ACEC Life/Health Trust
Administered by UnitedHealthcare
Quoting & Installation Checklist
51-99 Segment

Quoting an ACEC group:

- **Step 1: Submit RFP through normal UnitedHealthcare Channel**
  - Request an ACEC Proposal from you UHC Account Executive
- **Step 2: Standard UHC FI plans must be rated prior to requesting ACEC plans**
- **Step 3: After receipt of standard UHC FI plans, we will work to have the ACEC proposal generated**

Installation Requirements:

- **Submit Installation material to ACEC Account Executive assigned to your region**
  - **Sr. Account Executive:**
    - **Josh Fleming:** Joshua_Fleming@uhc.com
  - **Account Executive:**
    - **Daniel Martinez**: Daniel_A_Martinez@uhc.com

Paperwork and UHC Enrollment File Needed:

- **Employer Application** – Illinois 100+ Employer Application
- **Prime Enrollment Spreadsheet**
  - *Required Columns: A, B, C, D, E, G, H, N, O, P, Q, V, W, AA, AB*
  - *If Applicable: X, Y, AG, AH, AJ, AK, AM, AP, AR, AS, AT, AV, AW, AX, AZ*
- **Copy of the Sold Quote**
- **Product Selection Form**
- **ACEC Participation Agreement**
- **Confirm the firm has joined or joining the ACEC Association**
- **Confirmation that Agent/Agency has an IL Non-Resident License**
  - Brokers are required to be licensed in Illinois to receive commission on ACEC Life/Health Trust business
- **Payment Options**
  - **Direct Bill – Requires a pdf copy of the binder check for installation**
    - Check made payable to UnitedHealthcare
    - Complete binder check cover sheet & mail to either address below
  - **Direct Debit –** No binder check required

If using Regular Mail:
ACEC Life/Health Trust
Dept. CH 14382
Palatine, IL 60055

If using overnight services:
ACEC Life/Health Trust
Dept. CH 14382
5505 N. Cumberland Ave Ste: 307
Chicago, IL 60656-1471

Please Note:

- ACEC Life/Health Trust rates are contingent that the firm is an active dues paying member of ACEC
- The firm can select up to 5 plan designs (within 50% financial spread)
- CORE Plans are available to member firms with 90%+ of membership located in an approved CORE Zip code

Employer Application for Large Group

Illinois

To avoid processing delays, please make sure you:

1. Answer all questions completely and accurately.
2. **DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.**
3. Include a deposit check in the amount of any required premiums; such amount will be returned in the event coverage does not become effective and will be applied against the first month's premium if coverage does become effective.

United Healthcare

☐ UnitedHealthcare Insurance Company
☐ UnitedHealthcare Insurance Company of Illinois
☐ UnitedHealthcare of Illinois, Inc.
☐ UnitedHealthcare Insurance Company of the River Valley
☐ UnitedHealthcare Plan of the River Valley, Inc.

General Information

Requested Effective Date_____

Group's/Company's Legal Name

Group name to appear on ID card (maximum 30 characters)

Street Address				Tax ID
City	State	ZIP Code	Names of Owners/Partners (if applicable)	Internet Access? ☐ Yes ☐ No
Contact Person		Email Address		# of Years in Business
Billing Address (if different)		Telephone	Fax	
Multi-location group/company?* ☐ Yes ☐ No	# of Locations	Address(es) (or list on additional sheet of paper)		
Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC ☐ LLP ☐ Sole Proprietor ☐ Other _____		Nature of Business		Industry Code

Waiting Period for new hires (Waiting period for medical coverage cannot exceed 90 days)	Waiting Period waived for initial enrollees	Waiting Period for Rehires:	Medical Benefit Plan Option
☐ 1st of Policy Month following Date of Hire ☐ 1st of Policy Month following _____ ☐ months ☐ days of employment ☐ Date of Hire (no waiting period) ☐ ____ ☐ months ☐ days of employment following Date of Hire	☐ Yes ☐ No	☐ Yes ☐ No If yes, waived if rehired within ____ months.	☐ Calendar Year ☐ Policy Year

Number of Persons currently on COBRA/ Continuation and/or Short/Long Term Disability (employees/dependents)	Number of Employees Termed in last 12 Months	Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Salary
Have Workers' Comp? ☐ Yes ☐ No	Name of Workers' Compensation Carrier	Domestic Partner Coverage ☐ Yes ☐ No

Names of Owners/Partners not covered by Workers' Compensation

*If the majority of your employees are not located in your state of application, UnitedHealthcare policies and/or state law may require that your policy be written out of a different state and/or that your benefit plans vary.

Coverage provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company
Life, Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

Group Name _____

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
# Hours per week to be eligible_____		Basic EE Life/AD&D		Basic EE Life/AD&D		Basic EE Life/AD&D		
		Basic Dep Life		Basic Dep Life		Basic Dep Life		
# Hours per week to be eligible for disability coverage if different from above ** _____		Supp EE Life/AD&D		Supp EE Life/AD&D		Supp EE Life/AD&D		
		Supp Dep Life/AD&D		Supp Dep Life/AD&D		Supp Dep Life/AD&D		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD		STD		STD		
		STD Buy Up***		STD Buy Up***		STD Buy Up***		
***Only available to Groups with 100+ Eligible Employees		LTD		LTD		LTD		
		LTD Buy Up***		LTD Buy Up***		LTD Buy Up***		
		Voluntary AD&D***		Voluntary AD&D***		Voluntary AD&D***		
		Other		Other		Other		

General Information (continued)

Enter the Prior Calendar Year Average Total Number of Employees

Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage.

To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).

Enter the Prior Calendar Year Total Number of Eligible Employees

For purposes of determining your number of eligible employees, Eligible employees are those who are eligible to enroll in any medical plan you offer, even if they aren't eligible to enroll in a UnitedHealthcare plan. Here you may add COBRA and retirees.

Calculate your number of eligible employees from the preceding calendar year: (1) Count the total number of eligible employees at the end of each month (2) Add all the monthly eligible totals from line (1) and divide by 12. Use whole numbers only (no decimals, fractions or ranges and round down).

Enter the prior calendar year Full-Time Equivalent Total Number of Employees

For purposes of determining your number of full-time equivalent employee count, the number of employees means the average number of employees employed full-time (at least 30 hours/week in any given month), by the company on business days during the preceding calendar year.

In addition to the number of full-time employees noted above, for any month otherwise determined, include for such month the number of full-time employees divided by the aggregate number of hours of service of all employees who are not full-time employees for the month by 120. Employers should exclude employees who were seasonal workers who worked 120 days or fewer in the preceding calendar year.

☐Yes ☐No Subject to ERISA? (Most private sector plans are ERISA plans) If No, please indicate appropriate category:
- ☐Church (Additional information needed)
- ☐Federal Government
- ☐Indian Tribe – Commercial Business
- ☐Non-Federal Government (State, Local or Tribal Gov.)
- ☐Foreign Government/Foreign Embassy
- ☐Non-ERISA Other _____

☐Yes ☐No In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)

☐Yes ☐No In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?

☐Yes ☐No Does your group sponsor a plan that covers employees of more than one employer?
If you answered Yes, then indicate which of the following most closely describes your plan:
- ☐Professional Employer Organization (PEO)
- ☐Multiple Employer Welfare Arrangement (MEWA)
- ☐Taft Hartley Union
- ☐Governmental
- ☐Church
- ☐Employer Association

☐Yes ☐No Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)?

If you answered Yes, then by signing this application you agree with the certification in this section.

I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

☐Yes ☐No Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?

☐Yes ☐No Do you have common ownership with any other businesses? If you own multiple companies, or a parent-subsidiary relationship exists between your company and another, this may indicate common ownership of businesses.

Group Name _____

General Information (continued)

UnitedHealthcare's Leave of Absence (LOA) Policy; Eligibility for Medical Coverage
If the employee is on an employer approved leave of absence and the employer continues to pay required medical premiums, the coverage will remain in force for: (1) No longer than 13 consecutive weeks for non-medical leaves (i.e. temporarily laid-off). (2) No longer than 26 consecutive weeks for a medical leave. Coverage may be extended for a longer period of time, if required by local, state or federal rules.
If the employee's medical coverage terminates under this LOA policy, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or Conversion of Medical Benefits provision described in the Certificate of Coverage.
Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage)?
☐ Yes, we continue medical coverage during an approved leave of absence for full-time employees.
☐ No, we do not offer medical coverage during a leave of absence.

HRA and Supplemental Insurance Information

Health Savings Account (if selected): Which bank will be used: ☐ OptumBank ☐ Other
Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.
Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No
If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

HRA/HSA Employer Premium Contribution

	Option #1	Option #2	Option #3
Medical Plan			
Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Employer Account Funding Amount

Employee			
Employee + Spouse			
Employee + Child(ren)			
Family			

HRA/HSA Account Administrator:

Are there any other contributions or benefit reimbursements allowed? ☐ Yes ☐ No

Who will provide account balances to UnitedHealthcare?

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months?
☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date ___/___/___ End Date ___/___/___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Initial Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			
Current Vision Carrier	☐ None			

Group Name _____

Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. UnitedHealthcare is only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

☐ Yes ☐ No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?

☐ Yes ☐ No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?

☐ Yes ☐ No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?

☐ Yes ☐ No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?

☐ Yes ☐ No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?

☐ Yes ☐ No 6. Is any employee or dependent currently hospitalized?

☐ Yes ☐ No 7. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication for one of the following conditions?

- ☐ Cancer (any type)
- ☐ Lung disease or respiratory problem (any type)
- ☐ Heart disease or disorder (any type)
- ☐ Organ, tissue or cell transplant
- ☐ Liver disease (any type)
- ☐ Kidney disease (any type)
- ☐ Pancreatic disorder (any type)
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Morbid obesity
- ☐ Congenital abnormality
- ☐ Vascular disease (any type)
- ☐ Neurological disorder (any type)
- ☐ Alcohol or drug addiction or abuse
- ☐ Hemophilia or blood disorder (any type)

☐ Yes ☐ No 8. Within the past 3 years has any employee or dependent ever been diagnosed or treated by a medical professional for an immunological disorder (reportable types)?

If you have answered "Yes" to any of the questions above, please provide the requested information below for each individual. If necessary, use additional sheets of paper.

Question Number	Check One Employee	Check One Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	$ Amount of Claims	Current Treatment

Group Name _____

Important Information

The Group/Company certifies that the information provided above is complete and accurate. The Group/Company shall notify UnitedHealthcare and Affiliates promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly eligible employees or dependents. Prior to receiving notification of approval, the Group/Company shall notify UnitedHealthcare and Affiliates promptly of any significant changes in the health status of an eligible employee or dependent including any inpatient hospital admissions. UnitedHealthcare and Affiliates shall be entitled to rely on the most current information in its possession regarding the eligibility and health status of employees and their dependents in providing coverage under the policy/policies for which application is being made.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that intentional misstatement or misrepresentations of a material fact, or omissions that constitute fraud, in the information requested on this form can result in the adjustment of rating or voiding of insurance.

I understand that the Certificate of Coverage or Summary Plan Description and other documents, notices and communications regarding the benefit plan(s) indicated herein on this Application may be transmitted electronically to me and to the Group's/Company's employees. This consent remains in effect until it is withdrawn. The Group may withdraw their consent at any time or request a document in a paper or non-electronic form.

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

Upon receipt by UnitedHealthcare and Affiliates of this signed employer application and payment of the required policy charges, the group policy is deemed executed. The deposit check in the estimated amount of the first month's premium is not considered payment of the required policy charges.

UnitedHealthcare disclosure regarding producer compensation:

In some instances, we pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our products, in compliance with applicable law. In certain states, we may pay "base commissions" based on factors such as product type, amount of premium, group/company size and number of employees. These commissions, if applicable, are reflected in the premium rate. In addition, we may pay bonuses pursuant to programs established to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation may be subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature (form must be signed)

Group/Company Signature _____ **Date** _____ **Title**_____

DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Producer Information (if applicable)

Producer Name	Agency	Agent Code/Tax ID Number

Email Address	Social Security #	Phone Number

All Payments to:	Producer Commission Schedule (if applicable) _____ Std Scale of _____ %

Street Address	City	State	ZIP Code

Producer Signature	Date

Rep Name	Rep #

General Agent Information (if applicable)

General Agent	Phone #	Franchise Code	

Street Address	City	State	ZIP Code

Product and Benefit Selection Form

UnitedHealthcare

1a. Group Name _____

1b. Identify primary business location _____

1c. List all other locations besides primary business location _____

2. Medical Plan Code(s)

_____

_____

_____

_____

_____

2b. Will this plan co-exist with another health plan?

• Yes • No If yes, name of carrier _____

2c. Prescription Benefit Plan Number (Rx) _____

2d. Deductible Administration

• Calendar Year (from Jan. 1 to Dec. 31)

• Policy/Contract Year (from effective date to renewal date)

3. Dental Plan Code(s)

_____

_____

3b. Has this group been covered for major dental services for the previous 12 consecutive months?

• Yes • No If yes, name of carrier _____

4. Vision Plan Code(s)

_____

_____

5. Life Amount(s)

Employee $_____

Spouse $_____

Child(ren) $_____

• Yes • No Acceptance of this application will replace existing life insurance coverage.

6. Supplemental Coverage(s)

Life $_____

AD&D $_____

STD $_____

LTD $_____

7. Other Notes

ACEC Life/Health Insurance Trust Benefit Consortium
ACEC Life/Health Insurance Trust
Group Participation Agreement

This Agreement is entered into between the ACEC Life/Health Insurance Trust Benefit Consortium (the "Consortium"), the ACEC Life/Health Insurance Trust and the Participating Employer, effective as of _____, 20___.

Section 1: Defined Terms

"ACEC" means the American Council of Engineering Companies.

"Access Fee" means the amount payable by You to the administrative services provider of the Trust in connection with the maintenance and operation of the Plan. The Access Fee is determined by the Trustees and will not exceed two percent (2%) of the monthly Required Premium.

"Beneficiaries" are eligible dependents of Participants.

"Carrier" means the insurance company that has arranged to provide and/or administer welfare benefits on a fully-insured basis with respect to Participants and Beneficiaries.

"Coverage Classification" means the type of coverage elected by Participants (e.g., single, single plus one, or family).

"Eligible Employees" refers to employees or former employees of Eligible Member Firms who have the right to enroll in coverage under the terms of Your Plan.

"Eligible Employees and their Dependents" refers to employees or former employees of Eligible Member Firms, as well as their spouses, children and other dependents as defined under the IRC, who have the right to enroll in coverage under the terms of Your Plan.

"Eligible Member Firm" means a consulting engineering firm which is (a) certified by ACEC to be a dues-paying member in good standing in ACEC; (b) an employer of one or more employees, within the meaning of Section 3(5) and (6) of ERISA; and (c) approved for membership in the Consortium and participation in the Trust by the Board of Trustees of the Consortium.

"ERISA" means the federal employee benefits law known as the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"Group Policy" means the group insurance policy issued by the Carrier to the Trust.

"IRC" means the Internal Revenue Code of 1986, as amended.

"Participants and Beneficiaries" are Eligible Employees and their Dependents who are enrolled in the Plan and alternate recipients under a Qualified Medical Child Support Order (within the meaning of ERISA Section 609(a)(2)).

"Participating Employer" means an Eligible Member Firm that has elected to participate in the Plan.

"Participation Agreement" means this document which sets forth certain rights and responsibilities of Participating Employers.

"PHI" is health information protected by applicable medical privacy law.

"PII" is information about an individual that is protected by applicable privacy law.

"Plan" means the ACEC Life/Health Group Welfare Plan, an employee welfare benefit plan under ERISA.

"Qualified Beneficiary" means a Participant or Beneficiary that qualifies for continuation coverage under state or federal law.

"Required Contribution" means the payment required of Participating Employers under this Participation Agreement to secure coverage under the terms and conditions of the Plan.

"Trust" means the American Council of Engineering Companies Life/Health Insurance Trust, which holds the Group Insurance Policy. The Trust will not be deemed or construed to be the common law employer of Participants and is not responsible for fulfilling any duties of an employer other than those in connection with the Plan.

"Trustees" means the trustees of the Consortium and the Trust who are the individuals responsible for administering Your benefits under the Participation Agreement, Your SPD and ERISA.

"We," "Us," and "Our" are referring to the Consortium, the Trust or the Trustees, as well as any Carrier appointed by the Consortium, the Trust or the Trustees to furnish welfare benefits to Participating Employers.

"You" or "Your" means a Participating Employer that has accepted this Participation Agreement.

"Your SPD" is short for Summary Plan Description and means the document describing Your benefits under the Plan.

Section 2: Your Obligations to Disclose Information About Benefits and Services

ERISA requires that a Plan's covered benefits and limitations, as well as the rights and responsibilities of Participants and Beneficiaries, be explained in Your SPD. By signing this Participation Agreement, You agree to distribute the SPD to Your Participants within ninety (90) days of when they become covered under the Plan, as well as upon the occurrence of certain other events.

2.1 General Requirements for Electronic Distribution of Plan Documents. Plan documents may be distributed electronically when certain conditions are met. The following requirements apply to all recipients of electronic communications: (a) the information (e.g., PHI, PII) must be safeguarded from improper disclosure; (b) a notice (email is acceptable) informing the Participant of the significance of the document must be issued each time a document is furnished electronically; and (c) the distributor must permit the Participant to ask to receive any document in paper form.

2.2 Participants with Work-Related Computer Access. In addition to requirements (a), (b) and (c) in Section 2.1, Participants with work-related computer access may be required to consent to electronic delivery and must be able to access the electronic documents at any location where he or she is expected to work and access to electronic information systems must be an integral part of the employee's job duties.

2.3 Participants without Access to Computers as Part of Work-Related Duties. In addition to (a), (b) and (c) in Section 2.1, Participants without work-related computer access must affirmatively consent to electronic delivery of Plan information. Participants must also be provided with information about the types of documents that will be provided electronically; their right to withdraw consent; procedures for withdrawing consent and updating information (e.g., email address; the right to request paper documents; and the types of hardware and software required). Notice must be issued to the Participants alerting them to the fact that an electronic disclosure is being made. As a Participating Employer, You are required to furnish required documents in paper form (US Mail or hand delivery) if a Participant does not consent to the electronic distribution.

Upon Request. You also agree to provide Participants and Beneficiaries with a copy of the SPD within thirty (30) days of a written request. Participants and Beneficiaries should read their SPD so they understand the benefits to which they are entitled. You agree to ask Participants and Beneficiaries to keep their SPD in the same place they keep other important financial information.

Fully-Insured Plan. Because Your welfare benefits are fully insured, Your SPD will "wrap-around" or be attached to a Certificate of Coverage and Schedule of Benefits, as well as any riders and amendments, issued by the Carrier.

Changes to Your SPD. Because laws change frequently, the Carrier will periodically review Your SPD and update it to reflect any changes in the law or Your welfare plan. After the SPD has been furnished, changes may occur to the Plan or information contained in the SPD. Under ERISA, any modification in the Plan's terms that is "material"—and any change in required SPD content—must be disclosed to Participants and Beneficiaries.

- When this happens, the Carrier may either issue a new SPD to You or a Summary of Material Modifications (SMM) which is a description of the change. An SMM generally will be furnished within two hundred and ten (210) days after the end of the plan year in which a modification or change is adopted.

- If the change related to a material reduction in covered benefits or services, the SMM will be provided by the Carrier no later than sixty (60) days after the date of adoption of the reduction. Depending on the nature of the change, the Carrier may issue the SMM prior to the effective date of the change. You must distribute Your SMM in the same manner as the SPD explained above.

Updated SPD. You will also be required to furnish an updated SPD at least once every five years if there have been any material changes during that period of time. You will be required to furnish a new SPD once every ten years even if no material changes have been made.

Summary of Benefits and Coverage. Because Your coverage under the Plan is fully-insured coverage, applicants for coverage and Participants will also receive an additional document known as the summary of benefits and coverage (SBC) as required under the Affordable Care Act (ACA). The SBC is a document that will be distributed to applicants and Participants in connection with enrollment or re-enrollment. You are not responsible for distributing this document.

Summary Annual Report. We will provide You with a summary annual report (SAR) which is an annual statement summarizing the Plan's financial condition. You will be required to furnish the SAR to Participants within nine months of the close of the plan year.

Section 3: Required Contributions and Access Fees

Each Participating Employer is required to pay the monthly Required Contribution on behalf of Your Participants and Beneficiaries. The Required Contribution amount will be calculated based on the number of Participants for each Participating Employer that are shown in the Plan's (or the Carrier's) enrollment records at the time of calculation. In addition to the Required Contributions, you must also pay the Access Fee. It is important that you pay the Access Fee solely out of the funds that belong to your business. No Participant contributions can be used to fund the Access Fee. Your participation in the Consortium and the Trust means that you agree to this requirement. The Access Fee will be distributed to the administrative services provider for the Trust for services provided in connection with the maintenance of the Plan. No part of the Access Fee will be remitted to the Trust. Participant Contributions may be used to fund the Required Contribution. A pro rata Required Contribution, calculated on the number of days Participants and Beneficiaries are actually covered under this Participation Agreement, will be charged for Participants and Beneficiaries whose effective date of coverage falls on a date other than the first of the month or for Participants and Beneficiaries whose coverage is terminated on a date other than the first of the month.

The Participating Employer must notify Us in writing within 31 days of the effective date of enrollment, termination or other changes. The Participating Employer must also notify Us in writing each month of any change in the Coverage Classification for any Participant. We may make retroactive adjustments to the Required Contribution for any additions or terminations of Participants or Beneficiaries or changes in coverage that are not reflected in Our records at the time We calculate the Required Contribution.

We reserve the right to change the schedule of Required Contributions or Access Fee, after a 31-day prior written notice on the first anniversary of the effective date of this Participation Agreement specified in the application or on any monthly due date thereafter, or on any date the provisions of the Participation Agreement are amended. We also reserve the right to change the schedule of Required Contribution amounts at any time if such amount was determined based on a material misrepresentation that resulted in the rates being different than they would have been without such material misrepresentation. If this happens, we may change the rates retroactive to the effective date of Your coverage.

Payment of the Required Contribution and the Access Fee. The Required Contribution and the Access Fee must be paid in advance by the Participating Employer on a monthly basis. The first Required Contribution and Access Fee is due and payable on or before the effective date of coverage. Subsequent contributions are due and payable no later than the first day of each payment period, while this Participation Agreement is in force.

A charge for late payments may be assessed for any Required Contribution and Access Fee not received within ten calendar days following the due date. A service charge will be assessed for any insufficient funds check received. All Required Contributions and Access Fees must be accompanied by documentation that states the names of the Participant or Participating Employer, as applicable, for whom payment is being made. In the event of a delinquency, You may be charged attorney's fees and any other costs related to the collection of Required Contributions and Access Fees.

Grace Period. A grace period of 31 days will be granted for the payment of any Required Contribution and Access Fee not paid when due. During the grace period, Your coverage will continue in force. The grace period will not extend beyond the termination of this Participation Agreement. Participating Employers are liable for payment of the Required Contribution and Access Fee during the grace period. If we receive written notice from You to terminate the coverage during the grace period, we will adjust the Required Contribution so that it applies only to the number of days coverage was in force during the

grace period. Coverage terminates as described in Section 5.1 if the grace period expires and the Required Contribution remains unpaid.

Section 4: Eligibility and Enrollment

4.1 Eligibility Rules. You are responsible for establishing eligibility rules, which We will reasonably abide by, subject to any limits imposed by law or your SPD. You should summarize the Plan's eligibility rules for each Coverage Classification and attach that summary at the end of your Plan's SPD where indicated. The summary should explain the conditions for eligibility under the Plan such as hours worked, any applicable waiting period, and the day coverage will begin (e.g., the first day of the month following the satisfaction of the waiting period). Those rules are in addition to the eligibility provisions in Your SPD in the *When Coverage Begins* section of Your *Certificate of Coverage*. Minimum participation rules are set forth in Section 6 of this Agreement.

4.2 Initial Enrollment Period. Eligible Employees and their dependents may enroll for coverage under the Plan during an initial enrollment period, preceding the effective date of this Participation Agreement.

4.3 Open Enrollment Period. An Open Enrollment Period of at least 31 days must be provided annually during which Eligible Employees may enroll for coverage under the Plan.

4.4 Special Enrollment. The Plan also provides for special enrollment opportunities upon the occurrence of certain events. Refer to Your SPD to learn more about these special enrollment opportunities.

4.5 Effective Date of Coverage. The effective date of coverage for properly enrolled Eligible Employees and their dependents is the effective date of this Agreement, which shall be 12:01 a.m. on the first effective day of coverage in the time zone of the Participating Employer's location. For an Eligible Employee who becomes eligible after the effective date of the Participation Agreement, his or her effective date of coverage is the day following the last day of any required waiting period.

Section 5: Termination of Coverage

5.1 Conditions for Termination of Coverage Under This Participation Agreement. This Participation Agreement and all benefits for covered health services under the Plan and this Participation Agreement shall automatically terminate with respect to Participants and Beneficiaries on the earliest of the dates specified below:

A. On the last day of the grace period described in Section 3 of this Participation Agreement if the Participating Employer's Required Contribution and Access Fee remains unpaid. The Participating Employer remains liable for payment of the Required Contribution and Access Fee for the period of time the Participation Agreement remained in force during the grace period.

B. On the date We specify, after thirty-one (31) days' written notice to the Participating Employer, that this Participation Agreement shall be terminated with respect to the Participating Employer's coverage due to the Participating Employer's violation of participation and contribution rules.

C. On the date We specify, in written notice to the Participating Employer, that this Participation Agreement shall be terminated with respect to the Participating Employer's coverage because the Participating Employer provided Us with false information material to the execution of

this Participation Agreement or to the provision of coverage under this Participation Agreement. In this case, We have the right to rescind this Participation Agreement back to the effective date. Any unearned premium will be refunded.

D. On the date specified by the Participating Employer, after at least thirty-one (31) days' prior written notice to Us that Participating Employer's coverage under the Participation Agreement shall be terminated.

E. On the date We specify, in written notice to You, as a result of You no longer being a member of ACEC.

5.2 Payment and Reimbursement Upon Termination. Upon any termination of coverage under the Plan, the Participating Employer is and will remain liable to us for the payment of any and all Required Contributions and Access Fees that are unpaid at the time of termination, including a pro rata portion of the Required Contribution and Access Fee for any period in which this Participation Agreement was in force during the grace period preceding the termination.

Section 6: General Provisions

6.1 Entire Agreement. This Participation Agreement and any amendments, notices of change, and riders constitute the entire Agreement between the Trust and the Participating Employer. All statements made by the Participating Employer or by a Participant will, in the absence of fraud, be deemed representations and not warranties.

6.2 Amendments and Alterations. Amendments to this Participation Agreement are effective on the date We specify. No change will be made to this Participation Agreement unless made by an Amendment which is signed by one of Our authorized executive officers. No agent has authority to change the Participation Agreement or to waive any of its provisions.

6.3 Relationship Between the Parties.

- The relationships between Us and network providers, and relationships between Us and Participating Employers, are solely contractual relationships between independent contractors. Network providers, service providers and Participating Employers are not Our agents or employees, nor are We or any of Our employees an agent or employee of network providers and Participating Employers.

- The relationship between a network provider and any Participant or Beneficiary is that of provider and patient. The network provider is solely responsible for the services provided by it to any Participant or Beneficiary. The relationship between any Participating Employer and any Participant and Beneficiary is that of employer and employee (or former employee), dependent, or any other category of individuals specified in this Participation Agreement.

- Each Participating Employer is solely responsible for enrollment and Coverage Classification changes (including termination of a Participant or Beneficiary's coverage).

6.4 Records. Each Participating Employer must furnish Us with all information and proofs which We may reasonably require with regard to any matters pertaining to this Participation Agreement. We may at any reasonable time inspect:

- All documents furnished to the Participating Employer by any individual in connection with coverage.

- The Participating Employer's payroll.

- Any other records pertinent to the coverage under this Participation Agreement.

The parties agree that information and records with respect to benefits under the Plan will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

6.5 Administrative Services. The services necessary to administer the Plan and the benefits provided under it will be provided in accordance with standard administrative procedures or those standard administrative procedures of the Carrier. If the Participating Employer requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Participating Employer must pay for such services or reports at the then-current charges for such services or reports.

6.6 Examination of Participants and Beneficiaries. In the event of a question or dispute concerning benefits for covered health services, We may reasonably require that a network physician, chosen by Us, examine the Participant or Beneficiary at Our expense.

6.7 Clerical Errors. Clerical errors will not deprive any individual of benefits under this Participation Agreement or create a right to benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Employees. Failure to report the termination of coverage will not continue the coverage for a covered person beyond the date it is scheduled to terminate according to the terms of this Participation Agreement. Upon discovery of a clerical error, any necessary appropriate adjustment in premiums will be made. However, We will not grant any such adjustment in premiums or coverage to the Participating Employer for more than sixty (60) days of coverage prior to the date We received notification of the clerical error.

6.8 Workers' Compensation Not Affected. Benefits provided under this Participation Agreement do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.9 Conformity with Law. Any provision of this Participation Agreement which, is or becomes in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Participation Agreement is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.10 Continuation Coverage. Federal and state law sometimes requires that the Plan permit certain individuals known as "Qualified Beneficiaries" to continue coverage under the Plan even in the event that they are no longer otherwise eligible for coverage. The Plan makes continuation coverage available in these circumstances through the Carrier, although You will be assessed an additional charge for this service. The circumstances under which Participants and Beneficiaries become Qualified Beneficiaries are described in Your SPD in the *When Coverage Ends* portion of the Certificate of Coverage.

Written notice to Qualified Beneficiaries shall be provided by Us to the Participating Employee's last known address as contained in Your business records.

6.11 System Access. The term "systems" as used in this provision means systems that the Consortium and the Trust have made available, or arranged with the Carrier to make available to Participating Employers to facilitate the transfer of information in connection with this coverage.

The Trust and its service provider(s) grant Participating Employers the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Participation Agreement. Participating Employers agree that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain property of the Trust and/or the Carrier. In order to obtain access to the systems, the Participating Employer will obtain, and be responsible for maintaining, at its own expense, the hardware, software and Internet browser requirements we provide to the Participating Employer, including any amendments to those requirements. The Participating Employer is responsible for obtaining an internet service provider or other access to the Internet.

The Participating Employer will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by Us in order to access or utilize systems, for purposes other than as expressly permitted under this Participation Agreement.

- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Participation Agreement.

The Participating Employer may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Participating Employer assumes joint responsibility for such access.

The Participating Employer will use commercially reasonable physical and software-based measures, and comply with Our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Participating Employer will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

The Trust and the Carrier reserve the right to terminate the Participating Employer's system access:

- On the date the Participating Employer fails to accept the hardware, software and browser requirements provided by Us, including any amendments to the requirements.

- Immediately on the date We reasonably determine that the Participating Employer has breached, or allowed a breach of, any applicable provision of this Participation Agreement. Upon termination of this Participation Agreement, the Participating Employer agrees to cease all use of Our systems, and We will deactivate the Participating Employer's identification numbers and passwords and access to the system.

6.12 Trust Status. The Consortium nor the Trust will be deemed or construed to be the common law employer of Participants and is not responsible for fulfilling any duties of an employer other than those in connection with the Plan. The Consortium and the Trust does not agree to assume any of Your obligations. To the extent services offered through the Consortium and the Trust overlap with any action You are required to perform by law, the Consortium nor the Trust does not agree to assume Your legal duty and you should not rely on the Consortium or the Trust as the primary source of information or services in

order to meet Your legal obligations. No statements, representations or communications by the Consortium or the Trust should be construed as legal, medical or tax advice and should not be relied upon as such.

6.13 Minimum Participation Requirement. The minimum participation requirement for the Participating Employer is seventy-five (75%) of Eligible Employees and their dependents excluding spousal waivers, but no less than fifty percent (50%) of all Eligible Employees and dependents must be enrolled for coverage under this Participation Agreement.

6.14 Minimum Contribution Requirement. The Participating Employer must maintain a minimum contribution requirement of fifty percent (50%) of the total cost of coverage, including the Access Fee and the Required Contribution for each Eligible Employee who is enrolled for coverage.

You will be deemed to have accepted the terms of this Participation Agreement by the payment of any Required Contribution and the acceptance of coverage for Eligible Employees and their dependents, including the requirement that the Access Fee may not be paid with Participant contributions but may only be paid from employer funds.

PARTICIPATING EMPLOYER

By: _____

Date: _____

Exhibit 1

1. Parties. The parties to this Participation Agreement are the ACEC Life/Health Insurance Trust (Trust) and the Participating Employer.

2. Effective Date of this Participation Agreement. The effective date of this Participation Agreement is 12:01 a.m. on the first effective day of coverage in the time zone of the Participating Employer's location.

3. Contributions. We reserve the right to change the Schedule of Required Contribution Rates or Cost Summary, after a 31-day prior written notice on the first anniversary of the effective date of this Participation Agreement specified in the application or on any monthly due date thereafter, or on any date the provisions of this Participation Agreement are amended. We also reserve the right to change the Schedule of Premium Rates, retroactive to the effective date, if a material misrepresentation relating to health status has resulted in a lower schedule of rates.

4. Computation of Required Contribution. A pro rata Required Contribution, calculated on the number of days Participants and Beneficiaries are actually covered under this Participation Agreement, will be charged for Participants/Beneficiaries whose effective date of coverage falls on a date other than the first of the month or for Participants /Beneficiaries whose coverage is terminated on a date other than the first of the month.

5. Payment of the Required Contribution. The Required Contribution is payable to us in advance by the Participating Employer through contributions by the Participating Employers on a monthly basis.

6. Minimum Participation Requirement. The minimum participation requirement for the Participating Employer is 75% of Eligible Employees and their Dependents excluding spousal waivers, but no less than 50% of all Eligible Employees/Dependents must be enrolled for coverage under this Participation Agreement.

7. Minimum Contribution Requirement. The Participating Employer must maintain a minimum contribution requirement of 50% of the Premium for each Participant and Beneficiary under the terms of the Plan.

8. Class Description. This information is set forth in the Participating Employer's application

9. Eligibility. Each Participating Employer is responsible for establishing eligibility rules.

10. Open Enrollment Period. An Open Enrollment Period of at least 31 days will be provided during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

11. Effective Date for Eligible Persons. The effective date of coverage for eligible persons who are eligible on the effective date of the Participation Agreement is the date benefits under the Group Policy were first effective with respect to the Participating Employer. For an eligible person who becomes eligible after the effective date of the Participation Agreement, his or her effective date of coverage is the day following the last day of the required waiting period.

12. Schedule of Required Contributions. Monthly Required Contributions payable by or on behalf of Participants and Beneficiaries are specified in the Cost Summary.

New Business Binder Check Coversheet

Group Name	
Federal TAX ID#	
Policy Effective Date	
Check #	
Check Amount	

Please include copy of binder check with installation submission
Check payable to UnitedHealthcare or ACEC Life/Health Trust
Include customer name & TAX ID # on check Send check to below address

Street Address:	**Overnight Address:**
ACEC Life/Health Trust **Dept. CH 14382** **Palatine, IL 60055**	**ACEC Life/Health Trust** **Dept. CH 14382** **5505 N. Cumberland Ave. Suite 307** **Chicago, IL 60656-1471**

Employer eServices Scheduled Direct Debit

Sign up for UnitedHealthcare Scheduled Direct Debit to automatically deduct your premium payments from your bank account.

Streamline your monthly invoice payment process

Scheduled Direct Debit from Employer eServices® is a convenient way to pay your monthly insurance premiums.

After you sign up, your premium will be automatically deducted from your company's bank account.

Even better, Scheduled Direct Debit helps you streamline your monthly invoice payment process and better organize your payment records, which frees you up to focus on the business of your business.

Scheduled Direct Debit takes care of everything automatically, which may help you:

- Pay your premium at the same time, on time, each month
- Maintain a consistent process for your payments
- Better predict cash outflow
- Access an accurate record of your payments, which are listed on your bank statement

Enroll today and worry about one less thing tomorrow

To enroll:

1. Complete the Scheduled Direct Debit Authorization Form below.
2. List all customer numbers and bill groups that you wish to have paid by automatic withdrawal.
3. Return the completed form by email or fax. Contact information is listed on the form.

IMPORTANT: Please return the completed form along with a voided check (no deposit slips, please) or an authorized bank letter.

Printed name and title of signatory

Date

Employer name/Customer name/Policy name

Employer email address

UnitedHealthcare customer number

UnitedHealthcare bill group(s)

Name of your financial institution

Telephone number of financial institution

Routing/Transit Number (9 digits required)

Account number
(include all zeros and omit spaces/special characters)

Email to: Direct_Debit@uhc.com

Fax to: 1-888-476-5127
Attn: Accounts Receivable

continued

United Healthcare | ACEC LIFE/HEALTH TRUST

Statement of understanding

This agreement is made in accordance with the operating rules and regulations of the National Automated Clearinghouse Association. By executing this document in the space provided above, I confirm that I am authorized to act on behalf of the employer/customer ("Group") and agree on behalf of the Group to the following terms and conditions:

- **By choosing Scheduled Direct Debit, the customer understands all invoicing will be online only located at employereservices.com. Should there be any questions pertaining to accessing and/or location of the invoice, please call 1-800-651-5465, TTY 711, 8 a.m. – 8 p.m. ET, Monday – Friday.**
- Group authorizes UnitedHealthcare to debit the group checking or savings (account number provided above) for all monthly charges for coverage.
- Group understands that it may take up to one month to set up Scheduled Direct Debit and consequently all overdue premiums should be promptly paid in order to avoid receiving a delinquency letter and possible termination of your account during this initial set up period.
- Group understands and agrees that it will have sufficient funds in its account to cover the full premium invoice on the draft due date. If necessary funds are not in your account on the draft due date, group coverage may be subject to termination proceedings consistent with the terms stated in your UnitedHealthcare contract.
- Group understands that the amount drafted may vary based on billing premium adjustments reflected on your monthly invoice.
- Group understands UnitedHealthcare may make adjustments to the account whenever a correction or change is required. For example, if there is an error, the group/member agrees that UnitedHealthcare may correct the error immediately and without notice. Such errors may include, but are not limited to, reversing an improper credit, making adjustments for returned premium, and correcting calculation and input errors. The right to make adjustments are not subject to any limitations or time constraints, except required by law.
- Payment will be withdrawn on the date indicated on your monthly invoice.
- Group agrees to promptly notify UnitedHealthcare of any change to the information provided.

Authorization

Authorization is given to UnitedHealthcare to initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to UnitedHealthcare; it is canceled by UnitedHealthcare under the conditions stated above; or upon termination of coverage with UnitedHealthcare.

_____

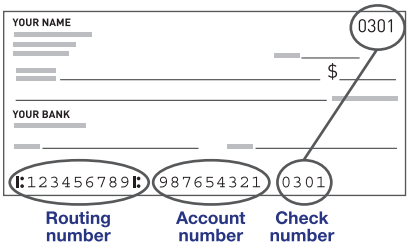
Signature required

Determining your routing number

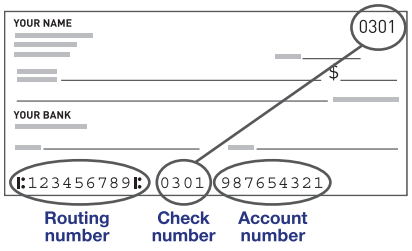
To determine your routing number, refer to your company check. The routing number is always 9 digits long and it is enclosed by colons. The location of the routing number and account number on your company check varies depending on your bank.

For example:

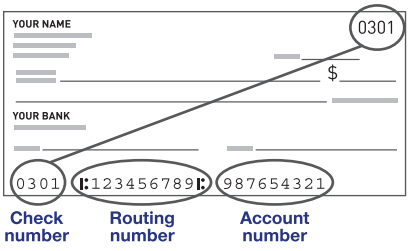
Bank 1



Bank 2



Bank 3



Please contact your financial institution if you have any questions about your routing number or account number.

United Healthcare | ACEC LIFE/HEALTH TRUST

Getting your non-resident insurance license in Illinois

ACEC LIFE/HEALTH TRUST

The ACEC Life/Health Trust is filed with the State of Illinois;
therefore, the large employer group is sitused in Illinois.

Illinois NON-RESIDENT Insurance License Requirement

All agents must be appointed in Illinois to receive commission on
ACEC Life/Health Trust business

If commission is paid directly to the Agent:

If commission is paid directly to the agent, then only the writing agent will be required to have a non-resident license in the state of Illinois to receive commission on ACEC Life/Health Trust business.

If commission is paid to the Agency:

If commission is paid directly to the agency, then both the writing agent and agency will be required to have a non-resident license in the state of Illinois to receive commission on ACEC Life/Health Trust business.

How to get a non-resident license in Illinois?

Apply Online: https://pdb.nipr.com/nrl/useAgreement.do

Submitting your non-resident license for processing:

Send the following to: appointment_credentialing@uhc.com
Name & Producer number
Attach: Non-Resident insurance license (actual certificate)