ACNA Benefits- Enrollment Information Form

Member Name: ____________________________________

Street Address: ____

City: __________________________State: ____Zip Code: ______________

Home Phone: _________________ Cell Phone: __________________ Office Phone: ________________

Member email address(s): ____

Name of Church Affiliation: ____

Church Street Address: ____

City: __________________________State:_____ Zip Code: _____________ Phone: _________________

Church Federal Tax ID:____________________ Church contribution %:___________________________

Contribution %: It is a requirement of the carrier that we report what amount the church is paying towards the premium. We have many churches that pay the entire premium at 100% and others who contribute less. The <u>minimum</u> requirement is for the church to contribute ½ of the cost of individual coverage on the lowest priced plan. Example- the lowest priced plan has a premium cost of $500.00 for employee only coverage (not our true cost, this is only an example). Your employee wants to enroll himself and his spouse. Regardless of the plan he chooses, the church would be responsible to contribute a minimum of $250.00 towards the premium (1/2 of $500). He would then be responsible to cover the rest of the employee/spouse cost of his elected plan.

Employment Position Held: _________________________________# Hours worked per week: ________

Number of full time employees at your work location :___________(Working a minimum of 30 hours per week.)

Attach census of all active full time employees including Name, Address, DOB, SSN, and <u>type of healthcare coverage</u> they will be on once your new enrollment is active. <u>Types of coverage include</u>: Spouse's employer group plan, Medicare, Federal or Military plan, Marketplace (Obamacare), Medishare, former employer retirement plan, current church group plan, ACNA plan.

Name of Diocese or ACNA affiliation: ____

Diocesan or affiliation Bishop: _______________________________

Name of Church or Diocese responsible for bill: ____

Street Address: ____

City: __________________________State:_____ Zip Code: _____________ Phone: _________________

Name of financial person responsible for bill: _________________________Phone: __________________

Email of financial person for bill: ___________________________________

Name of second person responsible for bill: __________________________Phone: __________________

Email of second person for bill: ___________________________________

Billing

The statement will be distributed by email through The Solomon Benefits Group who is the administrator on the ACNA account. The statement will reflect the premiums due for the next calendar month, any new additions or cancellations of your members plus a small administration fee*. Statements will arrive on or before the 15nd of every month and are due by the 25th of the same month. Please understand that the ACNA **does not** hold funds in reserve for paying past due premiums. The continuation of coverage for the entire group rests on the ability of all our members to get the premium payments in on time. Failure to do so will jeopardize the continuation of coverage for your members as the ACNA will have no option but to terminate coverage on your individual account. Please let us know if you have changes to your email contacts so your account can be updated and statements can be sent to the proper billing parties.

*Administration Fee- The ACNA account holds only those funds collected for the payment of premiums due. The administration fee covers all normal and regular monthly administration costs on the account. This monthly fee is based on the number of line entries on your statement. $3.50 per line entry; minimum fee of $5.00, maximum fee of $35.00.

ACNA Benefits Payment Policy:

Billing statements are sent by email on or before the 13th of the month and are due by the 25th of the same month. Timely payments are imperative because the carrier will debit our bank on the 28th of the month. Payments not received will put our entire group in jeopardy of default. We appreciate your cooperation and understanding in this regard. If you are experiencing a

payment issue please contact Teri Stephenson immediately for assistance in resolving the issue. Payments not received within 30 days of the bill date will put the account into pre-cancellation status. Payments not received within 60 days of the original bill date will terminate the coverage on all policies listed on the account. Once the account has moved to pre-cancellation status the account must be paid in full in order to continue coverage. Partial payments of past due balances will not be accepted

Termination of Coverage

Should you wish to terminate coverage at any time in the future please give us a minimum of 40 days notice. This will allow us to terminate the policy prior to the next billing cycle. Termination forms must be received within that time period to avoid continued billing. If billing continues the church will be responsible to pay the premium and a refund will be generated once the credit is received from the insurance carrier. Please contact Teri Stephenson directly for full termination instructions. Thank you very much.

Please return page 1 and 2 of this form to Teri Stephenson at tsolomongroup@verizon.net.

Teri Stephenson
ACNA Group Health and Dental Administrator
Phone: 703-999-0143