature

_____
Authorized signature

BOARD CHAIR
Title Date

EXCLUSIVE REPRESENTATIVE (if applicable)

I have reviewed the selections of coverages and acknowledge that the selections are in accordance with the current collective bargaining agreement. I further acknowledge that charges for selected coverages will be collected and remitted to the billing and enrollment administrator by their employer according to the procedures established by PEIP.

_____
Exclusive representative signature

_____
Title Date

Innovo Benefits Signature Date