RESOLUTION NO. 88-11-07

A RESOLUTION OF THE TOWN COMMISSION OF THE TOWN OF LAKE PARK, FLORIDA AUTHORIZING THE TOWN MANAGER TO CHANGE THE EFFECTIVE DATE OF COVERAGE FOR EMPLOYEE LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, SHORT TERM DISABILITY, LONG TERM DISABILITY, VOLUNTARY EMPLOYEE LIFE INSURANCE, VOLUNTARY SPOUSE LIFE INSURANCE, VOLUNTARY CHILD(REN) LIFE INSURANCE, DENTAL INSURANCE, HEALTH INSURANCE, AND VISION INSURANCE; AND PROVIDING AN EFFECTIVE DATE.

WHEREAS, the Town of Lake Park ("Town") is a municipal corporation of the State of Florida with such power and authority as has been conferred upon it by the Florida Constitution and Chapter 166, Florida Statutes; and

WHEREAS, the Town Commission has determined that it will provide the Town's employees with health insurance coverage and an employee assistance program for Fiscal Year 2008; and

WHEREAS, the Town Commission of the Town of Lake Park has determined that it is in the best interest of the Town of Lake Park and its employees to execute the Group Policy Amendment Request Form (a copy of which is attached hereto and incorporated herein as **Exhibit "A"**) to amend its current contract with Lincoln National Life Insurance Company to change the effective date of coverage for life and accidental death and dismemberment insurance, short term disability, long term disability, voluntary employee life insurance, voluntary spouse life insurance, voluntary child(ren) life insurance, and dental insurance for all eligible employees to thirty (30) days from the first of the month immediately following date of hire; and

WHEREAS, the Town Commission of the Town of Lake Park has determined that it is in the best interest of the Town of Lake Park and its employees to execute the Employer Application (a copy of which is attached hereto and incorporated herein as **Exhibit "B"**) to amend its current contract with Blue Cross Blue Shield to change the effective date of coverage for employee health insurance for all regular full time employees to thirty (30) days from the first of the month immediately following date of hire; and

WHEREAS, the Town Commission of the town of Lake Park has determined that it is in the best interest of the Town of Lake Park and its employees to change the effective date of coverage for employee vision insurance through CompBenefits for all eligible employees to thirty (30) days from the first of the month immediately following date of hire.

NOW, THEREFORE, BE IT RESOLVED BY THE TOWN COMMISSION OF THE TOWN OF LAKE PARK, FLORIDA AS FOLLOWS:

Section 1. The whereas clauses are incorporated herein as true and correct and are hereby made a specific part of this Resolution.

Section 2. The Town Commission hereby authorizes and directs the Town Manager to execute the Group Policy Amendment Request Form to amend its current contract with Lincoln National Life Insurance Company to change the effective date of coverage for life and accidental death and dismemberment insurance, short term disability, long term disability, voluntary employee life insurance, voluntary spouse life insurance, voluntary child(ren) life insurance, and dental insurance for all eligible employees to thirty (30) days from the first of the month immediately following the date of hire.

Section 3. The Town Commission hereby authorizes and directs the Town Manager to execute the Employer Application to amend its current contract with Blue Cross Blue Shield to change the effective date of coverage for employee health insurance for all regular full time employees to thirty (30) days from the first of the month immediately following date of hire.

Section 4. The Town Commission hereby authorizes and directs that the effective date for vision insurance through CompBenefits for all for all eligible employees to thirty (30) days from the first of the month immediately following date of hire.

Section 5 This Resolution shall become effective immediately upon adoption.

The foregoing Resolution was offered by Commissioner Balius, who moved its adoption. The motion was seconded by Vice-Mayor Daly, and upon being put to a roll call vote, the vote was as follows:

	AYE	NAY
MAYOR PAUL W. CASTRO	X	
VICE-MAYOR ED DALY	X	
COMMISSIONER CHUCK BALIUS	X	
COMMISSIONER JEFF CAREY	X	
COMMISSIONER PATRICIA OSTERMAN	X	

The Town Commission thereupon declared the foregoing Resolution NO. 88-11-07 duly passed and adopted this 28 day of November, 2007.

TOWN OF LAKE PARK, FLORIDA

BY: ______________________
PAUL W. CASTRO
MAYOR

ATTEST:

____
VIVIAN MENDEZ
TOWN CLERK

TOWN OF LAKE PARK SEAL FLORIDA

(TOWN SEAL)

Approved as to form and legal sufficiency:

BY: ______________________
for THOMAS J. BAIRD
TOWN ATTORNEY

Jefferson Pilot Financial Insurance Company, PO Box 2616, Omaha, NE 68103-2616
Phone (800) 423-2765

GROUP POLICY AMENDMENT REQUEST FORM

To: **Amendments**
Jefferson Pilot Financial Insurance Company
8801 Indian Hills Drive
Omaha, NE 68114
Fax: (402) 361-2941
Phone: (800) 423-2765 - Client Services

Date Submitted:

Submitted by: ■ Group ☐ Broker ☐ Regional Office

Group I.D.: 370083

Legal Name of Employer (as shown on contract): Town of Lake Park

Group Administrator Name: Bambi McKibbon-Turner

Group Administrator E-Mail Address: bturner@lakeparkflorida.gov

Broker Name: Gehring Group

Broker E-Mail Address: kurt@gehringgroup.com

Requested Effective Date of this Change: 11/28/07

Coverage(s) and Policy Number(s) Affected by this Change: 000010072458-00000; 000010072459-00000; 000010072460-00000; and 00001D013366-00000

■ List Billed or ☐ Self Billed

Types of Changes:

■ Waiting Period ☐ Anniversary / Renewal Date ☐ Contribution Level
☐ Benefit ☐ Class / Description ☐ Definition of Earnings
☐ Group Name ☐ Minimum Hours ☐ Subsidiary / Participating Employer - New Billing Location ☐ Yes ☐ No
☐ Other Changes:

Reason for Change / Explanation & Details:

Adoption of Resolution by Town Commission to change the waiting period for all eligible employees to thirty days from the first of the month immediately following date of hire. A certified copy of the Resolution is attached.

Enrollments / Census / E of I Attached? ☐ Yes ■ No

Mailing Instructions for Completed Group Amendment Request Form:

Mail Policy(s) to: ■ Policyholder ☐ Broker Mail Certificate(s) to: ☐ Policyholder ☐ Broker

Maria V. Davis
Printed Name of Authorized Company Officer

Signature of Authorized Company Officer

Town Manager
Title

Date Signed

The request will be reviewed for contractual risk and is subject to Jefferson Pilot Financial approval.

INSTRUCTIONS TO COMPLETE GROUP POLICY AMENDMENT REQUEST FORM

These instructions will assist in completing the Group Policy Amendment Request Form. When submitting a policy change or amendment, complete this form in its entirety. For assistance, contact Client Services at (800) 423-2765.

TYPE OF CHANGE	DEFINITION	REQUIRED INFORMATION
WAITING PERIOD	The date that Employees become eligible for coverage.	- New waiting period - Names of the Employees affected
BENEFIT	Schedule of Benefits, i.e., coverage amounts, reductions, or dental benefit waiting periods.	- Description of the new benefit - Class
GROUP NAME	Policyholder's Name as shown on the Contract.	- Current and future name
ANNIVERSARY DATE	The month of the year in which the Policyholder's renewal is effective.	- Requested renewal month
CLASS DESCRIPTION	The description of Eligible Employees in any given class.	- Current and revised description - Employees affected by this change - If a class is being added, provide Enrollment Cards or a Census
MINIMUM HOURS	The required minimum hours worked per week to be eligible for coverage.	- New hour requirement - Employees affected
CONTRIBUTION LEVEL	The percentage the Employer contributes to the cost of the coverage.	- New contribution percentage
DEFINITION OF EARNINGS	The definition of the salary or wage used for benefit purposes.	- New salary description - Updated salary listing
SUBSIDIARY/ PARTICIPATING EMPLOYER	A separate firm, subdivision or branch, owned or controlled by the Policyholder.	- Name of the Participating Employer affected - Enrollment Cards or Census of the division being added - Listing of the Employees affected by a termination - List in contract as Participating Employer

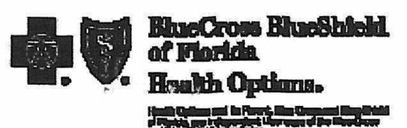
- In addition to submitting this form, please enclose any necessary attachments (i.e. - enrollment forms, evidence of insurability forms, billing address information, or a copy of the renewal notice). Incomplete forms may cause a delay in processing.

- Mail or fax the form page only (not the instructions page) to your Regional Group Office or Agent/Broker or forward directly to us at:

Attn: Amendments
Jefferson Pilot Financial Insurance Company
8801 Indian Hills Drive
Omaha, NE 68114

Attn: Amendments
Jefferson Pilot Financial Insurance Company
Fax: (402) 361-2941

The request will be reviewed for contractual risk and is subject to Jefferson Pilot Financial approval.



EMPLOYER APPLICATION
(True Group Application)

EXHIBIT B

☐ New Business ☐ Renewal Business ☒ Other: Eligibility Change

I. Group Information

Group # (BCBSF): 59581 (HMO):

A. Name of Group: TOWN OF LAKE PARK

Nature of Business: General government, nec SIC Code: 9199

Mailing Address: 535 PARK AVENUE LAKE PARK, FL 33403

Email Address:

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI). Upon acceptance of this application by BCBSF and/or HOI, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance:

HMO: UNITED HEALTHCARE CORP

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is: FLORIDA MUNICIPAL INSURANCE TRUST

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be 10/01/2002

Effective Date of this Change to the Policy shall be 12/01/2007

This Policy may be terminated by the applicant or BCBSF/HOI by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of 40 hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

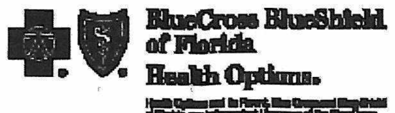
C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of MONTH after 30 days of employment, so long as the eligible employee submits an application to BCBSF/HOI within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least 75 % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet BCBSF/HOI's participation requirements.

F. BCBSF/HOI shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by BCBSF/HOI. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: 100 % Dependents: 75 %



EMPLOYER APPLICATION
(True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings: (Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in product	Accept	Decline	
☒	☐	☐	Mental & Nervous Disorder
☒	☐	☐	Alcohol & Drug Dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☒ Single Plan ☐ Blue Packages

Health Plan Name: **BlueOptions Advantage 1667 - Std**

Rx Option *(indicate copayments)*: **BlueScript C 15/30/50 C - Std**

Calendar Year Deductible:

- Per Person: **$0 / $500**
- Per Family: **$0 / $1,500**
- Pre-Existing: **Pre-Existing Applies**

Coinsurance:

- In-Network / Participating: **80**
- Out-of-Network / Non-Participating: **60**

Office Visit Copay:

- Family Phy.: **$15**
- All Other Providers: **$30**

Rates.

Employee	Employee/Spouse	Employee/Child(ren)	Family	Other
$465.74	$964.08	$875.58	$1,478.71	

See the Group Master Policy for a complete description of benefits.

IV. Health Saving Account (HSA) Banking Arrangement (optional with HSA Compatible health plans)

A. Are you choosing BCBSF's integrated HSA banking arrangement? (if left blank, the response is assumed to be No.) ☐ Yes ☒ No

V. Rate Information

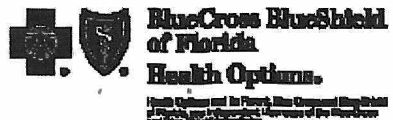
A. Premium/Prepayment fee are payable monthly on or before the due date which will be: **1st**

B. **Regular Billing**- Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, BCBSF/HOI may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements: BCBSF: **Discount**
HMO:

E. Rate Comments:



EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of BCBSF/HOI for this or any other purpose, nor shall BCBSF/HOI be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by BCBSF/HOI. 3) Notify BCBSF/HOI promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate BCBSF/HOI form. Applications from absentees will be accepted at BCBSF/HOI Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to BCBSF/HOI as specified in this application.

B. By choosing the HSA Banking Arrangement, if applicable, I authorize BCBSF to exchange certain limited information, for employees enrolling in a high deductible health plan designed for use with an HSA, **with BCBSF's preferred bank**, for the purposes of initial enrollment in and administration of, HSAs. I recognize that BCBSF does not provide banking services and that BCBSF is not responsible for the provision of HSA services. HSA services are provided by the bank of your choice subject to the terms and conditions of such arrangements, including fees the bank may charge.

C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.

D. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by BCBSF Corporate Headquarters

Issuance of the Policy by BCBSF/HOI will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title

Date	Blue Cross and Blue Shield of Florida, Inc. and/or Health Options, Inc. Licensed Agent (Print)

Signature of Agent	Agent License Identification Number