

# ADOPTION & PARTICIPATION REQUEST FOR PARTICIPATION IN:



INSURANCE SERVICES INDUSTRY TRUST-Pennsylvania (ISIT- PA), established under a Trust Agreement dated January 1, 1991 insured for the benefits provided under group insurance policies issued to the Trustee(s) by:

Please select from the following:

- ☐ Delta Dental of Pennsylvania (the "Insurance Company")
- ☐ National Vision Administrators (NVA)

FOR GBA USE:

Group #: \_\_\_\_\_

Plan Code# \_\_\_\_\_

Check # \_\_\_\_\_

ADMINISTRATOR: Gettysburg Benefits Administrators, Inc.  
PO Box 1060, 777 Baltimore Street, Suite 97, Gettysburg PA 17325  
800-497-4474 / 717-334-9247

## COMPANY INFORMATION:

Name of Firm		Requested Effective Date	
Tax ID# (EIN)			
Corresponding Person Name & Title			
Telephone	Email	Fax	
Street Address			
City	State	Zip	County
Nature of Business		SIC Code	

**1) Are any employees outside coverage area quoted by Gettysburg Benefits Administrators?** ☐ Yes\* ☐ No  
\*If Yes, # of employees Location

### 2) Total Number Of Employees

A) INSURED: # Full-Time # COBRA

B) DIS-ELECTION: # PartTime/Seasonal #Waivers

**All full-time employees who devote a minimum of 30 hours each week to the service of the applicant at their regular and customary place of employment are considered eligible.** It is agreed that the insurance applied for shall not become effective unless the number of persons insured is no less than the minimum number of lives required by law. It is also agreed that if contributions are required, at least 50% of the persons eligible for insurance must make written request for the insurance. It is further agreed that if contributions are not required, 100% of the persons eligible for insurance must make written request for the insurance. In addition to part-time and temporary employees, the following classes of employees or employees by name are NOT to be considered eligible:

### 3) Waiting Period For Eligible Full-Time Employees:

a) Delta Dental - Initial employees employed ON or BEFORE, Subsequent (new hires) employed after the effective date:  
Mandatory 90 Day Waiting Period

c) NVA Vision Plan Waiting Period: (Indicate Employer Waiting Period)

Form#GBAMA20231128

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PO 1060

Gettysburg, PA 17325

Initials \_\_\_\_\_

P: (800)-497-4474 | F: (717) 334-5851 | E: gcus@getbenefitsadmin.com | W: www.getbenefitsadmin.com

# INSURANCE PLAN INFORMATION

## 4) Employee Contributions

Insurance is: ☐ non-contributory ☐ contributory\* \*If contributory: Premium is ☐ Pre-Tax ☐ Post Tax

*The Applicant Employer agrees to make the payroll deduction authorized in writing by each employee.*

## Employee's Contribution to Insurance Premium

DENTAL	VISION		
_____% EE/Dependent	_____% EE/Dependent		

## DELTA DENTAL COVERAGE REQUESTED (For 2-4 lives only Employer Contrib; 2+ lives for Voluntary Plans):

Waiting period for subsequent employees (eligible full-time) employed after the effective date is 90 days.

### Employer Paid PPO Plan Option

Note: "+" Indicates PPO Plus Premier Network

- ☐ Basic Plan - \$25 DED - \$1000 MAX (2-4 EE's)
- ☐ Basic + Plan - \$25 DED - \$1000 MAX (2-4 EE's)
- ☐ Traditional Plan - \$50 DED - \$1250 MAX (2-4 EE's)
- ☐ Traditional + Plan - \$50 DED - \$1250 MAX (2-4 EE's)
- ☐ High Plan - \$50 DED - \$1500 MAX (2-4 EE's)
- ☐ High Plan + - \$50 DED - \$1500 MAX (2-4 EE's)

### Voluntary PPO Plan Option

- ☐ Basic Plan - \$25 DED - \$1000 MIN (2 EES's)
- ☐ High Plan - \$50 DED - \$1250 MIN (2 EE's)

**Notes:** For Employer paid: Rates require that the employer will contribute a minimum of 50 percent of the cost of the plan and that there will be no less than 50 percent enrollment of all eligible employees and no less than 50 percent enrollment of their dependents if dependent coverage is elected by the employer. Employees covered through a spouse's dental plan, and employees and/or dependents with dentures will be counted toward meeting the participation requirement. Minimum enrollment of two (2) lives for employer paid and voluntary plans. Administration Fee \$10.00 per group per month

## NVA COVERAGE REQUESTED (For 2-99 Employees) Administration Fee of \$7.50 per group per month for stand-alone vision coverage.

NVA Plans – 2 options (100% or 50% based on contribution level)

- ☐ 0% Employer Paid / 100% Employee Participation - Full Service Program ; voluntary program

- ☐ Plan 1A \$85 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment

- ☐ Plan 2A \$130 - Benefits Include: ☐ Plan 2A Enhanced \$130 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment

- ☐ Plan 3A \$130 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment

- ☐ Plan 4A \$200 - Benefits Include: ☐ Plan 4A Enhanced \$200 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment

- ☐ 50% Employer Paid / 50% Employee Participation - Full Service Program

- ☐ Plan 1B \$85 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment

- ☐ Plan 2B \$130 - Benefits Include: ☐ Plan 2B Enhanced \$130 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment

- ☐ Plan 3B \$130 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 24 months \$10/ \$15 Copayment

- ☐ Plan 4B \$200 - Benefits Include: ☐ Plan 4B Enhanced \$200 - Benefits Include:  
Exam every 12 months Lenses every 12 months; Frames every 12 months \$10/ \$15 Copayment

# ADOPTION & PARTICIPATION SIGNATURE PAGE:



The undersigned, subject to acceptance by the Administrator, hereby makes application to become a participant in and to be bound by all of the terms, provisions, conditions and limitations of the Trust and Trust Agreement, as amended, between the Trust and Gettysburg Benefits Administrators, Inc. and the master insurance policy or policies (Policy) issued thereunder and providing benefits for the employees of the undersigned Participant/Employer to the same extent as if it were the Policyholder named therein. The undersigned further agrees from time to time to execute and deliver such papers and documents and to furnish such records and information to said Administrator and Insurance Company as shall be required to effect and continue coverage for the undersigned's employees under such Policy. The undersigned further agrees that if it withdraws from the Trust and cancels its insurance plan, it thereby relinquishes any claim it may then or thereafter have to any benefits provided through the Trust. We understand and agree as follows:

1. The Trust may be amended, revised, supplemented, or terminated by the Trustee(s) as provided therein, and any such change shall be binding upon us.
2. The Policy may be amended, canceled or discontinued, according to its terms, by the Trustee(s) and the Insurance Company, and all of the terms of the Policy including such change shall be binding upon us.
3. Since premiums for said policy are payable in advance to the Administrator, we shall make in advance to the Administrator such premium payments and/or participating employer assessments as are requested of us by the Administrator to cover the cost of insuring our employees. An initial premium deposit must accompany this application for group insurance, but the remittance of this deposit does not constitute automatic acceptance of this group insurance application by the Insurance Company. We may be subject to having personal health statements for both employees and dependents completed prior to approval by the Insurance Company. Attending physician statements and other investigations may be requested by the Insurance Company through the Administrator. We understand that the submitted materials are subject to review for acceptability and that the insurance, as applied for, will not be in force until we have received formal, written notification of acceptance, and of the effective date of the coverage applied for, from the Administrator. Appropriate declinations may be made prior to acceptance. The initial premium deposit will not be credited to our account until such time as the formal notification has been released by the Administrator. We understand that this premium deposit will be returned to us in the event that the application is not approved by the Insurance Company.
4. The Insurance Company and Administrator reserve the right to adjust rates (with 30 days notice) from time to time to assure the actuarial soundness of the trust upon the recommendation of the Insurance Company.
5. All disclosures and declarations on Plan of Coverage and Coverage Requested (pages 2 and 3) and Field Underwriting Information (page 4) shall become a part of the coverage issued pursuant to this application.
6. It is critical that eligibility and coverage terminations be reported to Gettysburg Benefits Administrators, Inc. immediately upon termination of employment. If we fail to promptly terminate an employee's coverage, the Insurance Company reserves the right to recoup repayment of any claims incurred and paid beyond the employee's date of termination or expiration of eligibility.
7. Conversion Notice: It is the employer's responsibility under the terms of the Policy and Trust Agreement to present the employee with notification of his right to convert medical insurance to a non-group type of insurance, under certain conditions, after termination of employment.

The insurance benefits, eligibility requirements and effective date of the insurance are requested herein. I certify, as the employer, that to the best of my knowledge and belief all statements and answers in this Application are true. I have read and understand the Notice Regarding Limitations on Health Insurance Coverage (page 4). Advance payment, herewith, of \$\_\_\_\_\_ is to be applied toward the payment of premiums under the group insurance coverage hereby requested.

**PLEASE MAKE CHECK PAYABLE TO: GBA PREMIUM ACCOUNT.**

EMPLOYER NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ TITLE: \_\_\_\_\_ Date: \_\_\_\_\_

PRINT: \_\_\_\_\_

The above named Employer is eligible to participate in the above described Trust and is approved as a participant therein.

EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gettysburg Benefits Administrators, Inc. By: \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

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# PRODUCER SECTION

PRODUCER OF RECORD: The below signed producing agent is hereby recognized as the Agent of Record to receive credit for this application according to the Insurance Company rules and regulations on coverages issued in accordance with this application, provided he or she is duly licensed as required by law.

PRODUCER CERTIFICATION: I certify, as primary agent, that to the best of my knowledge and belief all of the statements and answers on this Adoption & Participation Agreement are true. I also certify that I have no knowledge or information regarding the applicant group which is not fully set forth herein.

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Independent Producer/Solicitor \_\_\_\_\_/\_\_\_\_\_%  
SIGNATURE

Independent Producer/Solicitor \_\_\_\_\_ Phone#(\_\_\_\_)\_\_\_\_\_ GBA Agent ID#\_\_\_\_\_  
PRINT NAME

Producer Email \_\_\_\_\_

Agency \_\_\_\_\_ Phone#(\_\_\_\_)\_\_\_\_\_ GBA Agency ID#\_\_\_\_\_

Agency Email \_\_\_\_\_

General Agency (If Applicable) \_\_\_\_\_ Phone#(\_\_\_\_)\_\_\_\_\_ GBA Agent ID#\_\_\_\_\_

General Agency Agent (If Applicable) \_\_\_\_\_ GBA Agent ID#\_\_\_\_\_  
SIGNATURE

General Agency Agent \_\_\_\_\_  
PRINT NAME

Commission payable to ☐ Independent Producer/Solicitor ☐ Agency ☐ General Agency

Commissions payable via ACH. Please complete ACH Authorization Form if not already on file.