APPLICATION FOR GROUP BENEFITS

Solstice Benefits, Inc. ("Solstice"), Post Office Box 19199, Plantation, Florida 33318 | Ph. 877.760.2247 | Fax 954.370.1701

SECTION I - GROUP INFORMATION

Legal Business Name: City of Delray Beach Name of Business City of Delray Beach

SIC Code: 9111 Tax ID#: 59-9600308 Contact Name: Sue Radig

Title: Benefits Manager E-mail Address: radigs@mydelraybeach.com

Phone Number: 561-243-7377 Fax Number: 561-243-7082

Street Address: 100 NW 1st Avenue City: Delray Beach State: FL ZIP: 33444

Mailing Address: (if different) same City: State: ZIP:

Please select one of the following:

☐ Corporation (Including S-Corp) ☐ Partnership ☐ Proprietorship ☐ Association ☑ Other (specify)

Are subsidiaries included:

☑ No ☐ Yes *(If Yes, please attach name and addresses)*

Separate billing statements required:

☑ No ☐ Yes *(If Yes, please provide special billing instructions)*

SECTION II – EMPLOYEE INFORMATION

EMPLOYEE ELIGIBILITY *(please print)*

An Eligible Employee is one who works on a **full time** basis with a normal work week of **30** or more hours for compensation.

A non-eligible employee is one who works less than hours per week or works on a basis.

Waiting periods for new employees:

☐ First of the month following days of continuous employment ☐ First of the month following months of continuous employment

☐ None ☑ Other: (specify) **31 days after date of hire**

ELIGIBILITY FOR COVERAGES *(please print)*

Annual open enrollment period? ☐ No ☑ Yes Duration: (31 days max)

Are dental benefits offered under Section 125 Plan? ☐ No ☑ Yes

Annual election period from **8** / **19** / **19** to **9** / **2** / **19** Ineligible classes or division: *(if none, please state)*

Prior group coverage? ☐ No ☑ Yes Carrier: Metlife Date of Termination: 09 / 30 / 2019

Plan currently in force? ☐ No ☑ Yes Effective Date: / / Attach Invoice

SECTION III – COVERAGE

COVERAGE REQUESTED *(please print)*

Select Your Plan: (Refer to your Schedule of Benefits for plan details)

☑ **Dental** - *If multiple plan options will be offered, please write in plan selection(s)*

Plan 1: Custom PPO Plan 2: S200B Plan 3:

☐ **Vision** - *If multiple plan options will be offered, please write in plan selection(s)*

Plan 1: Plan 2: Plan 3:

☐ **Discount Prescription** - *This is an optional free value-added benefit offered at no cost* ☐ No ☑ Yes

Indicate the number of persons who are eligible for coverage: 1198

Number of COBRA participants: 10 Number of retirees: 352 Domestic Partners covered? ☐ No ☑ Yes

DENTAL RATES AND CONTRIBUTIONS

Tier Structure	Rate Tiers	Rates			Number of Enrolled Employees			Employer Contribution %		
		Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3
2 ☐	EE									
	EE+ Family									
3 ☐	EE									
	EE + 1									
	EE + 2 +									
4 ☑	EE	33.38	9.89					0	0	
	EE + Spouse	65.97	18.13					0	0	
	EE + Child(ren)	72.93	20.03					0	0	
	EE+ Family	105.71	28.26					0	0	

Amount of Binder Check: ***This check must accompany the group application.**

APPLICATION FOR GROUP BENEFITS

VISION RATES AND CONTRIBUTIONS										
Tier Structure	Rate Tiers	Rates			Number of Enrolled Employees			Employer Contribution %		
		Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3
2 ☐	EE									
	EE+ Family									
3 ☐	EE									
	EE + 1									
	EE + 2 +									
4 ☐	EE									
	EE + Spouse									
	EE + Child(ren)									
	EE+ Family									
Amount of Binder Check:					***This check must accompany the group application.					

SECTION IV – AGENT/PRODUCER INFORMATION

Agent/Broker Name: FL License ID Number / Tax ID: / 65-0361295
Agency Name: Gehring Group % of Credit: E-Mail Address:
Phone Number: (561-) 626 - 6797 Fax Number: ( ) -
Address: 4200 Northcorp Parkway, Suite 185 City: Palm Beach Gardens State: FL ZIP: 33410
Signature: Date: 8/1/19

Agent/Broker Name: NONE FL License ID Number / Tax ID: /
Agency Name: % of Credit: E-Mail Address:
Phone Number: ( ) - Fax Number: ( ) -
Address: City: State: ZIP:
Signature: Date:

SECTION V – SIGNATURE

It is understood that no agent has power on behalf of Solstice to make or modify any request or application for coverage or to bind Solstice by making any promise or representation or by giving or receiving any information.

It is further understood that no coverage will be effective unless and until the application is accepted in writing by Solstice. Final rates will be based on enrollment data as of the Policy effective date. No coverage is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

It is understood and agreed that the Policy, if issued, shall include the Policy and/or membership fees and general provisions of the Policy and be binding upon the applicant and Solstice. Policy and/or membership fees are subject to the approval of Solstice and nothing contained herein shall be binding until this application is approved and accepted by Solstice.

I understand that this application will form a part of the group Policy issued by Solstice, and by my signature below I agree to be bound by the terms and conditions of that group Policy. I understand that Solstice may choose not to accept this application at its sole discretion subject to any state requirements.

Location signed: Delray Beach, FL Date signed: 8/1/19
Print Name of Officer, Partner or Proprietor: Neal de Jesus, Interim City Manager
Signature of Officer, Partner or Proprietor:
Witness to Signature:

Prepared For: City of Delray Beach
Eligible:1198 / Participating:715

Effective Date: 10/1/2019

Plan	Custom DPPO 1	S200B
Employee	$33.38	$9.89
Employee+Spouse	$65.97	$18.13
Employee+Child(ren)	$72.93	$20.03
Employee+Family	$105.71	$28.26

Product Type:	Dental PPO	Dental Prepaid
Rate Period:	48 months	48 months
Rate Cap (Year 5)	1%	1%
Rate Type:	Voluntary	Voluntary
Commission Load:	0%	0%

Proposal Created 4/19/2019 9:10 AM

- Quoted rates are valid until the listed effective date.
- Rates assume the Group's SIC Code to be 9111
- For PPO plans, the In- and Out-of-Network Annual Maximums & Lifetime Ortho Maximums are combined.
- Rates and plans assume an employer/employee relationship exist between all parties.
- Rates listed above assumes the plan design quoted. Rates may change, if plan design changes.
- Deductibles and maximums are assumed on a calendar year basis unless otherwise stated.
- Dependent age limitations are based on situs state requirements unless otherwise noted.
- Proposed rates are contingent on Solstice being the only dental plan(s) offered.