Cigna Client Application

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York

Cigna.

UNDERWRITING COMPANY

- [x] Life Insurance Company of North America
- [ ] Cigna Behavioral Health, Inc. (for Life Assistance Program and Employee Assistance Program)
- [ ] Connecticut General Life Insurance Company
- [ ] Cigna Life Insurance Company of New York

Documents for Customer Signature

- [x] Appointment of Claim Fiduciary
- [ ] Employee Assistance Program Agreement
- [ ] Life Assistance Program Agreement
- [ ] Cigna Absence Assistant Agreement

Document for Client Review

- [x] Benefit Reduction Schedule Notice
- [x] Disclosure of Producer Compensation Practices
- [x] Privacy Notice
- [x] Disability Tax Service Agreement

To assure operational readiness and accurate set-up of your contract/agreement(s) please provide the information requested below.

EMPLOYER INFORMATION - SECTION 1

Complete for all coverages

EMPLOYER FULL LEGAL NAME *Please include exact abbreviations, punctuation and /or capitalization.*				COMPANY TAX ID #
City of Carson				95-2513547
STREET ADDRESS	**CITY**		**STATE**	**ZIP CODE**
701 E Carson St.	Carson		CA	90745
PRIMARY CONTACT	**TITLE**	**PHONE**	**PHONE EXT.**	**FAX**
Elvia Parra	Senior HR Analyst	310-952-1700	1122	310-830-2471
Email:				
eparra@carson.ca.us				

AFFILIATED COMPANIES

Are there employees eligible for coverage working for an affiliated company? ☐ Yes ☒ No

If yes, please complete the following information.

AFFILIATE NAME (1)	TAX ID #	SEPARATE BILLING GROUP? ☐ Yes ☐ No	NUMBER OF EMPLOYEES

STREET ADDRESS	CITY	STATE	ZIP CODE

CONTACT NAME	PHONE	PHONE EXT.

E-MAIL _____

If more space is needed for additional affiliates, billing groups or contacts, please provide the information requested above on the Additional Notes page.

GENERAL PLAN AND COVERAGE INFORMATION - SECTION 2

Complete for all coverages

Policy Effective Date(s) March 1, 2017 Policy Anniversary Date(s) 03/01

GENERAL PLAN AND COVERAGE INFORMATION - SECTION 2 *(Continued)*

Complete for all coverages

Active Service Definition

An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel. **Applicable to all coverages**

The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days. An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day. Cigna standard is to not provide dual coverage for married couples. **Applicable only to Life and Accident Coverage.**

The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day. **Applicable only to Disability Coverage.**

Based on the above definition are there any employees who are not actively at work due to disability and are in the waiver waiting period? ☒ Yes ☐ No If yes, please assist these employees with applying for waiver of premium with the previous carrier.

Class Change Effective Date

☐ Date of change ☒ First of the month following change ☐ January 1 ☐ Anniversary Date ☐ Not Applicable
☐ Other: _____

Earnings Change Effective Date Date an employee's amount of insurance resulting from a change in the Employee's earnings will take effect.

☐ Date of change ☒ First of the month following change ☐ January 1 ☐ Anniversary Date ☐ Not Applicable
☐ Other: _____

Age band changes

☐ Date of change ☐ First of the month following change ☐ January 1 ☐ Anniversary Date ☒ Not Applicable
☐ Other: _____

Benefit Reduction Effective Date

☐ Date of change ☒ First of the month following change ☐ January 1 ☐ Anniversary Date ☐ Not Applicable
☐ Other: _____ For Basic Life Insurance

Continuation of Insurance *Allows insurance to be continued if an employee is no longer in active service. Premium payment is required. If applicable to your plan, please indicate maximum duration for each leave type listed.*

FML Leave

☒ The later of 12 weeks or the leave period required by state law (would include Military Caregiver Leave)
☐ Other: _____

Approved Unpaid Leave of Absence*

☒ End of the Month in which the leave began (standard) ☐ End of the Month following the month the leave began
☐ None ☐ Days_____ ☐ Weeks _____ ☐ Months_____

Layoff*

☐ None (standard) ☐ Days_____ ☐ Weeks _____ ☐ Months_____
☒ End of the Month in which the layoff began ☐ End of the Month following the month the layoff began

**These continuation options are not applicable to Disability Coverages.*

If any other Leave Types apply to your plan, please define (i.e.: Sabbatical, Military) and indicate maximum time frames in the space provided below.

LIFE AND ACCIDENT PLAN COVERAGE INFORMATION

Plan(s) Sold ☒ Life ☒ Accident ☐ Not Applicable
Beneficiary Maintenance ☒ Paper ☐ Electronic (a separate agreement will be provided for signature).

Do you possess a complete record, and copies of, existing beneficiary designations? ☒ Yes ☐ No

Do you allow Employees to make election changes any time throughout the year? ☒ Yes ☐ No ☐ Not Applicable

If yes, please advise if changes are allowed due to ☒ Life Status Event ☐ Annual enrollment period: _____

☒ Other Employees may change at any time of year with EOI

Medical Underwriting is required for an Employee if they are a late entrant.
Does this match your administrative practice? ☒ Yes ☐ No ☐ Not Applicable
If No, what amount of Guaranteed Coverage is provided? _____

If Domestic Partners are covered, does Cigna need to provide you with an affidavit? ☐ Yes ☒ No ☐ Not Applicable
If No, please provide Cigna with the affidavit that will be utilized

Calculation of Spouse Premium is based on ☐ Spouse Age ☐ Employee Age ☒ Not Applicable
Include financial dependency in definition of dependent child? ☐ Yes ☒ No ☐ Not Applicable
Rounding for Times Salary Plans - Salary is multiplied first then rounding occurs ☐ Yes ☐ No ☒ Not Applicable
If No, please describe: _____

Rounding for Increment Units Plans ☒ Rounding Up ☐ Rounding Down ☐ Nearest ☐ Not Applicable

Must Voluntary Accident amount match the Voluntary Life Election? ☐ Yes ☐ No ☒ Not Applicable
If Yes, Is it an independent election or automatic match? ☐ Independent Election ☐ Automatic Match

DISABILITY PLAN COVERAGE INFORMATION

Disability Plan(s) Sold ☒ Fully Insured STD ☐ Self Insured STD ☒ Fully Insured LTD ☐ Self Insured LTD ☐ Not Applicable

Short Term Disability Plan(s) Only
Weekly disability benefits are based on the number of days in a normally scheduled work week. They will be prorated if payable for any period less than a week. Do your employees work a 5 or 7 day work week? ☐ 5 Day Work Week ☒ 7 Day Work Week

Your response impacts the daily benefit amount. Benefits will be prorated on a 5 or 7 day basis. *If your hours of operation include weekends or shift work schedules it is recommended that you select 7 day work week.*

Self Insured Disability Plan(s) Only
Does the Maximum Benefit Period include the Benefit Waiting Period? ☐ Yes ☐ No
Benefit Waiting Period is based on ☐ Calendar Days ☐ Business Days

Advice to Pay Medical Expense Funding
☐ Cigna funds medical record expenses
☐ Employer funds expenses through a Cigna banking arrangement
☐ Employer receives invoices from Cigna as medical expenses are incurred

Statutory Coverage Information
Do you have Employees working in the statutory states listed below? ☒ Yes ☐ No
If Yes, please check the boxes below to indicate coverage type.

Is Cigna providing any statutory coverages? ☐ Yes ☒ No
Your Cigna Sales Representative will generate a separate quote if not already provided. We may also provide additional state required application forms for policy issuance.

☒ California

☐ New York
Number of males_____
Number of females_____

☐ New Jersey
(Please provide prior carrier DP 1 if available.)
Number of males_____
Number of females_____

☐ Puerto Rico

☐ Hawaii Hawaii DOL Number:_____

Number of males_____ Number of females_____
Hawaii Address:_____

DISABILITY CLAIMS STRUCTURE & ADMINISTRATIVE CLAIMS REPORTING – SECTION 3

Claim Structure Set-Up

Is it necessary to provide claims reporting by department or division? ☐ Yes ■ No

If Yes, list desired reporting location(s) below.

Note: Employees will be required to identify their location when reporting claim.

Reporting Location(s) *(i.e., Hourly, Salary, Union, Non-Union, Location, Region, Sales, Manufacturing)*

Claim Reporting Set-Up *On-line Reporting access is provided for all Disability Coverage*

Primary contact will have full administrator access to reporting functions and ability to delegate access functions. *(Must be an Employee of the Company)*. Name an alternate administrator contact below, if needed.

ALTERNATE ADMINISTRATOR *(Must be an Employee - can delegate access to other users and has full access to reporting functions)*

NAME	ADDRESS/CITY	STATE	ZIP CODE
Grisel Rodriguez	701 E. Carson Street, Carson	CA	90745

PHONE	EMAIL
(310) 952-1736, Ext. 1121	grodrigu@carson.ca.us

A. Additional users to be set-up during implementation for online reporting access? ■ Yes ☐ No
   If Yes, please provide list that includes Name, Address and Email.
B. Can these users access reports for all locations? ■ Yes ☐ No
   If No, you must also specify applicable reporting locations by user.
C. Select day for posting of Weekly STD Status Reports ■M ☐T ☐W ☐TH ☐F
   STD Closed claims will appear for 2 weeks.
D. LTD Reports will be posted on the first day of each month LTD Closed claims will appear for 2 months.
E. Employee Name appears on claim reports. Please select an additional identifier if needed.
   ☐ Employee Social Security Number ■ Employee ID Number
F. Would you like access to new claim intake reports? ■ Yes ☐ No
G. Is there any other Company Name the Employee could use when reporting a claim? ☐ Yes ■ No
   If Yes, please list the Company Names: _____
H. Please provide Employer contact for Eligibility Verification. ☐ Primary contact
   ■ Other contact name: Grisel Rodriguez e-mail: grodrigu@carson.ca.us
I. Would you like to receive an email notification when new reports are posted? ■ Yes ☐ No
J. In addition to having report access, would you like to be copied on claim decision letters? ■ Yes ☐ No
K. If Cigna Healthcare is your medical provider, should outreach letters be sent to Employees? ☐ Yes ■ No

Please provide contact for claim decision letters if other than primary contact identified on page 1.

NAME	EMAIL		
ADDRESS	**CITY**	**STATE**	**ZIP CODE**

DISABILITY PLANS - EMPLOYER CONTRIBUTION, TAX AND YEAR-END REPORTING INFORMATION - SECTION 4

ANNUAL TAX INFORMATION FOR DISABILITY BENEFIT PLANS
NEW BUSINESS

Disability Tax Service Agreement - Schedule I
APPLICABLE UNTIL DECEMBER 31st OF THE YEAR IN WHICH THE FIRST POLICY YEAR ENDS

I. Exemption from Social Security, Medicare Taxes and Federal Income Taxes *(check all that apply)*

☐ Our disability plan is not exempt from either Social Security, Medicare or Federal Income taxes.

■ Our disability plan is exempt from Social Security for the following reason:
☐ Religious Institution ■ Other *(Specify)* municipality

■ Our disability plan is exempt from Medicare taxes for the following reason:
☐ Religious Institution ■ Other *(Specify)* Reference employer provided list

☐ Our disability plan is exempt from Federal Income taxes for the following reason:
☐ Religious Institution ☐ Other *(Specify)* _____

☐ Our disability plan is provided through
☐ Union ☐ an association; no employer is a party to the plan, and no employer contributes to plan costs.

II. Taxable and Nontaxable Percentages

Under Internal Revenue Code Section 105(a), and IRS Regulations §1.105-1(c)(1) and §1.105-1(d)(2), whether a disability benefit paid to an employee is subject to income tax depends on the extent to which premium contributions were made by the employer, or by employees, on a pre-tax basis.

For partially contributory plans, this determination is to be made based on the total cost paid on a pre-tax basis for the three policy years ending on or before the start of the calendar year in which the employee becomes disabled. Example: For claims incurred in 2015, premiums for the last three policy years ending on or before 12/31/2014 are taken into account.

Where a plan provides for two or more levels of employee contribution (e.g. core/buy-up plans), this determination is made separately for each class or employee type. For a buy-up plan where employee contributions are post-tax, this requires that employer-paid (core) premiums be allocated among core-only and core/buy-up participants. (See IRS Letter Ruling 9709051).

Please check which of the following is applicable. If your policy or plan contains more than one class or employee type with different benefit or contribution structure, please identify in the space provided below.

■ **Non-Contributory Plan** - This policy/plan is paid for entirely by the employer on a pre-tax basis. Taxable Percentage is 100%.
■ STD ■ LTD
LK752174 (STD) & LK965343 (LTD)

☐ **Payroll Deduction Plan** - This policy/plan is paid for entirely by employees on a post-tax basis. Includes mandatory as well as voluntary plans. Taxable Percentage is 0%.
☐ STD ☐ LTD

☐ **"Gross-Up" Plan** - This policy/plan is paid for entirely by the employer; the employer cost is reported to employees on Form W-2 (IRS Letter Ruling 9708018). Taxable Percentage is 0%.
☐ STD ☐ LTD

☐ **Section 125 Plan** - This policy/plan is paid for entirely by employees on a pre-tax basis. Taxable Percentage is 100%.
☐ STD ☐ LTD

☐ **STD Partially Contributory Plan** - This policy/plan is paid for partially by employees on a post-tax basis. The Taxable Percentage during _____ (year) is _____ %. The Nontaxable Percentage during _____ (year) is _____%. (Must total 100%.) (See attached worksheet.)

☐ **LTD Partially Contributory Plan** - This policy/plan is paid for partially by employees on a post-tax basis. The Taxable Percentage during _____ (year) is _____ %. The Nontaxable Percentage during _____ (year) is _____ %. (Must total 100%.) (See attached worksheet.)

☐ **STD Core/Buy-Up Plan** - Core premium is paid by the employer on a pre-tax basis. The Taxable Percentage for core only participants is 100%.
☐ Employees pay buy-up premium on a pre-tax basis. Taxable Percentage for buy-up participants is 100%.
☐ Employees pay buy-up premium on a post-tax basis. Taxable Percentage for buy-up participants during _____ (year) is _____ %. The Nontaxable Percentage during _____ (year) is _____ %. *(Must total 100%.)*
(See attached worksheet.)

DISABILITY PLANS - EMPLOYER CONTRIBUTION, TAX AND YEAR-END REPORTING INFORMATION - SECTION 4 (Continued)

II. Taxable and Nontaxable Percentages *(Continued)*

☐ **LTD Core/Buy-Up Plan** - Core premium is paid by the employer on a pre-tax basis. The Taxable Percentage for core only participants is 100%.

☐ Employees pay buy-up premium on a pre-tax basis. Taxable Percentage for buy-up participants is 100%.

☐ Employees pay buy-up premium on a post-tax basis. Taxable Percentage for buy-up participants during _____ (year) is _____ %. The Nontaxable Percentage during _____ (year) is _____ %. *(Must total 100%.) (See attached worksheet.)*

☐ **Tax Choice (Rev. Rul. 2004-55) Plan** - Participants can choose whether all contributions (employer or employee) are paid on a pre-tax basis or a post-tax basis. We will, at time of claim, notify the insurance company whether the claimant had elected pre-tax or post-tax contributions prior to the start of the year.

☐ STD ☐ LTD

III. Service Level Requested

☐ Preparation of Form W-2 only

☐ Self Insured STD ☐ Self Insured LTD ☐ Fully Insured STD ☐ Fully Insured LTD

■ Preparation of Form W-2 with Employer FICA depositing service
(If not previously confirmed selecting this option may require a rate view)

☐ Self Insured STD ☐ Self Insured LTD ■ Fully Insured STD ■ Fully Insured LTD
LK752174 (STD) & LK965343 (LTD)

☐ No tax services (Annual payment report provided January 15th; Employer prepares Form W-2)

☐ Self Insured STD ☐ Self Insured LTD ☐ Fully Insured STD ☐ Fully Insured LTD

If W2 services are selected, please review the attached Disability Tax Service Agreement for complete disclosure of terms and conditions. Form W-2 will be mailed to Employees home address unless otherwise specified.

IV. Funding of Self-Insured Benefits (Does not apply to "advice to pay")

☐ All benefits provided through the plan are insured (no self-insured benefits are provided).

☐ Self-insured benefits are funded through a trust which bears an insurance risk (may include employee contributions).

☐ Self-insured benefits are NOT funded through a trust which bears an insurance risk (e.g. the benefits are funded with employer general assets). ☐ Mandatory FIT Withholding ☐ W-4 Based Withholding

V. Addresses for Tax Reports and Remittance

Tax reports should be sent to the following address:

Attention: same as primary contact

Mailing Address: _____

Remittances of withheld taxes should be sent to the following address*:

Attention: same as primary contact

Mailing Address: _____

**Applies to any self-insured plan, unless (1) the plan is funded through a trust which bears an insurance risk, or (2) Form 2678 has been filed with and accepted by the Internal Revenue Service.*

If any information provided on this form changes before the next year's annual update, please notify your account manager.

LIFE ASSISTANCE PROGRAM INFORMATION - SECTION 5

Life Assistance or Employee Assistance Program Sold ☐ Yes (*If Yes, select type)* ☒ No

☐ Life Assistance Program "LAP" ☐ 3 visit clinical sessions ☐ 5 visit clinical sessions

☐ Full Employee Assistance Program "EAP" (includes up to 3 clinical sessions and Employer Service hours of 10 per 1,000 employees)

Until the LAP or EAP Agreement is finalized and executed, all services provided by Cigna Behavioral Health, Inc. shall be in accordance with the terms of Cigna Behavioral's standard LAP or EAP Agreement. Employer shall reimburse Cigna Group Insurance for Cigna Behavioral LAP or EAP services through the agreed upon combined product and LAP or EAP services rate.
The parties agree to negotiate in good faith the terms of the definitive LAP or EAP Agreement, and to execute such Agreements as soon as practicable. Once the LAP or EAP Agreement is finalized, that agreement will supersede this Application and will apply retroactively to the effective date of Cigna Behavioral's administration of the LAP or EAP services.
By signing this Application, Employer indicates acknowledgement of and agreement with this arrangement.

CIGNA ABSENCE ASSISTANT - SECTION 6

Cigna Absence Assistant Sold ☐ Yes ☒ No
Cigna Absence Assistant Service Agreement must be executed prior to the Absence Assistant Orientation Meeting. Upon receipt of a signed agreement, Cigna will schedule an orientation meeting to provide the client with Cigna Absence Assistant Resource Guide for Managing FMLA and ADA. The client will also be given access to MD Guidelines™ Leave of Absence Advisor, a web-based compliance database of federal and state job-protect leave laws and FML & ADA 101 Brainshark training tutorial for managers and supervisors. Once the orientation process is completed, the client can refer FMLA leave or ADA accommodation case requests for consultative guidance and recommendation.

ERISA PLAN INFORMATION - SECTION 7

Please refer to Cigna's ERISA Coverage Worksheet to determine whether a policy is issued in conjunction with ERISA. In general, any group insurance policy issued to an employer to insure employees, or to a labor union to insure union members, is subject to ERISA.
Does your Company file annual ERISA reports? ☐ Yes ☒ No If Yes, please complete the following information.
ERISA PLAN NAME

_____ ERISA PHONE NUMBER _____

ERISA PLAN NUMBER(S)

	☐ Life_____	☐ Accident_____	☐ STD _____	☐ LTD_____
PLAN OF BENEFITS IS FINANCED BY	☐ Employer ☐ Employees ☐ Employer & Employees	☐ Employer ☐ Employees ☐ Employer & Employees	☐ Employer ☐ Employees ☐ Employer & Employees	☐ Employer ☐ Employees ☐ Employer & Employees

PLAN YEAR ENDS ☐ Calendar Year ☐ Policy Year (Anniversary) ☐ Fiscal Year *(provide fiscal year date)*

PLAN ADMINISTRATOR
☐ Employer ☐ Other – *if other, please provide*

Name _____

Address _____

AGENT FOR LEGAL PROCESS
☐ Same as Plan Administration ☐ Other – *If other, please provide* _____

PREMIUM AND BILLING INFORMATION - SECTION 8

Premium Administration

On-line Premium Reporting System ☒ Yes ☐ Other _____

a. Please list each desired billing locations(s) Optional Life Class 9-Retirees

b. Will we receive payment from each Billing Location? ☒ Yes ☐ No, assumes one payment will be remitted from the primary billing contact.

Billing Contact Name:	Elvia Parra	Phone:	310-952-1736, Ext. 1122	E-mail:	eparra@carson.ca.us
Billing Contact Name:	Grisel Rodriguez	Phone:	310-952-1736, Ext. 1121	E-mail:	grodrigu@carson.ca.us
Billing Contact Name:	Mary Rojas	Phone:	310-830-7600, Ext. 1748	E-mail:	mrojas@carson.ca.us
Billing Contact Name:		Phone:		E-mail:	

VOLUNTARY ENROLLMENT INFORMATION – SECTION 9

Enrollment Event ☒ **Yes Event Start Date** 3/20/2017 **End Date*** 4/6/2017 **No** ☐

* Please indicate the last day the employee is allowed to sign the enrollment application.

Date Enrollment Materials needed _____ **Printed Brochures required?** ☒ **Yes** ☐ **No**

If Yes, please provide distribution instructions including physical address, contact name, phone number and quantity needed by class on a separate

Combine Enrollment Brochures for Voluntary Life and Voluntary Accident Coverages? ☒ **Yes** ☐ **No** ☐ **Not applicable**

Medical Underwriting Status Report Format ☐ **PDF** ☐ **Excel**

Please note Medical Underwriting Status Report will be sent to Primary Contact unless otherwise indicated below.

NAME	EMAIL		
ADDRESS	CITY	STATE	ZIP CODE

PRODUCER/GENERAL AGENT COMMISSION INFORMATION - SECTION 10

Writing Agent currently appointed with Cigna Group Insurance in group situs state? ☒ Yes ☐ No

If applicable, our Central Licensing Department will provide appointment package for completion.

PRODUCER/GENERAL AGENT COMPANY NAME					COMMISSION TAX ID#
Bender Benefits & Insurance Services, Inc.				27-2628329	
PRODUCER NAME (WRITING AGENT)				TITLE	
Rick Bender				President	
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE	EMAIL
46-E Penninsula Center, #333	Rolling Hills Estates	CA	90274	310-892-5058	rb@benderbenefits.com
LICENSING CONTACT NAME AT PRODUCER/GENERAL AGENT OFFICE				PHONE	EMAIL
Rick Bender				310-892-5058	rb@benderbenefits.com
DAY TO DAY PRODUCER CONTACT NAME				PHONE	EMAIL
Rick Bender				310-892-5058	rb@benderbenefits.com

IS PRODUCER A GENERAL AGENT? ☐ Yes ☒ No

SUB-PRODUCER COMPANY/CONTACT NAME		PHONE	PHONE EXT.

EMAIL	ADDRESS	CITY	STATE	ZIP CODE

COMMISSION PAID TO ☐ Individual ☒ Corporation ☐ No Commission Paid

☒ Life	☒ Accident	☒ STD	☒ LTD
☐ Standard Blanket Commission	☐ Standard Blanket Commission	☐ Standard Blanket Commission	☐ Standard Blanket Commission
☒ Case Specific Commission Standard 15 %	☒ Case Specific Commission Standard 15 %	☒ Case Specific Commission Standard 15 %	☒ Case Specific Commission standard 15 %

Utilize this space to identify any other commission arrangements not specified above.

If Split Commission complete Second Producer Information below.

SECOND PRODUCER INFORMATION

Writing Agent currently appointed with Cigna Group Insurance in group situs state? ☐ Yes ☐ No

SECOND PRODUCER COMPANY NAME					COMMISSION TAX ID#
SECOND PRODUCER NAME (WRITING AGENT)				TITLE	
STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE	EMAIL
LICENSING CONTACT NAME AT SECOND PRODUCER OFFICE				PHONE	EMAIL
DAY TO DAY SECOND PRODUCER CONTACT NAME				PHONE	EMAIL

COMMISSION PAID TO ☐ Individual ☐ Corporation ☐ No Commission Paid

☐ Life	☐ Accident	☐ STD	☐ LTD
☐ Standard Blanket Commission	☐ Standard Blanket Commission	☐ Standard Blanket Commission	☐ Standard Blanket Commission
☐ Case Specific Commission_____%	☐ Case Specific Commission_____%	☐ Case Specific Commission_____%	☐ Case Specific Commission_____%

If more space is needed for additional contact information, please attach on a separate page.

EXCHANGE SERVICE PROVIDER ☐ Yes ☐ No

Exchange Service Provider Fee ☐ Yes ☐ No

Exchange Service Provider

SERVICE FEE PAYABLE TO ☐ Individual ☐ Corporation

Life Service Fee _____%	Accident Service Fee _____%	STD Service Fee _____%	LTD Service Fee _____%

EMPLOYER REPRESENTATIVE SIGNATURE

We acknowledge receipt of this Implementation Kit. We confirm the accuracy of the proposal from the insurance company named above and hereby accept the terms and conditions of the proposal and any attachments or modifications made to the proposal.
We confirm the accuracy of the plan and coverage identification information contained in Section 2 and agree to the premium billing information contained in Section 8. We hereby request the issuance of insurance policies on the basis of this coverage and premium billing information.
If applicable, we authorize LINA Benefit Payments, Inc. to perform the tax-related services related to our disability benefits described in Section 4. We confirm the appointment of our producer identified in Section 10 above and authorize payment of compensation as described therein.
We confirm that benefit payments of $5,000 or more under non-disability policies will be credited to a Draft Account in the name of the claimant or beneficiary with the Insurance company if not otherwise directed by us.
We acknowledge receipt of the Privacy Notice.
We understand that the following insurance policies are to be issued to the Group Insurance Trust for Employers in the

PUBLIC ADMINISTRATION 9111-9721 Industry SIC Code 9111

TRUST ISSUED POLICY TYPE ■ Life ■ Accident ■ STD ■ LTD

We hereby adopt the above-named trust as co-settlor and subscribe to that trust for the purpose of participation in these policies, which shall only cover our eligible employees, and, if applicable, retirees and dependents. We confirm the appointment of Wilmington Trust Company as Trustee, and of Life Insurance Company of North America ("LINA") as trust administrator. We appoint LINA, in its capacity as trust administrator, to represent us in dealings with the Trustee related to the insurance trust. We understand that, in the event the policy(ies) are terminated for any reason, we will cease to be a participant in the insurance trust. We understand that no benefits are provided by the trust other than the benefits described in the insurance policy(ies).

Kenneth C. Farfsing
Authorized Employer Representative
(please print name here)

Authorized Employer Representative
(please sign name here)

Date

TO BE COMPLETED UPON RECEIPT OF COMPLETED AND SIGNED DOCUMENT

Assigned Policy Number(s)

FLX967822	OK969324	LK752174	LK965343	
Life	AD&D	STD	LTD	

Cigna

ADDITIONAL NOTES

> Please make sure that the Optional Life Class 9 (included under the Basic Life)- Retirees is broken out for Life claims and billing purposes.

Cigna.

ERISA COVERAGE WORKSHEET

Use this worksheet to determine whether a policy is issued in conjunction with ERISA. Where a policy is issued in conjunction with ERISA, the following will apply:

1. The insurance company will serve as the employer's named fiduciary for handling claims in accordance with ERISA regulations. The "Appointment of Claim Fiduciary" is required.

2. Certificates of insurance will be prepared with ERISA Summary Plan Description wording included.

3. Information will be provided for the ERISA Annual Report, Form 5500, Schedule A.

4. Claim-related correspondence will comply with ERISA requirements, including notification of rights granted by ERISA regulations.

Name of Policyholder:	City of Carson	Effective Date:
Life Policy No(s):	FLX967822	03/01/2017
Accident Policy No(s):	OK969324	03/01/2017
Disability Policy No(s):	LK752174 (STD) & Lk965343 (LTD)	03/01/2017
Accidental Injury Policy No(s):		
Critical Illness Policy No(s):		
Hospital Care Policy No(s):		

In general, any group insurance policy issued to an employer to insure employees, or to a labor union to insure union members, is subject to ERISA. **All policies will be considered to be subject to ERISA unless one of the following exemptions applies.**

- ☐ The policy is not issued to insure employees of an employer, or members of a labor union.
- ☐ The policy is a statutory disability policy (e.g. Hawaii, New Jersey, New York).
- ☑ The policyholder is a government employer (e.g. state, county, city, special services district, public school district, public hospital, state college or university).
- ☐ The policyholder is a church group (religious organization, or hospital, school, or college operated by a religious organization) which has not made an election under IRC Section 410(d) to be subject to ERISA.
- ☐ The plan is a short-term, uninsured salary continuance plan funded with general assets of the employer.
- ☐ The plan is voluntary, funded entirely with employee contributions, and is not enrolled or endorsed by the employer; employer participation is limited to permitting the insurance company to conduct enrollments, and handling payroll deductions.
- ☐ None of the above exemptions apply. The policy is issued as part of an ERISA-covered employee benefit plan. **If this is the case, then the Policyholder should sign the next page, "Appointment of Claim Fiduciary," instead of this page.**

Ashlinn O'Brien
Implementation Coordinator

2/10/17
Policyholder Representative

EMPLOYEE WELFARE BENEFIT PLAN APPOINTMENT OF CLAIM FIDUCIARY (For Use With Insured Benefits Only)

Name of Plan: City of Carson

Plan Number(s): LK965343

Plan Administrator: City of Carson

Claim Fiduciary: LIFE INSURANCE COMPANY OF NORTH AMERICA
CONNECTICUT GENERAL LIFE INSURANCE
COMPANY CIGNA LIFE INSURANCE COMPANY OF
NEW YORK

Plan Administrator hereby appoints the companies named above (collectively, "Claim Fiduciary") as the designated fiduciary for the review of claims for benefits under the Plan identified above, to the extent that such benefits are funded by policies of insurance issued by such companies ("Policies"). Claim Fiduciary hereby accepts this appointment. Claim Fiduciary shall discharge its duties hereunder in accordance with 29 CFR §2560.503-1, Claims Procedure, as revised effective January 1, 2002.

The Claim Fiduciary shall serve as such effective from and after the effective date of each of the Policies, even though signed subsequent to such effective date, and shall continue to serve in such capacity unless and until the Policies are no longer in force, provided, however that the Claim Fiduciary shall continue to serve as such after the Policies are no longer in force to the extent necessary to process any run-out claims under the Policies.

Within the scope of this appointment, Claim Fiduciary shall be responsible for adjudicating claims for benefits under the Plan, and for deciding any appeals of adverse claim determinations. Claim Fiduciary shall have the authority, in its discretion, to interpret the terms of the Plan, including the Policies; to decide questions of eligibility for coverage or benefits under the Plan; and to make any related findings of fact. All decisions made by such Claim Fiduciary shall be final and binding on Participants and Beneficiaries of the Plan to the full extent permitted by law. Plan Administrator shall include the foregoing in Summary Plan Descriptions furnished to Participants. Claim Fiduciary shall provide Plan Administrator with a form of Summary Plan Description, based on its standard Certificates of Insurance, which contains in substance the foregoing, in addition to a summary of the terms of the Policies. Plan Administrator is solely responsible for assuring that any form of Summary Plan Description which differs from the wording of the Summary Plan Description provided by Claim Fiduciary is consistent with the terms of the applicable Plan documents including the Policies. Plan Administrator shall provide Claim Fiduciary with copies of its Summary Plan Description for use of the Claim Fiduciary in discharging its duties as such. Plan Administrator hereby authorizes the issuance of appropriate amendments to any Policies to reflect this appointment and the authority and responsibility granted to the Claim Fiduciary.

This instrument does not authorize to Claim Fiduciary any fiduciary responsibility with respect to the administration of the Plan except as provided herein. It is understood that Claim Fiduciary's sole liability to the Plan and to Participants and Beneficiaries shall be for the payment of benefits provided with respect to Policies issued by Claim Fiduciary to the Plan.

For the Plan:

By: Kenneth Farfs Jr.
Title: City Manager
(Must be executed by a person authorized to amend the Plan)

For the Claim Fiduciary:

Officer Signature

Policy or Agreement Number(s):

FLX967822

OK969324

LK752174 (STD) & Lk965343 (LTD)