

# Group Plans — Employer Acceptance Agreement

## 1. EMPLOYER INFORMATION

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Employer: \_\_\_\_\_ Employer number: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

GuideStone Financial Resources of the Southern Baptist Convention (GuideStone) offers the Group Plans to eligible employees through eligible employers such as churches, agencies and other institutions. The Employer (“you”) wants eligible employees and/or retirees to participate in at least one of the Group Plans offered by GuideStone, and specifies details in this Employer Acceptance Agreement (“Agreement”).

## 2. AGREEMENT

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**By signing this Agreement, you agree to the following terms and conditions:**

1. You agree to the specific rates and benefits outlined in this document.
2. You agree that GuideStone sets and changes plan rates and benefits for Group Plans self-funded plans.
3. You understand that GuideStone can change or terminate the Group Plans or any of its plans or benefits at any time.
4. You understand that the Group Plans may include some insured products selected at the discretion of GuideStone. Insurance carriers may set and change rates and benefits for these products and may stop offering them at any time.
5. You represent that the person signing the Agreement has full legal authority to sign it and that you have followed the correct church, corporate or legal procedures to adopt this Agreement.
6. You agree to the plan language, terms and conditions of each Group Plans plan you adopt.
7. You agree to promptly pay GuideStone for Group Plans coverage. Non-payment could result in termination of coverage.
8. You agree that any employee you enroll in the Group Plans is eligible by working at least the number of hours in your normal full-time workweek but not less than 20 hours per week.
9. You agree that all employees and dependents you enroll in Group Plans meet the eligibility rules for the Plan(s). Your failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s) and you may be required to reimburse GuideStone, at its sole discretion, for claims paid on behalf of ineligible enrollees.
10. You represent that you meet the minimum participation requirements of the Group Plans, and that you will continue to maintain those requirements. If you no longer meet them, you will report this to your Insurance Operations customer service representative.
11. You agree to follow all administrative procedures required by GuideStone or insurance carriers and to promptly give GuideStone the information it needs in the format it needs to administer the Group Plans. Here is some of the information you must give GuideStone:
  - The names and addresses of all eligible employees, retirees and qualified dependents, and additions, deletions or changes to those names and addresses.
  - Employee marital status, salary information and changes to that and other information that would affect an employee’s Group Plans participation.
  - Beneficiary designations and changes.
  - Notification of different employee or retiree classes you use to determine eligibility for benefits and changes to those classes, including available plans, waiting periods for plan participation, any contribution arrangements you choose for each class and any changes to these arrangements.
12. You agree to comply with any legal requirements that apply to your choice of Group Plans coverage and classes. Employers must use job classes that are non-discriminatory. For example, employers may classify employees as ministerial or non-ministerial, but they may not classify employees by race or gender.
13. You agree to promptly send completed enrollment change forms to GuideStone and to request changes in writing. The enrollments and changes will be made only when GuideStone receives and approves them.
14. Other than giving general information about the plans, you agree not to interpret plan language. You also agree to instruct your employees not to interpret plan language, but to refer questions about benefits to the claims administrator of each plan. The claims administrators are identified in each plan.
15. You can voluntarily terminate your adoption of the Group Plans by taking all of these actions: 1) Having your governing body decide to terminate it; 2) Informing your employees and retirees about the change in writing; and 3) Informing GuideStone about the termination by giving at least 31 days notice in writing.



# Group Plans Employer Acceptance Agreement

## EMPLOYER INFORMATION

Employer name: \_\_\_\_\_ Employer number: \_\_\_\_\_

Authorized contact name/title: \_\_\_\_\_

Billing/eligibility contact name/title: \_\_\_\_\_

Employer address: \_\_\_\_\_

City/county: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Phone number: (\_\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_ Fax number: (\_\_\_\_\_) \_\_\_\_\_

Employer Tax ID (EIN): \_\_\_\_\_ E-mail: \_\_\_\_\_

Indicate one or more:  New account  Transfer from Personal Plans\*  Existing account  Class/contribution change  Plan change  Add coverage

Effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee classes:\* Class 1 \_\_\_\_\_ Class 2 \_\_\_\_\_ Class 3 \_\_\_\_\_

Waiting period:\* Class 1 \_\_\_\_\_ Class 2 \_\_\_\_\_ Class 3 \_\_\_\_\_

Medical continuation provision offered?  Yes  No Dental continuation provision offered?  Yes  No

Rating group: \_\_\_\_\_ Hours for full time: \_\_\_\_\_ Geo area: \_\_\_\_\_ SBC entity:  Yes  No

## LIFE, ACCIDENT AND DISABILITY COVERAGE OPTIONS\*

	Class 1		Class 2					
	Total eligible	Total enrolled (GuideStone use only)	Volume coverage (GuideStone use only)	Employer contribution	Plan code	Employer contribution	Schedule	Plan code
<input type="checkbox"/> Employee life								
<input type="checkbox"/> AD&D								
<input type="checkbox"/> Spouse life								
<input type="checkbox"/> Child life								
<input type="checkbox"/> Employee optional life								
<input type="checkbox"/> Spouse optional life								
<input type="checkbox"/> Retiree life								
<input type="checkbox"/> Employee personal accident								
<input type="checkbox"/> Spouse personal accident								
<input type="checkbox"/> Short-term disability								
<input type="checkbox"/> Long-term disability								

\*(Give details where any non-standard benefits and/or rates apply; attach a copy to this form. If there are additional classes, complete and attach the *Employer Acceptance Agreement Addendum* form 9474. For transfers from Personal Plans complete and attach Addendum B, form 9474B.)

Employer name: \_\_\_\_\_ Employer number: \_\_\_\_\_ Effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Complete this section only if benefits and/or rates are non-standard.

**LIFE**

	Benefits	Rates
Employee base life	Schedule:	Rate: _____ (per \$1,000 of coverage)
Employee – optional life	Schedule:	Rate: _____ (per \$1,000 of coverage)
Spouse base life	Schedule:	Rate: _____ (per \$1,000 of coverage)
Spouse – optional life	Schedule:	Rate: _____ (per \$1,000 of coverage)
Child life	Schedule:	Rate: _____ (per family unit)
Retiree life	Maximum:	Rate: _____ (per \$1,000 of coverage) or age <input type="checkbox"/>

**ACCIDENT**

	Benefits	Rates
Accidental death and dismemberment	Schedule:	Rate: _____ (per \$1,000 of coverage)
Employee – personal accident	Schedule:	Rate: _____ (per \$1,000 of coverage)
Spouse – personal accident	Schedule:	Rate: _____ (per \$1,000 of coverage)

**DISABILITY**

	Benefits	Rates
Long-term disability plan	Schedule:	Rate: _____ ( per \$100 of monthly salary) or age <input type="checkbox"/>
Short-term disability plan	Schedule:	Rate: _____ ( per \$10 of weekly salary) or age <input type="checkbox"/>

Employer name: \_\_\_\_\_ Employer number: \_\_\_\_\_ Effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL COVERAGE OPTION**

- Standard**
 **Non-standard**  
 **Mid-year renewal**    **Renewal date:** \_\_\_\_/\_\_\_\_/\_\_\_\_
  **Rate Guarantee**    **Guarantee date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

	Plan code	Total eligible	Total enrolled	EE	Total covered*		EF	Employer contribution			
					ES	EC		Class 1		Class 2	
								EE	Dep	EE	Dep
<input type="checkbox"/>											
<input type="checkbox"/>											
<input type="checkbox"/>											
<input type="checkbox"/>											
<input type="checkbox"/>											
<input type="checkbox"/>											

\*EE=Employee only; ES=Employee plus spouse; EC=Employee plus child/children; EF=Employee plus family.

**MEDICAL RATES**

	Employee only	Employee plus spouse	Employee plus child/children	Employee plus family
	Employee only	Employee plus one (spouse or child)	Employee plus child/children	Employee plus family

Name of prior carrier: \_\_\_\_\_ Date coverage ended: \_\_\_\_/\_\_\_\_/\_\_\_\_ Deductible: \_\_\_\_\_

**Employer Size**

For reporting to the Centers for Medicare and Medicaid Services (CMS), please indicate the number of employees currently on your payroll (both full-time and part-time, regardless of GuideStone medical plan participation):

- 1-19 employees   
  20-99 employees   
  100 or more employees

**For Senior plan elections**

I acknowledge that to maintain eligibility for the Senior or Senior Plus plans, (employer name) \_\_\_\_\_ must contribute at least 50% of the plan cost for each employee or retiree who joins the Senior or Senior Plus plan effective 1/1/09 or later.

Employer name: \_\_\_\_\_ Employer number: \_\_\_\_\_ Effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**DENTAL COVERAGE OPTIONS**

<input type="checkbox"/> Standard <input type="checkbox"/> Non-standard	Plan code	Total eligible	Total enrolled	EE	Total covered*			Employer contribution			
					ES	EC	EF	Class 1		Class 2	
								EE	Dep	EE	Dep
<input type="checkbox"/> Premier Dental Care Plan	42001										
<input type="checkbox"/> Choice Dental Care Plan	43001										
<input type="checkbox"/> Guided Dental HMO Plan	41001										
<input type="checkbox"/> Retiree Dental											

\*EE=Employee only; ES=Employee plus spouse; EC=Employee plus child/children; EF=Employee plus family

**DENTAL RATES**

	Employee only	Employee plus spouse	Employee plus child/children	Employee plus family
Premier Dental Care Plan				
Choice Dental Care Plan				
Guided Dental HMO Plan				

Name of prior carrier: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Deductible: \_\_\_\_\_

Waiting periods apply. Choose one:  All services  Ortho only  None

Special instructions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employer's name: \_\_\_\_\_

Signature of authorized person: \_\_\_\_\_

Print name: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

GuideStone representative: \_\_\_\_\_ Code: \_\_\_\_\_

\_\_\_\_\_ Code: \_\_\_\_\_

**Please make a copy of this Agreement for your files. Return this original Agreement to:**

GuideStone Financial Resources, SBC  
 Insurance Solutions and Services  
 2401 Cedar Springs Road  
 Dallas, TX 75201-1498