aetna

Illinois

Employer Application and Joinder Agreement

FOR GROUP COVERAGE (2 – 100 ELIGIBLE EMPLOYEES)

Life, Accidental Death & Dismemberment, Disability, Aetna Managed Choice® (Open Access) and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company.

Company Name (Legal Name) The Dana Point Condominium Association	DBA/Doing Business As (if applicable)		
Street Address (P.O. Box not acceptable) 1519 E. Central Rd.	City Arlington Heights	State IL	ZIP 60005
Billing Address (If different than above)	City	State	ZIP
Phone Number (847) 228-5176	Fax Number (847) 228-5190		
Company Contact Name, Title & DOB (DOB needed for eBilling setup and authentication) Lisette Ray, Property Manager, 8/5/80	Company Contact E-mail Address LRay@LMSnet.com		
Billing Contact Name (if different from Company Contact) Dana Point Management Office	Billing Contact E-mail Address		
Enrollment Contact Name (if different from Company Contact)	Enrollment Contact E-mail Address		

Federal Tax ID Number	Date Business Established (Mo/Yr):	SIC Code:	Nature of Business:
36-3125426	11/1980		Condominium Association

Employer Classification ☒ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Other: _____

Are multiple companies or multiple addresses to be included under this plan? If "Yes," provide details. ☐ Yes ☒ No

Effective Date

Requested effective date may be the 1st or the 15th of the month. The actual effective date will be assigned by the Aetna underwriting department if the Joinder Agreement/Application is approved. 7/1/13

Medical Coverage Selection - Groups with 5 or more enrolled employees may offer two or three medical plans.

☐ **HMO – Plan Option:** _____
☐ **Managed Choice® (Open Access) Plan**
Plan Option: _____
☒ **Open Choice® PPO Plan - Plan Option:** _____
☐ **Savings Plus - Plan Option:** _____
☐ **Indemnity Plan - Plan Option:** _____
☐ **Other Plan - Plan Option:** _____

Is employer, plan sponsor or a third party funding any of the deductible? ☐ Yes ☒ No If "Yes," what percentage? _____

Does this group have a flex plan under Section 125 of the Internal Revenue Service Code? ☐ Yes ☒ No

Aetna Dental™ Plan Coverage Selection

Standard Plans:
Option Number N/A
Plan Option Name _____

Voluntary Plans:
Option Number N/A
Plan Option Name _____

N/A

Orthodontic coverage is included for dependent children in groups with 10 or more eligible employees with 5 enrolled employees.

Life, AD&D, Short Term Disability and Packaged Life & Disability Coverage Selections

- Groups of 2 to 9 eligible employees are limited to one class.
- Groups with 10 to 50 employees may select one, two or three options for Life; Disability and Packaged Life/Disability; with a minimum requirement of three employees in each option. If more than one option is selected: describe each class of employees; indicate the amount selected for each class; and attach a list of employee names with each class designation. (Limited to 3 classes. The highest option selected can be no more than 5 times the lowest option.)
- Groups of 51 to 100: contact your Aetna Account Executive.

N/A

Life Options for All Group Sizes:	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000			
Additional Life Options for Groups with 10-50 eligible employees:	☐ 75,000	☐ 100,000	☐ 125,000				
Packaged Life & Disability: (limit one selection)	☐ Low Option	☐ Low Option 2	☐ Medium Option	☐ Medium Option 2	☐ High Option		
Short Term Disability	☐ Option 1	☐ Option 2	☐ 100	☐ 200	☐ 300	☐ 400	☐ 500
Class Description	**Class 1**		**Class 2**		**Class 3**		
Optional Dependent Term Life (Available only to groups with 10 to 50 eligible employees.): ☐ Yes ☐ No							

Please keep a copy of this application for your records. If the application is accepted by Aetna, it becomes part of the issued Group Agreement and/or Group Policy.

Benefit Waiting Period (BWP)

The date will be the first day of the policy month following the waiting period.	
Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period).	☒ Yes ☐ No
Waiting period for future employees: ☐ 0 days ☐ 1 month ☐ 2 months ☒ 3 months ☐ 4 months ☐ 5 months ☐ 6 months	

Group Ownership Information – OPTIONAL

(This information is designed for the purposes of data collection and will not be used for underwriting.)

Check one or both if applicable:

☐ Woman Owned Business ☐ Minority Owned Business (indicate status below):

☐ African American or Black ☐ Hispanic or Latino ☐ Asian ☐ Other _____

Business Eligibility

Is your company a subsidiary of another company, an affiliate of another company, or under common control with another company? If yes, complete the Common Ownership Form.	☐ Yes ☒ No
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis? If "Yes," complete the Common Ownership Form.	☐ Yes ☒ No
Is your company a branch of another company, or does your company have branch offices? If "Yes," complete the Branch questions of the Common Ownership form.	☐ Yes ☒ No
Has your business been insured with Aetna? If "Yes," provide group number. _____	☐ Yes ☒ No
Are you currently a client of a Professional Employer Organization (PEO)? If "Yes," is this an Aetna PEO? Aetna group #: _____ (A letter of intent is needed for 51+ groups.)	☐ Yes ☒ No

Employer Eligibility/Employee Status

Work Location (list by state) Please note if locations are a work site or "work-at-home".	Number of Employees						
	Full-time	Part-time	Retired	COBRA	1099	Union	Other (i.e., temporary, substitute, seasonal, etc.)
IL - on-site	3	Ø	Ø	Ø	Ø	Ø	Ø

What is the normal work week you require a full-time employee to work to be eligible for coverage? 40 hours per week

Total number of eligible employees	2	Total number of spousal waivers	
Total number of employees enrolling	2	Total number of employees in benefit waiting period	
Total number of employees waiving	0		

Are there excluded classes of employees other than part-time and temporary employees (for example, Union employees)? If "Yes," describe class(es) and/or the union local name and number. _____ ☐ Yes ☒ No

Affordable Care Act (ACA) Medical Loss Ratio Requirement

What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part-time, and seasonal workers, and regardless of insurance eligibility.	3

Employer Contribution(s)

Coverage	Medical	Dental	Employee Life	Dependent Life	Disability	Packaged Life & Disability
Employer Contribution for Employee	50%	—	—	NA	—	—
Employer Contribution for Dependent	—	—	NA	—	NA	NA

Employee Disability Contribution

Employee's disability contribution percent – check one: ☐ Pre-Tax ☐ Post-Tax N/A

Workers' Compensation

Does company offer Workers' Compensation?	☒ Yes ☐ No

Medicare Primary versus Secondary

Is your group Medicare Primary (employed less than 20 employees for 20 consecutive weeks in the current or prior year) or Aetna Primary (employed 20 or more employees for 20 consecutive weeks in the current or prior year)?	☑ Medicare Primary ☐ Aetna Primary
In total, how many full-time and part-time employees (including any seasonal employees, owners or partners) have you employed on 50% or more of your business days during the prior calendar year?	3
How many of the employees noted above are self-employed, independent contractors (or their employees and agents), leased employees, or non-employee directors?	0

COBRA versus Continuation

Is your employer group required to comply with COBRA regulation?			☐ Yes ☐ No
If you answered "Yes" to the above question but you currently employ less than 20 full-time and part-time employees, provide in total, how many full-time and part-time employees (including any seasonal employees, owners or partners) have you employed for 20 or more weeks during this calendar year or prior calendar year?			
Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? If "Yes," enter information below. Attach a separate sheet, if necessary.			☐ Yes ☑ No
Name of Applicant	**Qualifying Event (e.g., termination of employment, divorce, etc.)**	**Date of Qualifying Event**	**Date of COBRA or State Continuation Coverage Terminates**

Prior Carrier Information

	Health	Dental	Life	STD
Is this group transferring from another group carrier?	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Carrier Name	United Health			
Carrier Telephone Number	866-432-5992		NA	NA
Effective Date of Coverage	7/1/12			
Proposed Termination Date	6/30/13			
Is this total replacement?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Number of health carriers within the past 5 years	2	NA	NA	NA
If prior carrier is Aetna, provide Group/Control Number	N/A			
Dental Only – Prior coverage included, check all that apply:	☐ Major Services ☐ Orthodontia		N/A	

Medical Information

Is any person to be covered unable to work due to illness or injury?	☐ Yes ☑ No
Is any person currently receiving workers' comp benefits?	☐ Yes ☑ No
Is any person currently on leave of absence? If "Yes," provide start date and expected date of return below.	☐ Yes ☑ No
If "Yes" is answered to any of the above, provide names of the individual(s) and details.	

Signature Section

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. It is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Policy and/or Group Agreement). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent, or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

Applicant has selected, in accordance with applicable state law, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant's employees and the contribution amounts.

Information on agent's compensation is available from your agent or at Aetna.com.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a schedule. Aetna disclaims any responsibility if the employer elects such a schedule and it is later deemed discriminatory.

The plan documents will determine the rights and responsibilities of member(s) and will govern in the event of conflicts with any benefits comparison, summary, or other description of the plan. Any direct conflict between this form and the plan documents will be resolved according to the terms which are most favorable to the member.

With the exception of Aetna Rx Home Delivery®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery®, LLC, is a subsidiary of Aetna Inc.

Applicant agrees to deliver, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

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.

All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Group Agreement or Group Policy is in force.

continued on next page

Signature Section *(continued)*

The availability of a plan or program may vary by geographic service area. Some benefits are subject to limitations or maximums. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome.

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. I understand Aetna will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Aetna reserves the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

JOINDER AGREEMENT - REQUEST FOR PARTICIPATION (For life, disability, accidental death and dismemberment, out-of-state medical and out-of-state dental employee benefits): The undersigned employer agrees to the establishment of an insurance trust fund ("Fund") for the purposes of implementing a Trust Agreement ("Agreement"), and to the designation of the Chase Manhattan Bank Delaware, Wilmington, DE, as "Trustee" for the Fund and Agreement. The undersigned, as a Participating Employer in the Industry Trust corresponding to the standard industry classification ("SIC") code selected above: 1) agrees to be bound by the terms of the Agreement and the policy issued to the Trustee (including any amendments); 2) requests coverage for its eligible employees under the policy (subject to applicable underwriting requirements) as of the effective date requested or as of the date of approval of the Employer for participation under the Agreement, whichever is later, and continue as long as the Employer remains actively in business; and 3) agrees to make the required contributions to the Fund; in the event of default, it will be liable to the insurer for such unpaid contributions for the coverage period, and such insurer will terminate coverage. The insurer may also terminate coverage as of the date the group fails to meet minimum underwriting requirements in effect on that date. In addition, the Participating Employer, in accordance with ERISA Title I Section 503, designates Aetna Life Insurance Company ("Aetna") as the Named Fiduciary under the Plan, for the purposes of reviewing all denied claims for benefits under the Plan, and interpreting Plan provisions, including those necessary to determine benefits.

Signed at (Location)	City, State	Applicant (Company Name)
	Arlington Heights, IL	The Dana Point CA
	Authorized Applicant Signature	Official Title
	Lisette Ray AS AGENT	Property Manager
	Print Name of Authorized Applicant	Date
	Lisette Ray, AS AGENT	6/24/13

Agent/Broker Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk, for all products being applied for including life insurance, if applicable.

I hereby represent that I am licensed to sell Aetna products in the state of Illinois.

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage being applied for by this application is accepted.

Broker Name:		SSN:		
Agency Name:		TIN:		
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of credit:

Broker Name:		SSN:		
Agency Name:		TIN:		
Pay commissions to: (check one) ☐ Broker ☐ Agency		Phone:	Fax:	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of credit:

General Agent Name:		TIN:		
Selling Agent:		TIN:		
Phone:		Fax:		
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		

GCG FINANCIAL, INC.
Business Associate Agreement
for HIPAA Privacy and Security Compliance

This Business Associate Agreement (the "Agreement") is intended to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule"), the Health Insurance Reform: Security Standards (the "Security Rule"), and the Breach Notification for Unsecured Protected Health Information; Interim Final Rule (the "Breach Rule"). All ambiguities in this Agreement should be resolved to carry out such compliance.

While providing insurance services and employee benefit plan advice, GCG Financial, Inc. ("GCG") may use or disclose health information relating to employees and their dependents who participate (or may become eligible to participate) in the group health plan (the "Plan") sponsored by the Client named below. Plan, Client and GCG enter into this Agreement as a means of protecting the privacy of this "protected health information," or PHI (as defined by the Privacy Rule). PHI includes "electronic protected health information," or e-PHI (as defined by the Security Rule). Under this Agreement, GCG shall disclose PHI only to those Client employees designated by Plan or Client as responsible for the Plan's administrative functions. The provisions of this Agreement apply to the PHI (including e-PHI) of current, prospective, and former Plan participants (the "Participants") to the extent GCG uses or discloses such PHI (and/or e-PHI). GCG further acknowledges that, under the HITECH Act, GCG may only use or disclose PHI in a manner that is consistent with the provisions of this Agreement.

Permitted Uses and Disclosures of PHI

GCG may use or disclose PHI for the following purposes, if such use or disclosure would not violate the Privacy Rule, if done by Plan:

(1) To assist Plan in obtaining health insurance or administrative services;

(2) To provide billing, claims and other troubleshooting services on behalf of Plan; and

(3) To provide underwriting, premium rating, utilization review and other renewal services to Plan.

In addition, GCG may use or disclose PHI for GCG's management and administration, if the use or disclosure is either:

(1) Required by law; or

(2) GCG obtains reasonable assurances from the recipient that the PHI disclosed will be protected as follows:

a) The recipient agrees to keep the PHI confidential and use or further disclose the PHI only as required by law or for the purpose for which it was disclosed to the recipient; and

b) The recipient notifies GCG when the recipient becomes aware that the confidentiality of the PHI has been breached.

GCG also may use PHI to provide data aggregation services to Plan as permitted by the Privacy Rule.

Obligations and Activities of GCG

To the extent GCG uses or discloses PHI to or on behalf of Plan, or has access to e-PHI, GCG agrees to:

(1) Not use or disclose PHI other than as permitted or required by this Agreement or as required by the Privacy Rule or other federal or state law.

(2) Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement.

(3) Report to Plan any use or disclosure of PHI which violates this Agreement when GCG becomes aware of such violation.

(4) In the event of a breach (as defined in the Breach Rule) of unsecured PHI that occurs on or after September 23, 2009, promptly (and, in no event, no more than sixty (60) days after GCG has knowledge of a breach or a reasonable belief that a breach has occurred) notify the Plan or Client of such a breach in accordance with the requirements of the Breach Rule.

(5) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of e-PHI that it receives, maintains, transmits or destroys on behalf of Plan as required by the Security Rule.

(6) Report to Plan any security incident related to Plan's e-PHI of which GCG becomes aware.

(7) Ensure that its agents and subcontractors who are given Plan PHI or e-PHI agree to the same restrictions and conditions under this Agreement which apply to GCG, including agreeing to implement reasonable and appropriate safeguards to protect e-PHI.

(8) Unless expressly stated otherwise in a written agreement, GCG, Plan and Client do not intend for GCG to maintain PHI in a file (a "designated record set" under the Privacy Rule). If a written agreement does require GCG to maintain PHI in a file, GCG will, at the request of Plan or Participant:

  (a) Make PHI available to Plan for purposes of Participant access, amendment and accountings of disclosures in accordance with the Privacy Rule; and

  (b) Make such amendment(s) to PHI maintained by GCG as the Plan directs or agrees to pursuant to the Privacy Rule.

(9) Upon reasonable notice, make internal practices, books, and records, relating to the use and disclosure of Plan PHI available to the Secretary of the Department of Health and Human Services for purposes of determining Plan's compliance with the Privacy Rule.

(10) Document such disclosures of PHI and information related to such disclosures as would be required for Plan to respond to a request by Participant for an accounting of disclosures of PHI in accordance with the Privacy Rule and make this documentation available to Plan or, as directed by Plan, to Participant in order to meet the requirements of the Privacy Rule.

Obligations of Plan, Client

To the extent necessary for GCG to perform its obligations under this Agreement, Plan shall inform GCG of Plan policies and procedures governing the use and disclosure of PHI. GCG will have a reasonable time to act on these changes.

Plan shall notify GCG of any changes in, or revocation of, permission given by Participant to Plan to use or disclose PHI, to the extent that such changes may affect GCG's use or disclosure of PHI.

Plan shall notify GCG, prior to acceptance by Plan, of any restriction on the use or disclosure of PHI made in accordance with the Privacy Rule so that GCG can determine whether it is infeasible to comply with such restriction. Once agreed to, GCG shall have a reasonable period of time to act on such notice.

Plan represents and warrants to GCG that Plan will not disclose any PHI to GCG unless Plan has obtained any consents and authorizations that may be required by law or are otherwise necessary for such disclosure.

Plan warrants that it shall not request GCG to use or disclose PHI in any manner that would not be permissible under applicable law if done by Plan.

Term, Termination and Amendment

This Agreement shall become effective on the date signed below, except that the provisions of this agreement relating to the HITECH Act, unless otherwise indicated above, shall become effective on the later of the date signed below or February 17, 2010.

The Agreement shall terminate as follows:

(1) The Agreement shall terminate when the relationship between GCG and Client ends provided that all PHI is returned or destroyed as described in Section 3 below.

(2) A party may terminate this Agreement for what it reasonably believes to be a material breach of the terms of this Agreement if such breach is not substantially cured within thirty (30) days. This cure period shall start upon receipt by the breaching party of written notice indicating the reasons the non-breaching party believes the Agreement has been breached and describing the alleged breach in sufficient detail to enable the breaching party to make its own assessment of whether a material breach has occurred.

(3) When the Agreement terminates, GCG (and its agents and subcontractors) shall return or destroy all PHI received from Plan, or created or received by GCG on behalf of Plan. GCG shall not retain any copies of the PHI. If, however, return or destruction of the PHI is not feasible, GCG shall notify Client of this and extend the protections of this Agreement to the PHI retained and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as GCG maintains such PHI. Feasibility will be determined based on the document retention policy developed by GCG.

Plan, Client and GCG may amend this Agreement from time to time as necessary for Plan to comply with the requirements of HIPAA, the Privacy Rule, the Security Rule, and the Breach Rule.

Miscellaneous

Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and respective successors or assigns of the parties, any rights, remedies, obligations or liabilities whatsoever.

All notices required or desired in connection with this Agreement shall be sufficient, if given by mail addressed to the party receiving the notice at the address designated herein or at such other address as may be agreed to in writing by the parties.

(Signature of GCG Agent)
GCG Financial, Inc.
3000 Lakeside Dr.
Suite 200 S.
Bannockburn, IL 60015
Date: _____

Annette Roy AGENT
(Signature of Authorized Client Representative)
The Dana Point CA
1519 E. Central Rd.
Arlington Heights, IL 60005

(Client Name & Address)
Date: 6/24/13

(Signature of Plan Privacy Official or other representative)*

(Name & Address)
Date: _____

*If no Plan Privacy Official the Authorized Client Representative will need to sign in both places.

Appendix A

Plan and Client hereby designate the following employees titles as responsible for the Plan's administrative functions who are permitted to use and disclose PHI (including e-PHI):

Please use employee titles only

Property Manager

Assistant Property Manager

Board President

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