## **Agenda Summary Report (ASR)**

## Franklin County Board of Commissioners

DATE SUBMITTED: 10/7/2019	PREPARED BY: Carlee Nave
Meeting Date Requested: 10/15/2019	PRESENTED BY: Carlee Nave
ITEM: (Select One) X Consent Agenda	☐ Brought Before the Board Time needed:
SUBJECT: Premera Blue Cross Group Verification	on Report
FISCAL IMPACT: Budgeted Expense	
employee medical and dental insurance. The Groւ	al to move forward with Premera Blue Cross plans for 2020 up Master Verification Report is an administrative document e part of the Premera Health Care Contract for 2020.
RECOMMENDATION: Approve the resolution authorizing the Chair to	o sign the Report as the Group's Representative.
Nave, HR Director. Because the document will be	C Hanks at Conover insurance, in partnership with Carlee come part of the contract, legal review was requested, and . Johnson, Chief Civil Deputy Prosecuting Attorney/Risk
ATTACHMENTS: (Documents you are submitting to the Box	ard)
<ol> <li>Resolution</li> <li>Premera Blue Cross Group Verification Report</li> </ol>	
that will need a pdf)	l it will be imported into Document Manager. Please list <u>name(</u> s) of parties
n/a	

I certify the above information is accurate and complete.

Carlee Nave, HR Director

### FRANKLIN COUNTY RESOLUTION

# BEFORE THE BOARD OF COMMISSIONERS FRANKLIN COUNTY, WASHINGTON

#### 2020 PREMERA BLUE CROSS GROUP VERIFICATION REPORT

WHEREAS, the Board of Franklin County Commissioners has selected Premera Blue Cross plans for 2020 employee medical and dental insurance; and

WHEREAS, Premera Blue Cross requires a Group Verification Report for new plans; and

WHEREAS, the Group Verification Report will become part of the 2020 Premera Blue Cross contract to provide health care coverage; and

WHEREAS, the Board of Franklin County Commissioners constitutes the legislative authority of Franklin County.

**NOW, THEREFORE, BE IT RESOLVED** the Premera Blue Cross Group Verification Report is approved by the Board of Franklin County Commissioners.

**AND, BE IT FURTHER RESOLVED** the Board of Franklin County Commissioners authorizes the Chair of the Board to sign the Premera Blue Cross Group Verification Report as the Group's Representative.

APPROVED this day of	, 2019.
	BOARD OF COUNTY COMMISSIONERS FRANKLIN COUNTY, WASHINGTON
	Chair
	Chair Pro Tem
	Member
ATTEST:	
Clerk to the Board	_



### **Group Verification Report (Application)**

Please review and note any changes in the Revisions / Additions column.

Group Number:

4012688

Effective Date From: 01/01/2020 To: 12/31/2020

	oup Information		Revisions / Additions
A.	Legal Name	Franklin County	
	Common Name	Franklin County	
	Physical Address	1016 N 4TH AVE,	
	City, State, Zip	PASCO, WA, 99301	
В.	Mailing Address	1016 N 4TH AVE.	
	City, State, Zip	PASCO, WA, 99301	
C.	Sub Group Name	Franklin County - Franklin County	
Ο.	Billing Address		Peter Gadomskiy
	City, State, Zip	1016 N 4TH AVE,	509-545-3556
		PASCO, WA, 99301	pgadomskiy@co.franklin.wa.u
	Billing Contact Name	ROSA GOMEZ	pgadomskiy@co.mankim.wa.u.
	Billing Contact Phone	5095453505Ext6096	
	Billing Contact Email	rgomez@co.franklin.wa.us	
	Billing Contact Fax		
	Sub Group Name	Franklin County - LEOFF 1 Retirees	
	Billing Address	1016 N 4TH AVE,	
	City, State, Zip	PASCO, WA, 99301	
	Billing Contact Name	DONNA-CRISP	The second secon
	Billing Contact Phone	5095465813	Human Resources
	Billing Contact Email	dscrisp@co.franklin.wa.us	hr@co.franklin.wa.us
	Billing Contact Fax	dochop@oo.narmmi.tra.ao	ili@co.irankiiii.wa.us
	Sub Group Name	Franklin County - Retirees	
	Billing Address	PO BOX 10088.	
	City, State, Zip		
	Billing Contact Name	YAKIMA, WA, 98909	
		TERESA HARPER	No. 1 Table 1
	Billing Contact Phone	5099727417	
	Billing Contact Email	teresah@verdeservices.com	
	Billing Contact Fax		
	Sub Group Name	Franklin County - COBRA	
	Billing Address	PO BOX 10088,	
	City, State, Zip	YAKIMA, WA, 98909	2 Table 1 Tabl
	Billing Contact Name	TERESA HARPER	
	Billing Contact Phone	5099727417	
	Billing Contact Email	teresah@verdeservices.com	
	Billing Contact Fax		
).	Benefit Administrator Information		
	Billing Address	1016 N 4TH AVE	
	City, State, Zip	PASCO, WA 99301	
	Benefit Administrator Contact Name	CARLEE NAVE	
	Benefit Administrator Phone	5095465817	
	Benefit Administrator Phone Benefit Administrator Email		the same of the sa
		cnave@co.franklin.wa.us	
_	Benefit Administrator Fax	IOADEL DALIENA	
Ξ.	Other Contact Person Name	ISABEL BAHENA	
	Other Contact Person Phone	5095465813	
	Other Contact Person Email	ibahena@co.franklin.wa.us	
	Other Contact Person Fax		
	Other Contact Person Name	DONNA CRISP	
	Other Contact Person Phone	5095465813	
	Other Contact Person Email	dscrisp@co.franklin.wa.us	
	Other Contact Person Fax		

	Other Contact Person Name Other Contact Person Phone Other Contact Person Email Other Contact Person Fax Other Contact Person Name Other Contact Person Phone Other Contact Person Email Other Contact Person Fax	RAUL RAMIREZ-HERNANDEZ 5095453355 rramirez@co.franklin.wa.us  ERIC WYANT 5095465813 ewyant@co.franklin.wa.us	
F.	COBRA Administrator Information (bill will be sent to this address) Billing Address City, State, Zip COBRA Administrator Contact Name COBRA Administrator Phone COBRA Administrator Email COBRA Administrator Fax	None on file	Verde Services Teresa Harper PO Box 10088, Yakima, WA 98909 509-972-7417 teresah@verdeservices.com
G.	Employer Identification Number Type of Business SIC # NAICS #	916001315 General Government, NEC 9199 921190	
Company of the last	ss Information		
Emp	oloyee Eligibility Requirements		
Α.	All employees who work a minimum of:	20.77 Hour(s) per Week	<b>C</b>
	Specific class or classes:	Appraisers	
B.	Employee probationary period - all eligible employees are effective on the:	First day of the Month following Date of Hire	

Domestic partners coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation of coverage.

subscription is paid

Other

Last day of the month for which

If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners please contact your sales representative. If your group is self-funded please contact your sales representative for your options.

Group Notes: Only state registered domestic partners are eligible .

 $\checkmark$ 

C. Coverage will end:

	ployee Participation and Employe	r				5		
	tribution Requirements The minimum eligible employee		************	100		Kev	visions / Add	itions
	participation requirement is:			100				
	The minimum eligible dependent participation requirement is:			0				
В.	Effective date of contribution:			01/01/2020				
	(month/day/year)	Medic	cal	Dental	Vision	Medical	Dental	Vision
C.	The employer will contribute the following percentage or dollar amount toward the		%	100%	0%			
	cost of eligible employee coverage: The employer will contribute the following percentage or dollar amount toward the							
	cost of spouse / domestic partner coverage:	0%	٠	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:			0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or mor coverage:	9 0%		0%	0%			
	Please Note: If you differentiate contril	butions by clas	ss of e	employee, those	same classes	must be repres	sented here.	4
	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be			☑ No tier of coverage	e has decrease	d by more than	s 5 percentage	points since
Clas	ss Information							
Emp	loyee Eligibility Requirements							
Α.	All employees who work a minimum of:	0 Hour(s) pe		ek			Ar Dalla	
В.	Specific class or classes:  Employee probationary period - all eligible employees are effective on the:	Under Age 6 First day of t		onth following D	ate of Hire	Under Ag	e 65 Retiree	
C.	Coverage will end:		criptio	f the month for v n is paid	which			·
D.	Domestic partners coverage is standa same sex, opposite sex, and state reg eligibility for COBRA continuation of co	istered will be overage.	consi	dered eligible d	ependents. Do	mestic partner	eligibility will in	clude
	If you would like to limit domestic partic coverage for domestic partners please representative for your options.							
	Group Notes: Only state registered domestic partners are e	eligible ,		\$40.00 A \$40				

En	ployee Participation and Employ	/er						
Co	ntribution Requirements					Rev	isions / Add	litions
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	participation requirement is:		1	V				
	The minimum eligible dependent participation requirement is:			0				
В.	Effective date of contribution:							
	(month/day/year)			01/01/2020				
			Medical	Dental	Vision	Medical	Dental	Vision
C.	The employer will contribute the follow	wing				,ouioui	Dentai	VISIOII
	percentage or dollar amount toward the	he	0%	0%	0%			
	cost of eligible employee coverage: The employer will contribute the follow							
	percentage or dollar amount toward the	wing					Comment of the commen	
	cost of spouse / domestic partner		0%	0%	0%			
	coverage:							
	The employer will contribute the follow							
	percentage or dollar amount toward th	ne	0%	0%	0%			
	cost of dependent child (1 child)		070	0,0	0 /0		.0	
	coverage: The employer will contribute the follow	vina						
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	coverage:							
	Please Note: If you differentiate contri	ibutions	s by class of e	employee, those	same classes	must be repres	ented here.	
D.	Has the employer contribution towards							<u> </u>
υ.	the cost of any tier of coverage been	s		☐ Yes				
	decreased by more than 5 percentage	,		⊠ No				
	points since March 23, 2010							
		1			1			
	Note: If the Employer contribution tow	ards th	e cost of any	tier of coverage	haa daaraaaad	h	F	
	March 23, 2010, the plan ceases to be	e grand	fathered.	nor or coverage	nas decreased	by more man	o percentage p	oints since
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Cla	ss Information							
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	All employees who work a minimum	0.115	(-)					
Α.	of:	U HOI	ur(s) per Weel	K				
	Specific class or classes:	LEOF	FF 1 Retirees					-
B.	Employee probationary period - all			nth following Dat	te of Hire			
	eligible employees are effective on		•		· · · · · · ·			
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C.	Coverage will end:	[2]	Look deres	the meaning of				
			subscription	the month for wh	nich			
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D.	Domestic partners coverage is standar	rd for a	Il fully insured	groups with 51	or more employ	yees. All dome	stic partners, ir	ncluding
	same sex, opposite sex, and state regi	istered	will be consid	lered eligible der	pendents. Dom	estic partner el	igibility will incl	lude
	eligibility for COBRA continuation of co	overage	<del>.</del>					
	If you would like to limit domestic partn	ner cov	erage to state-	-registered dome	estic partners a	nd/or choose r	not to extend C	ORRA
	coverage for domestic partners please	contac	ct your sales re	epresentative. If	your group is s	self-funded plea	ase contact voi	ur sales
	representative for your options.					p.00	and the second second	
	Group Notes: Only state registered demonits and as	iaibla						
	Group Notes: Only state registered domestic partners are elig	yible .						

Em	oloyee Participation and Employe	r				The state of the s	
	tribution Requirements				Rev	risions / Add	itions
A.	The minimum eligible employee participation requirement is:		100				
	The minimum eligible dependent participation requirement is:		0			ACTOR	
В.	Effective date of contribution:		01/01/2020				
	(month/day/year)	Medical	Dental	Vision	Medical	Dental	Vision
C.	The employer will contribute the following percentage or dollar amount toward the	ng	0%	0%	Miculai	Dentai	VISION
	cost of eligible employee coverage: The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:		0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more coverage:	00/	0%	0%			
	Please Note: If you differentiate contrib	outions by class of	f employee, those	same classes	must be repres	sented here.	
D.	Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towards March 23, 2010, the plan ceases to be		☐ Yes ☑ No ny tier of coverage	e has decrease	d by more than	5 percentage	points since
Clas	ss Information						
Emp	loyee Eligibility Requirements						
Α.	All employees who work a minimum of:	40 Hour(s) per V	Veek		30 hours	per week	
В.	Specific class or classes:  Employee probationary period - all eligible employees are effective on the:	Corrections First day of the M	Month following D	ate of Hire			•
C.	Coverage will end:		of the month for tion is paid	which			
D.	Domestic partners coverage is standar same sex, opposite sex, and state reg eligibility for COBRA continuation of co	istered will be con					
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	Group Notes: Only state registered domestic partners are of	eligible ,					

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	The minimum eligible employee				water a service of the service	Rev	visions / Add	itions
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	The minimum eligible dependent			_				
	participation requirement is:			0				
В.	Effective date of contribution:			01/01/2020				
	(month/day/year)				risioner a single property of the same of			
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	cost of eligible employee coverage:		.0070	100%	0 /8			
	The employer will contribute the follow	ving						
	percentage or dollar amount toward the	ne	0%	0%	0%			
	cost of spouse / domestic partner coverage:		0,0	0,0	0 /6			
	The employer will contribute the follow	vina						
	percentage or dollar amount toward th	ne						
	cost of dependent child (1 child)		0%	0%	0%			
	coverage:							
	The employer will contribute the follow	ving						
	percentage or dollar amount toward the cost of dependent children (2 or more		0%	0%	0%			
	coverage:	16)						
	Please Note: If you differentiate contri	ibutions	by class of e	emplovee, those	same classes	must he renres	ented here	
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D.	Has the employer contribution towards the cost of any tier of coverage been	S		□ <b>v</b>			The state of the s	
	decreased by more than 5 percentage	. 1		☐ Yes Й No				
	points since March 23, 2010							
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	Note: If the Employer contribution tow	ards th	e cost of any	tier of coverage	has dooroos	by more than	F	
	March 23, 2010, the plan ceases to be	grand	fathered.	iici oi coverage	nas decreased	by more than	o percentage p	oints since
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Clas	s Information			VA				
-	loyee Eligibility Requirements	T						
A.	All employees who work a minimum	20.77	Hour(s) per V	Neek				
	of:			, voca				
	Specific class or classes:	Court	house					
В.	Employee probationary period - all	First	day of the Mor	nth following Dat	te of Hire			
	eligible employees are effective on the:							
C.	Coverage will end:							
		$\square$	Last day of t	the month for wh	nich			
			subscription					
			Other					
D.	Domestic partners coverage is standar	rd for al	I fully incured	groupe with E4	or more emple	(000 All	-4'	1 "
	same sex, opposite sex, and state regi	istered	will be consid-	ered eligible der	or more employ	yees. All dome	stic partners, in	cluding
	eligibility for COBRA continuation of co	verage		sa sagible dep	o.idenia. Delli	canc barrier er	iAmilità Mili IUCI	uue
		_						
	If you would like to limit domestic partners please	CONTAC	rage to state-	registered dome	estic partners a	nd/or choose r	ot to extend Co	OBRA
	coverage for domestic partners please representative for your options.	CONTRO	t your sales re	epresentative. If	your group is s	ent-tunded plea	ase contact you	ır sales
	, Joan opnone.							V 4
Gro	up Notes: Only state registered domestic partners are eligible	э.						

016588 (01-2019)

	ployee Participation and Employentribution Requirements				Rev	visions / Add	litions
۹.	The minimum eligible employee participation requirement is:		100				
	The minimum eligible dependent participation requirement is:		0			***************************************	
3.	Effective date of contribution: (month/day/year)		01/01/2020				
-	(montuuday/year)	Medical	Dental	Vision	Medical	Dental	Visio
С.	The employer will contribute the follow percentage or dollar amount toward the cost of eligible employee coverage:	e 100%	100%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	e 0%	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	e 0%	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or mor coverage:  Please Note: If you differentiate contribute the following percentage of the contribute of the con	e 0%	0%	0%			
).	Has the employer contribution towards		□ Ves				
<b>O</b> .	Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towards and the Employer contribution towards 23, 2010, the plan ceases to be	ards the cost of a	☐ Yes ဩ No ny tier of coverage	e has decrease	d by more than	5 percentage	points sin
las	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution town March 23, 2010, the plan ceases to be see Information	ards the cost of a	⊠ No	e has decrease	d by more than	5 percentage	points sin
:las	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution town March 23, 2010, the plan ceases to be see Information	ards the cost of a grandfathered.	⊠ No	e has decrease	d by more than	5 percentage	points sin
mp	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution town March 23, 2010, the plan ceases to be see Information  loyee Eligibility Requirements  All employees who work a minimum of:	ards the cost of a	⊠ No	e has decrease	d by more than	5 percentage	points sin
mp A.	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution town March 23, 2010, the plan ceases to be see Information ployee Eligibility Requirements All employees who work a minimum	ards the cost of a grandfathered.  20.77 Hour(s) F	⊠ No  ny tier of coverage  er-Week			5 percentage	
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ila:	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tows March 23, 2010, the plan ceases to be see Information  See Information  All employees who work a minimum of:  Specific class or classes:  Employee probationary period - all eligible employees are effective on the:	20.77 Hour(s) F  Public Works (t  First day of the  Last day subscrip Other  rd for all fully instituted will be cooverage.	iny tier of coverage  our Week  Courthouse)  Month following Description is paid  ured groups with 5- insidered eligible descriptions	ate-of-Hire  which  or more emplependents. Do	This class will be oyees. All dommestic partner of and/or choose	estic partners, eligibility will in	including clude

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Co	ntribution Requirements	·				Pos	visions / Add	litions
Α.	The minimum eligible employee					Ke	visions / Add	itions
	participation requirement is:			100				
	The minimum eligible dependent			0				
	participation requirement is:			U				
B.				01/01/2020				
	(month/day/year)			,	•			
C	The employer will contribute the follow	wing	Medical	Dental	Vision	Medical	Dental	Vision
٥.	percentage or dollar amount toward th	villy ne	100%	100%	0%			
	cost of eligible employee coverage:		100 /0	100%	0%			
-	The employer will contribute the follow	vina						
	percentage or dollar amount toward th	ne	00/					~ *
	cost of spouse / domestic partner		0%	0%	0%			
	coverage:	1						
	The employer will contribute the follow	ving.						
	percentage or dollar amount toward th	ne	0%	0%	0%			
	cost of dependent child (1 child) coverage:			0,0	0 70			
	The employer will contribute the follow	ring						
	percentage or dollar amount toward th	ie						
	cost of dependent children (2 or mor	re)	0%	0%	0%			
	coverage:							
	Please Note: If you differentiate contri	ibutions t	y class of e	mployee, those	same classes i	must be repres	sented here.	
D.	Has the employer contribution towards	5						The second secon
	the cost of any tier of coverage been			☐ Yes ☑ No				
	decreased by more than 5 percentage points since March 23, 2010			L4 NO				
	points since March 25, 2010							
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	Note: If the Employer contribution tow	ards the	cost of any	tier of coverage	has decreased	by more than	5 percentage p	oints since
	March 23, 2010, the plan ceases to be	grandra	inerea.					
Clas	ss Information			AND THE PROPERTY OF THE PARTY O				Manuscript of the Parks
Emp	loyee Eligibility Requirements							
	All employees who work a minimum	40 Hou	r(s) per Wee	ek		20 hausa		
	of:		·(-/ po			30 hours	per week	
	Specific class or classes:	Deputie	es					
В.	Employee probationary period - all	First da	y of the Mor	nth following Dat	te of Hire			
	eligible employees are effective on							
	the:							
U.	Coverage will end:		l act day of	the month for	rich			
			subscription	the month for wh	IICN			
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D.	Domestic partners coverage is standar	rd for all f	fully insured	groups with 51	or more employ	yees. All dome	stic partners, ir	ncluding
	same sex, opposite sex, and state regi	istered w	ill be consid	ered eligible der	pendents. Dom	estic partner e	ligibility will incl	ude
	eligibility for COBRA continuation of co	overage.					3000	
	If you would like to limit domestic partn	er cover	ane to state.	registered dome	actic nastrose -	nd/or observe		ODDA
	coverage for domestic partners please	contact	vour sales r	enresentativa If	vour group is a	riu/or choose r	ior to extend C	UBRA
	representative for your options.		,	-procentative. If	Jour group is s	en-iunueu piei	ase contact you	ıı Saies
					У.			
0	Group Notes: Only state registered domestic partners are eligib	ble .						
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	ployee Participation and Employentribution Requirements	er			Rev	visions / Add	itions
A.	The minimum eligible employee participation requirement is:		100	W	, , , ,	AUGIONS / Aug	itions
	The minimum eligible dependent		0	William I was a second of the			
В.	participation requirement is:  Effective date of contribution:						
	(month/day/year)		01/01/2020		ļ.,	<del></del>	
C.	The employer will contribute the follow	Medical ing	Dental	Vision	Medical	Dental	Vision
	percentage or dollar amount toward the cost of eligible employee coverage:		100%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of spouse / domestic partner coverage:	e 0%	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	e 0%	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or mor coverage:	e 0%	0%	0%			
	Please Note: If you differentiate contri	butions by class of	employee, those	same classes	must be repres	sented here.	A
D.	Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage		☐ Yes				
	points since March 23, 2010  Note: If the Employer contribution town March 23, 2010, the plan ceases to be	ards the cost of an	☑ No y tier of coverage	e has decrease	d by more than	5 percentage	points since
-	points since March 23, 2010  Note: If the Employer contribution town March 23, 2010, the plan ceases to be see Information	ards the cost of an		e has decrease	d by more than	5 percentage	points since
Emp	Note: If the Employer contribution town March 23, 2010, the plan ceases to be ss Information bloyee Eligibility Requirements All employees who work a minimum	ards the cost of an	y tier of coverage	e has decrease	d by more than		points since
Emp	points since March 23, 2010  Note: If the Employer contribution town March 23, 2010, the plan ceases to be see Information	ards the cost of an grandfathered.	y tier of coverage	e has decrease			points since
Emp	Note: If the Employer contribution town March 23, 2010, the plan ceases to be  ss Information Bloyee Eligibility Requirements All employees who work a minimum of: Specific class or classes: Employee probationary period - all eligible employees are effective on	ards the cost of an grandfathered.  40 Hour(s) per W	y tier of coverage				points since
Emp A.	Note: If the Employer contribution town March 23, 2010, the plan ceases to be  ss Information Hoyee Eligibility Requirements All employees who work a minimum of: Specific class or classes: Employee probationary period - all	ards the cost of an grandfathered.  40 Hour(s) per W Elected First day of the M	y tier of coverage  /eek  Ionth following De	ate of Hire			points since
A. B.	Note: If the Employer contribution town March 23, 2010, the plan ceases to be  ss Information Bloyee Eligibility Requirements All employees who work a minimum of: Specific class or classes: Employee probationary period - all eligible employees are effective on the:	ards the cost of an grandfathered.  40 Hour(s) per W Elected First day of the M  Last day of subscripti Other  rd for all fully insur- istered will be consistered.	y tier of coverage  /eek  Ionth following Di of the month for von is paid	ate of Hire  which	30 hours p	er week	includina

	ployee Participation and Employ ntribution Requirements				Rev	isions / Add	itions
A.	The minimum eligible employee participation requirement is:		100				
	The minimum eligible dependent						
	participation requirement is:		0				
B.	Effective date of contribution: (month/day/year)		01/01/2020				
		Medical	Dental	Vision	Medical	Dental	Visio
C. —	The employer will contribute the follow percentage or dollar amount toward th cost of eligible employee coverage:	e 100%	100%	0%			
	The employer will contribute the follow percentage or dollar amount toward th cost of spouse / domestic partner coverage:	0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward th cost of dependent child (1 child) coverage:	e 0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward th cost of dependent children (2 or mor coverage:	e 00/	0%	0%			
	Please Note: If you differentiate contri	butions by class of e	mployee, those	same classes	must be repres	sented here.	
J.	the cost of any tier of coverage been	3	☐ Yes				
<b>.</b>	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be	ards the cost of any	☐ Yes ☐ No	has decreased	d by more than	5 percentage p	points sinc
	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be	ards the cost of any		has decreased	d by more than	5 percentage p	points sinc
llas	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be see Information	ards the cost of any		has decreased	d by more than	5 percentage p	ooints sinc
ilas	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be see Information  loyee Eligibility Requirements  All employees who work a minimum	ards the cost of any	tier of coverage	has decreased	d by more than	5 percentage p	points sinc
Clas	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be see Information loyee Eligibility Requirements All employees who work a minimum of:	ards the cost of any grandfathered.	tier of coverage	has decreased	d by more than	5 percentage p	points sinc
mp A.	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be see Information  loyee Eligibility Requirements  All employees who work a minimum	ards the cost of any grandfathered.	tier of coverage		d by more than	5 percentage p	points sinc
mp A. B.	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be seen to be seen the seen to be see	ards the cost of any grandfathered.  20 Hour(s) per We  Non-Bargs  First day of the Mo	tier of coverage ek  nth following Da	te of Hire	I by more than	5 percentage p	points sinc
Clas	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be see Information  loyee Eligibility Requirements All employees who work a minimum of:  Specific class or classes:  Employee probationary period - all eligible employees are effective on the:	ards the cost of any grandfathered.  20 Hour(s) per We  Non-Bargs  First day of the Mo  Last day of subscription  Other  rd for all fully insured istered will be considered.	ek  the month for what is paid	te of Hire	vees. All dome	estic partners ii	ncluding

	ployee Participation and Employentribution Requirements	er				Dec		1141
A.	The minimum eligible employee			100	The state of the s	Kev	isions / Add	itions
	participation requirement is: The minimum eligible dependent			100				
	participation requirement is:			0				
В.	Effective date of contribution:			01/01/2020				
	(month/day/year)	Med	ical	Dental	Vision	Medical	Dontal	Vision
C.	The employer will contribute the follow		licai	Dentai	VISION	Wedicai	Dental	Vision
	percentage or dollar amount toward the		)%	100%	0%			
	cost of eligible employee coverage:  The employer will contribute the follow	ing						
	percentage or dollar amount toward the	_	.,	00/	00/			
	cost of spouse / domestic partner	09	70	0%	0%			
	coverage: The employer will contribute the follow	ina						
	percentage or dollar amount toward the		2/	0%	0%			
	cost of dependent child (1 child)	0	/0	0%	076			
-	coverage: The employer will contribute the follow	ina						
	percentage or dollar amount toward the	9 09	2/	0%	0%			
	cost of dependent children (2 or mor	e)	/0	0%	076			
	coverage:  Please Note: If you differentiate contri	hutions by cla	ass of	emolovee those	same riesses	must be repres	sented here	
D.	Has the employer contribution towards							
	the cost of any tier of coverage been			☐ Yes				
	decreased by more than 5 percentage points since March 23, 2010			Ď No				
	pointe direct March 20, 2010	1				I		
	Note: If the Employer contribution tow	arde the coet	of any	tier of coverage	has decrease	d by more than	5 percentage	nointe sinco
	March 23, 2010, the plan ceases to be			tion of coverage	1140 40010400	a by more than	o percentage	points since
Cla	ss Information							<del></del>
Emp	loyee Eligibility Requirements			THE TAXABLE PARTY OF THE PARTY				ACCORDANGE OF THE SAME
A.	All employees who work a minimum of:	20 Hour(s)	per We	eek			Ja. (1)	
	Specific class or classes:	Sherrif's Cl	erical			Sheriff's S	Support	
В.	Employee probationary period - all eligible employees are effective on	First day of	the Mo	onth following Da	ate of Hire			
C.	the: Coverage will end;							
				f the month for w	vhich			
		sub:		on is paid		1		
		Oun	EI .					
D.	Domestic partners coverage is standa same sex, opposite sex, and state reg eligibility for COBRA continuation of co	istered will be						
	If you would like to limit domestic partrecoverage for domestic partners please representative for your options.							
		-	i sales	тергезептатіче.	ii youi group k	sell-lunded pl	ease contact y	our sale

	ployee Participation and Employ ntribution Requirements					Rev	isions / Add	itions
A.	A. The minimum eligible employee participation requirement is:			100				
	The minimum eligible dependent participation requirement is:		***************************************	0		1		
В.				01/01/2020				
		Me	edical	Dental	Vision	Medical	Dental	Vision
C.	The employer will contribute the follow percentage or dollar amount toward the cost of eligible employee coverage:	he 1	00%	100%	0%	inicalcar	Demai	VISIO
	The employer will contribute the follow percentage or dollar amount toward the cost of spouse / domestic partner coverage:	he	0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of dependent child (1 child) coverage:	ne (	0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of dependent children (2 or mo coverage:	re)	0%	0%	0%			
	Please Note: If you differentiate contr	ributions by c	class of er	nployee, those	same classes i	nust be repres	ented here.	
D.	Has the employer contribution towards the cost of any tier of coverage been	S						
	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be	ards the cos	st of any ti	☐ Yes ☑ No er of coverage	has decreased	by more than	5 percentage p	oints since
loc	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be	ards the cos	et of any ti	⊠ No	has decreased	by more than a	5 percentage p	oints since
NAME OF TAXABLE PARTY.	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be as Information	ards the cos	st of any ti red.	⊠ No	has decreased	by more than	5 percentage p	oints since
mp	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be selected in the selected size of th	ards the cos	rea.	⊠ No er of coverage	has decreased	by more than	5 percentage p	oints since
mp	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be a light of the second	vards the cos e grandfather	per Wee	⊠ No er of coverage l	has decreased	by more than	5 percentage p	oints since
mp A.	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be a second secon	vards the cose grandfather	per Wee	⊠ No er of coverage l		by more than	5 percentage p	oints since
тр А. В.	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be seen to be seen the seen to be see	20 Hour(s) Public Wor	per Weeks (Non If the Mon	er of coverage l	e-of-Hire	by more than	5 percentage p	oints since
mp A.	decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be seen to be s	vards the cose grandfather  20 Hour(s)  Public Wor  First day of  □ Las sub □ Oth  rd for all fully istered will b	per Weeks (Non I	er of coverage less args) th following Datase month for whis paid	e-of-Hire	vees All domes	tio portners in	

Jor	ployee Participation and Employe stribution Requirements				Rev	isions / Add	itions
	The minimum eligible employee participation requirement is:		100				
	The minimum eligible dependent participation requirement is:		0				
3.	Effective date of contribution: (month/day/year)		01/01/2020	1000			11.5
		Medical	Dental	Vision	Medical	Dental	Visio
C.	The employer will contribute the following percentage or dollar amount toward the cost of eligible employee coverage:	100%	100%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of spouse / domestic partner coverage:	0%	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
	The employer will contribute the following percentage or dollar amount toward the cost of dependent children (2 or more coverage:	9 0%	0%	0%			
	Please Note: If you differentiate contrib	butions by class	of employee, those	same classes	must be repre	sented here.	
D.	Has the employer contribution towards		□ Vaa				
Ö.	Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towards and the Employer contribution towards 23, 2010, the plan ceases to be	ards the cost of a	☐ Yes ☐ No	has decrease	d by more than	5 percentage	points sind
Clas	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towarch 23, 2010, the plan ceases to be see Information	ards the cost of a	⊠ No	has decrease	d by more than	5 percentage	points sinc
Clas	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towarch 23, 2010, the plan ceases to be as Information ployee Eligibility Requirements	ards the cost of a	☑ No	has decrease	d by more than	5 percentage	points sind
Clas	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towarch 23, 2010, the plan ceases to be see Information  Note: If the Employer contribution towarch 23, 2010, the plan ceases to be see Information  Note: If the Employer contribution towarch 23, 2010, the plan ceases to be see Information  Note: If the Employer contribution towarch 23, 2010, the plan ceases to be see Information  Note: If the Employer contribution towarch 23, 2010	ards the cost of a grandfathered.	☑ No	has decrease	d by more than	5 percentage	points sinc
Clas	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towarch 23, 2010, the plan ceases to be see Information ployee Eligibility Requirements All employees who work a minimum	ards the cost of a grandfathered.  O Hour(s) per V	☑ No		d by more than	5 percentage	points sind
Clas	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tows March 23, 2010, the plan ceases to be see Information  Note: Eligibility Requirements All employees who work a minimum of:  Specific class or classes:  Employee probationary period - all eligible employees are effective on	o Hour(s) per V  Retiree  First day of the	☑ No  any tier of coverage	ate of Hire	d by more than	5 percentage	points sind
Classing A.	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution towards March 23, 2010, the plan ceases to be see Information  Dioyee Eligibility Requirements All employees who work a minimum of:  Specific class or classes:  Employee probationary period - all eligible employees are effective on the:	ards the cost of a grandfathered.  O Hour(s) per V  Retiree  First day of the  Last da subscriction Other  rd for all fully insistered will be consistered.	No  any tier of coverage  Veek  Month following Day  y of the month for wotion is paid	ate of Hire  which	loyees. All dom	nestic partners,	including

	ployee Participation and Employ ntribution Requirements	ei .			Rev	isions / Add	litione
A.	The minimum eligible employee participation requirement is:		0	H. Marian and A.	, not	/ISIONS / Add	itions
	The minimum eligible dependent participation requirement is:		0				
3.	Effective date of contribution: (month/day/year)	,	01/01/2020				
C.	The employer will contribute the follow percentage or dollar amount toward the cost of eligible employee coverage:	wing ne 0%	Dental 0%	Vision 0%	Medical	Dental	Visio
	The employer will contribute the follow percentage or dollar amount toward the cost of spouse / domestic partner coverage:	ne 0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of dependent child (1 child) coverage:	0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of dependent children (2 or molecoverage:	ne 0%	0%	0%			
	Please Note: If you differentiate contri	ibutions by class of	employee, those	same classes	must be repres	ented here.	
`							
).	Has the employer contribution towards the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be	ards the cost of an	☐ Yes ☒ No	has decreasec	by more than	5 percentage p	ooints sinc
	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be	ards the cost of an	⊠ No	has decreased	by more than	5 percentage p	ooints sinc
as	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be as Information	ards the cost of an	⊠ No	has decreased	d by more than	5 percentage p	ooints sinc
as	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be sometimes of the single since the single singl	ards the cost of an	☑ No y tier of coverage	has decreased	by more than	5 percentage p	ooints sinc
las	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be seen that the seen	ards the cost of an grandfathered.	☑ No y tier of coverage	has decreased			ooints sinc
las	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be sometimes of the single since the single singl	ards the cost of an grandfathered.	y tier of coverage  Week		by more than s		points sinc
las	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be seen that the seen	ards the cost of an grandfathered.  18.46 Hour(s) per Public Works (Lo	▼ Week  cal 874) onth following Date	e of Hire			points sinc
las	the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be seen that the seen	ards the cost of an a grandfathered.  18.46 Hour(s) per subscription of the Month o	y tier of coverage  Week cal 874) onth following Dat on the month for whom is paid	e of Hire	Roads (Lo	cal 874)	

	ployee Participation and Employ ntribution Requirements	er				Rev	risions / Add	itions
A. The minimum eligible employee participation requirement is:				100				1110110
	The minimum eligible dependent participation requirement is:			0				
В.	Effective date of contribution: (month/day/year)			01/01/2020				-
			Medical	Dental	Vision	Medical	Dental	Vision
C.	The employer will contribute the follow percentage or dollar amount toward the cost of eligible employee coverage:	ne	100%	100%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of spouse / domestic partner coverage:		0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of dependent child (1 child) coverage:		0%	0%	0%			
	The employer will contribute the follow percentage or dollar amount toward the cost of dependent children (2 or mo coverage:	ne	0%	0%	0%			
	Please Note: If you differentiate contr	ributions	by class of e	mplovee, those	same classe	es must be repres	sented here.	
	•		7.	, ,				
D.	Has the employer contribution toward the cost of any tier of coverage been decreased by more than 5 percentage points since March 23, 2010  Note: If the Employer contribution tow March 23, 2010, the plan ceases to be	vards th		☐ Yes ☑ No	e has decreas	sed by more than	5 percentage	points since
							21 21	
	Producer			1		Revisi	ons / Addition	ons
_A	Producer of record name:		GUYLL					
-	Producer number:	50954	er Insurance	Comisso II C				
	Firm / Agency name: Effective Date of the Producer	01/01/		Services LLC				
	Appointment:							
	Producer email address:		@conoverins					
	Commission:	\$12.00	PEPM Medi	cal / \$3.21 PEP	M Dental			
В.	Split Commission: Producer of record name:							
	Producer of record name: Producer number:				·			
	Commission:							
	CIIIIGOIGII.							
Com	plete/Verify the sections below							
-	ployee Enrollment							
A.	Total number of employees on payroll	l in the	orior calandar	vear: 302				
B.	Total number of eligible employees er	rollina:	274	year. 002				- Carrier Control
		····						

11	elpful Hint: We strongly urge you to consult lega ntended to be or to replace legal advice on your p nmediately if facts change which would cause th	particular group, It is the d	roun's responsibi	r. The summaries below are no lity to inform Premera Blue Cro
Α	. Is the group subject to the federal Medicare Second group coverage based on their (or a spouse's) cu	ondary Payer (MSP) laws tl urrent employment status w	hat prohibit discrimir /ho have Medicare d	nation against individuals with due to age?
1. 2.	to the plan will pay printary to McGicarc as	s required by federal law. ho now meet Medicare's de	☐ No. Under 20 e	employees. e."302
	Helpful Hint: These laws do not apply to any employer calendar weeks in either the current <b>or</b> preceding caler "Employees" include all full-time and part-time empleased employees if they would be counted as employed by an "affiliated service group" under IRC §414(m) or b	ndar year. For these small grou ployees as well as those emplo ees under \$414(n)(2) of the Int	up plans, Medicare pay yees on disability and ternal Payonyo Codo (	ys primary to the group plan. subject to FICA taxes. Also count
В.	Is the group subject to COBRA?			
		on for exemption:		
	Helpful Hint: Generally, these laws apply to any non-ch the preceding calendar year. "Employees" are full-time and part-time common-law independent contractors should not be counted unless who qualify as common-law employees. Please see CC employee as a fraction of a full-time employee.	r employees. Self-employed wo	orkers as defined in IR	C §401(c)(1), corporate directors, or
C. 1. 2.	Is the group subject to the federal Medicare Seco group coverage based on their (or a family memb ☑ Yes. This plan will pay primary to Medicare as Please also provide the number of employees wh	er's) current employment s required by federal law	tatus who have Med	dicare due to disability?
	Helpful Hint: Generally, these laws apply to any employ preceding calendar year. See the helpful hint in A above	er that employed at least 100 o e for a definition of "employee"	employees on 50% or for this purpose.	more of its working days in the
D.	Is this group subject to ERISA?			
	☐ Yes, Enter the month the ERISA plan	year ends: Month		
	✓ No. Give the legal reason for exempti	ion: ☒ Governmeı ☐ Other, plea	nt or Public Plan	☐ Church Plan
	Helpful Hint: Generally, ERISA applies to all emp alone does not exempt an employer from ERISA	oloyer health plans except ( l.	governmental, public	c or church plans. Non-profit state
Gr	oup Materials  Important Note: Electronic copies of benefit boo	oklets are available online a	at <u>www.premera.co</u>	<u>om</u> .
Pro	ducer Agreement to Contract			
	You, the producer(s), certify that you have met wit contents. You have discussed coverage, eligibility charge billing administration.  Producer Signature	, the effect of misrepresent	agreement and that ations, termination p	t you have fully explained its provisions and subscription
		0		

Federal Requirements

#### **Group Agreement to Contract**

You, the group named in the Group Information section of this application, understand and agree to the following.

- A. This application becomes part of the contract to provide health care coverage after:
  - The application is signed by you;
  - · The application is received and approved by us; and
  - We receive the initial month's subscription charges

You may not assign this contract without our written consent. Any attempt to do so will not have any binding effect on us. You agree to promptly deliver materials and notifications, including benefit booklets, received from us to all covered employees. You attest to have read this application, and certify that all statements are true and complete. You agree to the terms and obligations stated in this application. It is understood that provisions of the Health Care Contract, including subscription charges, may be amended or changed from time to time, upon our notice to you. All prior applications, to the extent that you have not made changes to them in this application, remain in full force and effect. The agent/broker listed in The Producer section will remain effective until written notice is given by either party. We are authorized to pay, on your behalf, commission, if any, for which you are liable to the above named agent/broker.

- B. You may elect to allow the producer listed above to act as a group benefit administrator beginning on the group's first effective date. This means that the producer/administrator will be able to access membership and billing functions, and obtain information about group members via the Web on behalf of the group. These functions may include, but are not limited to:
  - Reinstate Terminated Members
  - Request Invoice
  - View Benefit Detail
  - Search for a member
- Inquire on Invoice
- Inquire on Eligibility
- Enroll a Member
- Order ID Cards for an Individual or Whole Family
- View Group Demographic Information
- Cancel a Member

Do you elect and authorize Premera Blue Cross to provide such information to the producer? (Producer authorized as Group Benefits Administrator?)

□ No Deres

C. I affirm that this Group has a physical location outside Clark County in the State of Washington, and I am authorized to sign on behalf of the group.

Signature of Group's Representat	ive			Date
Group's Representative (Print Nat	me)			Title
Please note: It is a crime to known of defrauding the company. Pena	wingly provide false, incomplete calties include imprisonment, fines	or mislead , and den	ding infor	rmation to an insurance company for the purpose purance benefits.
Tracking Information - To be co	empleted by Premera Blue Cros	s Washi	ngton	
Date Received by Sales	Information Complete	□Yes	□No	Date Missing Information Received
Account Manager_	Extension			Rep. Code

Approved as to form:
PROSECUTING ATTO HINEYS OFFICE