Personnel 4-21-14

PARTICIPATION AGREEMENT – THE HARTFORD EMPLOYERS GROUP INSURANCE TRUST 14-815

The undersigned Employer hereby requests that it be accepted as a Participating Employer under The Hartford Employers Group Insurance Trust (the "Trust"). The undersigned Employer wishes to make certain group insurance coverage under a group insurance policy(ies) (the "Contracts"), underwritten by Hartford Life Insurance Company or Hartford Life and Accident Insurance Company (the "Insurer"), issued to the Trustee available to its employees and former employees, their respective spouses, issue and other persons related to the employees or former employees (the "Insureds"), as may be approved by the Insurer.

The undersigned employer represents that:

1. It has established or is establishing and will maintain an employee welfare benefit plan which includes certain life and/or accident and health and/or disability income benefits.
2. The purpose of its participation in this Trust is to obtain the insurance coverage available under the Contracts to fund its obligations under said plan.
3. Unless otherwise provided in plan documents, the benefits available under said plan are identical to and subject to the same terms and conditions as those provided under the Contracts issued to the Trustee and applicable to the undersigned employer.
4. In those cases where it does not pay all the premium for insurance coverages available under the Contracts through its participation in this Trust, it will cooperate with the Insurer and its agent in establishing and maintaining a list bill or payroll deduction or other method of collecting and paying premiums due for its Insured Persons in accordance with the Insurer's reasonable requests.

The undersigned Employer understands and agrees that in no event will the Trustee of The Hartford Employer Group Insurance Trust be a Plan Administrator or other Fiduciary as to a Participating Employer's employee welfare benefit plan.

The undersigned Employer agrees: (1) to be bound by the terms and conditions of the Trust Agreement and any amendments thereto, and to assume all obligations of a Participating Employer under said Trust Agreement; (2) to be bound by the terms and conditions of the Contracts; and (3) to accept the terms of the proposal, if any, attached to this Participation Agreement.

The undersigned Employer hereby designates M3 Insurance Solutions, Inc.as Agent of Record to the group insurance coverage issued in connection with this Participation Agreement.

The undersigned Employer agrees to furnish, and permit the inspection of, any records or information required by the Settlor, Trustee or Insurer under said Trust in connection with the administration of the Contracts.

The undersigned Employer understands that the effective date of any insurance coverage will depend on the terms of the Contracts and that each eligible individual must apply to and be approved for coverage by the Insurer under said Contracts. The Employer further understands that said Contracts may be amended or canceled by the Insurer, and that the Settlor may terminate said Trust, and that participation of a Participating Employer and coverage of its Insured Persons may be terminated by the Insurer if the Participating Employer fails to comply with the terms of the Trust, Contracts or proposal.

City of Manitowoc

Date _____ By: Justin M. Nickels, Mayor

By: Jennifer Hudon, City Clerk

The above named employer is accepted as a Participating Employer in The Hartford Employers Group Insurance Trust by the Settlor.

SETTLOR, THE HARTFORD EMPLOYERS GROUP INSURANCE TRUST

Date _____ By: _____

Nadine M. Schaber

Title: Director of Group Retiree Health

Once accepted, the policy number(s) is (are): AGP-_____

The Hartford's Group Retiree Health Plan Group Application Form

Through The Hartford Employer Group Insurance Trust (HEGIT) Program

The undersigned employer requests retiree medical coverage under The Hartford's GRIP, SMIP or Medicare Supplement Plans (refer to Plan Designs and Rates for specifics).

Employer Name: City of Manitowoc (herein referred to as the Participating Firm)

Address: 900 Quay Street Manitowoc, WI 54220

Employer Identification Number (EDI): _____

Requested Coverage Effective Date: July 1, 2014

Employer's Contribution: 0% towards the cost of the premium for Retirees
0% towards the cost of the premium for Dependents

Do you consider this plan to be an ERISA Plan: ☐ yes ☒ no
If yes, will you be requesting a Schedule A Form 5500? ☐ yes ☐ no
If yes, when (date) will you be requesting it _____

Eligible Insured (please choose all that apply):

Class	Description of Class
I ☒	Retirees only, of the Participating Firm who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over.)
II ☒	Retirees and their Eligible Dependents who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over). Eligible Dependents are as follows: ☒ Spouse ☐ Domestic Partner
III ☒	All Retirees of the Participating Firm under age 65 are not eligible for coverage under this policy, but they may enroll their Eligible Dependents who are entitled to Medicare benefits by Reasons of Age.
IV ☐	All widow or widowers who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over) whose deceased spouse was an active employee of the Participating Firm.

Coverage is **not** available to persons under age 65 who are Medicare disabled.

The Hartford's Group Retiree Health Plan Group Application Form (cont'd)

Through The Hartford Employer Group Insurance Trust (HEGIT) Program

Plan Design(s) & Rate(s)
Plan Design and rates available in most states; refer to proposal document for details and exceptions:

☒ Silver Plan: $ Age Banded Rates as reflected in the proposal

Premium and /or benefit adjustments for the **Silver** Plan will occur on January 1st of each year.

The PARTCIPATING FIRM agrees to the following:

- Agrees that they will be joining a Trust;
- The Minimum Participation required to put the policy in force is 2 lives;
- The Maximum number of lives is 250;
- The Hartford plan(s) may be the only Group plan(s) sponsored by the Participating Firm;
- There no other competing group insurance plans and that The Hartford medical and prescription drug plan options will be the only options available to the firm's eligible retirees and their eligible dependents;
- The Hartford must review and approve all announcement letters and/or solicitation materials prior to their release (other than those set up for the HEGIT Program); and
- Claim experience is pooled together with all of the other Participating Firms under the Trust.

The Hartford's Group Retiree Health Plan Group Application Form (cont'd)

Through The Hartford Employer Group Insurance Trust (HEGIT) Program

Responsibilities

Please complete any additional information that is being requested in the spaces that are provided. Any incomplete information could result in the delay of the policy effective date and/or the materials that are needed.

Billing

Type: **Direct Bill**

Mode: **Monthly**

Billing Performed by: **The Hartford's Approved Billing Administrator**

Bill sent to: **N/A**

Primary Contact for Billing:
Name: **N/A**

Address: **N/A**

Phone Number: ( ) - E-Mail Address: @

Claims

Claims Paid by: **The Hartford's Approved Claims Administrator**

Eligibility

Duties Performed by: **The Hartford's Approved Enrollment Administrator**

Verify Eligibility: _____

Provide Eligibility
to The Hartford: _____

Maintain Eligibility: _____

Primary Contact for Eligibility

Name: _____

Address: _____

Phone Number: ( ) - E-Mail Address: @

The Hartford's Group Retiree Health Plan Group Application Form (cont'd)

Through The Hartford Employer Group Insurance Trust (HEGIT) Program

Enrollment

Duties Performed by: **The Hartford's Enrollment Administrator**

Number of Plans Offered: ☒ One (1) Plan to Retiree ☒ & Dependent Spouse

Type of Enrollment: ☒ Auto-enroll Retirees
☐ True voluntary for Retirees

Agent of Record:

Agent Name and Address: (Please print or Type)

M3 Insurance Solutions, Inc.

Nancy Cirra, Account Executive

N19 W24200 Riverwood Drive #140 Waukesha, WI 53188

Sub-Agent of Record:

Sub-Agent Name and Address: (Please print or Type)

_____

_____

Participating Firm Name and Signature

Name: (Please print or type) _____City of Manitowoc_____

Signed_____

Title_____ Date_____

Licensed Producer*

Name (Print): _____

Signature: _____

Date: _____

** For Illinois situsedPolicies – Producer must sign the Group Application*

Please see the enclosure for important information on disclosure

Group Benefits Disclosure Notice

The Hartford compensates both internal and external producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions regarding your insurance producer's compensation directly to your insurance producer. For specific questions on The Hartford's internal producers, please contact our Customer Service 800 number (800-523-2233).

SilverScript Prescription Drug Plan (PDP) Application Form

For coverage issued through The Hartford

Participating Firm Name: City of Manitowoc	**Policy Effective Date:** July 1, 2014
Enrollment	
Number of Eligible members for PDP	20
Employer Contribution Amount for PDP	$_____ or 0 % towards cost of ☐ Retiree only or ☒ Retiree & Dependent
Medical & PDP offered as combined coverage?	☒ Yes ☐ No
Additional Employer eligibility requirements for PDP?	☐ Yes ☒ No If yes, explain:
Is there an Annual Enrollment Period for coverage selection?	☐ Yes ☒ No If yes, what period:
Sold PDP Plan Design & Rate **(Plan Designs and rates available in all states.)**	
Monthly Rate per person: $ 161.00 (TPA admin fee is included) Standard Medicare Part D Prescription Drug Plans ☐ Sapphire **X** Sapphire Enriched ☐ Topaz Enriched	
Special Instructions/ Notes:	
Formulary	
Sold Formulary	Platinum
Creditable Coverage	
Was previous prescription drug plan considered Creditable Coverage? ☒ Yes ☐ No If yes, please include letter of Creditable Coverage, If previous plan was not creditable members may be assessed a late enrollment penalty mandated by the Centers for Medicare & Medicaid Services (CMS).	
Late Enrollment Penalty	
Employer/Policyholder hereby represents and warrants the following to SilverScript Insurance Company ("SSIC") All individuals Employer will group enroll in the SilverScript plan for the 2014 plan year do not and will not meet the requirements for imposition of the late enrollment penalty (LEP) under 42 CFR §423.36(a). A LEP should not be assessed against these enrollees based on the fact that each such enrollee had creditable coverage (as defined in 42 CFR §423.36(a)) through a plan sponsored by the Employer continuously since the Part D Initial Enrollment Period (IEP) for that individual, or for those individuals who did not have such continuous coverage, that any gaps in such coverage since the enrollee's IEP were for less than 63 continuous days each, up to the proposed effective date of enrollment in SSIC. Will Employer/Policyholder attest to creditable coverage? ☒ Yes ☐ No If not, who will be responsible for paying the penalty? ☐ Employer ☐ Retiree	

Employer Name and Signature

Name: (Please print or type)_____City of Manitowoc_____

Signed_____