

MINNESOTA ASSOCIATION OF TOWNSHIPS

Executive Director, David A. Fricke



The Minnesota Association of Townships recommends the Township Officers Group Dental Program sponsored by the Minnesota Benefit Association. MBA is a non-profit association of public officials and employees, whose mission is to provide fraternal and benevolent services and benefits for its member group. Minnesota Townships are permitted by Minnesota Statute 471.61 to establish group benefit programs covering their officers and employees.

How To Enroll:

1. Adopt and complete this Enrollment Resolution and the Census Information below.
2. Complete the Adoption and Participation Agreement form.
3. Have the Officers/Employees complete individual enrollment cards
4. Calculate the premium on the rate sheet. Select billing mode and calculate modal premium below.
(We recommend the convenient Quarterly or Semi-Annual modes of payment, however a monthly billing/payment option is available)

____ Quarterly (Fill in total monthly premium from rate sheet and multiply by modal factor) _____ x 3 = \$ _____

____ Semi-Annual (Fill in total monthly premium from rate sheet and multiply by modal factor) _____ x 6 = \$ _____

____ Monthly _____ = \$ _____

5. Make initial premium check payable to Security Life Insurance Company
6. Mail Enrollment Resolution, Adoption and Participation Agreement, Enrollment Cards and check in the enclosed envelope to Minnesota Benefit Association, 6701 Upper Afton Road, Woodbury, MN 55125.

If you have any questions, please contact MBA at 800-360-6117.

ENROLLMENT RESOLUTION

Be it resolved that _____ Township located in _____ County adopts and applies for coverage to be funded for its officers under the Township Officers Group Dental Program provided under Group Policy No. GH-1112-37790 MBA issued by Security Life Insurance Company of America to the Minnesota Benefit Association. Further, the Officers of said Township select the following plan of coverage as a fringe benefit program for its Officers:

____ CHOICE ____ SELECT ____ PLUS

____ Check here if applying for Township Employee Coverage. (Employee plan must be the same as Officer's plan)

Name (Please Print) _____ Date _____

Signature Of Officer _____ Title _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

CENSUS INFORMATION

Officer (please print name & title)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Employees (please print name & title)

1. _____
2. _____
3. _____
4. _____
5. _____

Monthly Premium Rates
Rates Effective February 1, 2007
Valid Through October 2007 Effective Dates
Minnesota Association of Townships
Employer Paid

Choice Plan

Select Plan

Plus Plan

	Officer/EE Cost Twsp Paid	Dependent Cost Officer/EE paid	Total Cost	Officer/EE Cost Twsp Paid	Dependent Cost Officer/EE paid	Total Cost	Officer/EE Cost Twsp Paid	Dependent Cost Officer/EE paid	Total Cost
Officer/EE	\$24.62	-	\$24.62	\$22.08	-	\$22.08	\$19.82	-	\$19.82
Officer/EE +1	\$24.62	\$25.17	\$49.79	\$22.08	\$22.46	\$44.54	\$19.82	\$21.41	\$41.23
Family	\$24.62	\$45.41	\$70.03	\$22.08	\$40.50	\$62.58	\$19.82	\$38.07	\$57.89

To determine the monthly premium rate find the applicable monthly rate listed above, enter it in the base rate box below and calculate the premium for any optional benefits to get the Total Monthly Premium.

Determine your monthly premium	Base Rate (from table)	Increase Calendar Year Maximum to \$1500	Premium Subtotal	Add For Waiting Period Credit? Class A,B,C note: see replacement sale paragraph	Base Premium Total
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Officer/EE	\$	X 1.10	\$	X 1.10	\$
Officer/EE + 1	\$	X 1.10	\$	X 1.10	\$
Family	\$	X 1.10	\$	X 1.10	\$

Add Optional Orthodontia Class D (Available for Groups of 5 or more only)	Employer Paid Premium	Add for Optional Credit for Prior Time (CPT) Class D note: see replacement sale paragraph	Orthodontia Premium Total
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Officer/EE	NA	NA	NA
Officer/EE +1	\$5.95	X 1.25	\$
Family	\$10.27	X 1.25	\$

Monthly Premium Calculation	Total of Base & Ortho Premium	Monthly Premium Total	Multiply by # of Employees	Initial Remittance Payable to Security Life
Officer/EE	\$	\$		\$
Officer/EE +1	\$	\$		\$
Family	\$	\$		\$
Total Monthly Premium				\$

Class 1 - Township Officer.

Class 2 - Township Full Time Employees, scheduled for 20 hours week / 1000 hours annually.

A final premium split to include added cost for optional increased maximum of \$1500, CPT, orthodontia, CPT for orthodontia will be sent to you upon your enrollment. (Detail of Township cost versus dependent cost)

If you have any questions, please call Minnesota Benefit Association at (800) 360-6117.

SECURITY APEX GROUP DENTAL

ADOPTION AND PARTICIPATION AGREEMENT

How to enroll...

- 1) Complete all sections of the Adoption and Participation Agreement based upon the plan selected. Be sure to complete both sides of the agreement page and sign/date where applicable.
- 2) Obtain signed enrollment forms from each employee electing coverage. Review each enrollment form, completing the top section of each form with applicable employer information.
- 3) If prior dental plan credit is requested, attach copy of the most recent billing statement from the prior carrier indicating coverage for each employee. This statement must also include the effective date of the

- 4) prior coverage from which appropriate credit shall be calculated. Determine your initial monthly premium due, make check payable to: Security Life Insurance Company of America.
- 5) Submit Adoption Agreement, Enrollment Forms, Prior plan details (if applicable), and initial premium check to:

Minnesota Benefit Association
6701 Upper Afton Road
St. Paul, MN 55125

The undersigned Employer hereby requests participation in the Employers' Voluntary Benefit Insurance Trust, to insure eligible persons under the Policy, GH-1112-37790, and hereby accepts and agrees to be bound by the terms and conditions as now in effect, or hereafter may be modified. If accepted, the undersigned Employer agrees: (a) to make such benefits available to all present employees and all employees becoming eligible in the future; and (b) to make payroll deductions as required for the plan as are applicable to the employees. The undersigned Employer further agrees that only those full-time employees who meet the eligibility requirements are to be included, and that participation requirements must be met before the benefit plan can be made effective.

The employer agrees that not less than two (2) non-related employees of the employer's eligible employees must be enrolled in the Security Apex Dental Plan to prevent cancellation of coverage. This plan does not require any contribution from the employer. To be eligible for the Employer Paid premium rates illustrated, the employer agrees to contribute no less than 100% of the employee only premium or 50% of the combined employee/dependent premiums. Further, 100% of the eligible employees must be enrolled in this plan to prevent cancellation of employer paid coverage.

- ★ **Effective Date:** The Effective Date of Participating Employer Unit shall be limited to the first of the month.
- ★ **Eligibility Date:** Eligibility for present Employees will be the initial Effective Date, while new hires will be eligible on the first of the month following one month of continuous employment unless other provision have been agreed upon between the Administrator and the Participating Employer Unit.
- ★ **Premiums:** Applicable Premium Rates are guaranteed to twelve (12) months from the Employer's initial Effective Date. Thereafter, premium rates are subject to change in accordance with the Policy.

EMPLOYER INFORMATION

Name of Employer:		
Address:		
City	State	Zip
Phone Number: ()		Fax: ()
Correspondence to:		
Nature of Business: TOWNSHIP GOVERNMENT		

PLAN SELECTION

Choice Select Plus

Class I Township Officers

Class II Employees

Desired Effective Date _____

(Limited to 1st of the month)

CURRENT DENTAL PLAN

Is this group currently enrolled under another group dental program? YES NO

Did you include a copy of the current Plan and a copy of the last billing? YES NO

Are CPT Benefits requested? YES NO

PARTICIPATION AND CONTRIBUTIONS

The undersigned Employer agrees to contribute:

Officer/Employee : \$ /or 100 %

Officer/Employee +1: \$ /or 0 %

Family: \$ /or 0 %

There are initially _____ Township Officers of which _____ are enrolled in this Plan.

There are initially _____ Fulltime employees of which _____ are enrolled in this Plan.

INITIAL PROBATIONARY PERIOD

(a) For current employees NONE

(b) For future employees NONE

New hires to be effective on the first of the Month following probationary period.

The undersigned Employer requests that benefits be made available to all employees subject to the following conditions:

- (a) No coverage for any employees shall take effect until this Agreement and the employee's individual Enrollment Cards are accepted by the Company and the initial premium paid; and
- (b) Employer agrees to remit regularly, in advance, the required premium payments to the Administrator and acknowledges and agrees that this Plan is established under and is subject to the provision of the Employee Retirement Income Security Act (ERISA), as amended. The undersigned Employer is the Plan Administrator as defined in ERISA, as amended.

Township Name _____

Date _____

Authorized Signature _____

Email _____

Security Apex Group Enrollment Card: Return completed form to your employer
Employer Information (TO BE COMPLETED BY THE EMPLOYER)

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date Employee
	Telephone

FOR COMPANY USE ONLY	
Effective Date: ___/___/___	
Plan Code: _____	
Group #/ Division _____	
CPT: _____	

Employee Information (PLEASE PRINT CLEARLY)

I apply for coverage on: Employee Only Employee + 1 Family

Last Name	First Name	Initial			
Address	Telephone Number				
City	State	Zip			
LIST ALL YOUR ELEGIBLE DEPENDENTS BELOW					
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Birth Date: / /
Sex: M [] F []
Marital Status
Married [] Single []

Please note: If additional dependent information is necessary please attach a separate sheet of paper.

- Does Spouse have a dental plan: Yes No
 With whom? _____
 If answer is "Yes", are dependents enrolled under spouses plan? Yes No
- Do you claim a tax exemption for all eligible dependents listed above? Yes No
 If no, who is not? _____
- All dependent children above over age 18 are full time students. Yes No
 If not, who is not? _____

By my signature below, I hereby apply for coverage under Group Dental Insurance Policy Form GH-1112 issued to the Employer's Voluntary Benefit Insurance Trust insured by Security Life Insurance Company of America - Minnetonka, Minnesota. I certify that I have read the applicable Fraud Notice on the reverse side. I also hereby authorize payroll deductions from my earnings for any contributions required. This Authorization remains in effect until revoked by me in writing.

Employees Signature _____ Date _____ S106449 (1/04)
 GH-1112(97)

Security Apex Group Enrollment Card: Return completed form to your employer

Employer Information (TO BE COMPLETED BY THE EMPLOYER)

Name and Address of Employer or Organization (if applicable)	Full-Time Hire Date Employee
	Telephone

FOR COMPANY USE ONLY	
Effective Date: ___/___/___	
Plan Code: _____	
Group #/ Division _____	
CPT: _____	

Employee Information (PLEASE PRINT CLEARLY)

I apply for coverage on: Employee Only Employee + 1 Family

Last Name	First Name	Initial			
Address	Telephone Number				
City	State	Zip			
LIST ALL YOUR ELEGIBLE DEPENDENTS BELOW					
Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Birth Date: / /
Sex: M [] F []
Marital Status
Married [] Single []

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IMPORTANT FRAUD NOTICES

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STATE SPECIFIC NOTICES

Arkansas/ Louisiana - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia - WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky - Any person who knowingly and with intent to defraud any insurer or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information

concerning any fact material thereto commits a fraudulent insurance act which is a crime.

New Mexico - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia - It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

S10650 (2/04)

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S10650 (2/04)