

**CIGA GROCERS INSURANCE FUND HEALTH BENEFITS PROGRAM  
PARTICIPATION AGREEMENT**

TO THE PLAN TRUSTEES: The undersigned hereby applies for participation in the CIGA Grocers Insurance Fund Health Benefits Program ("Plan") for the purpose of establishing a plan of group insurance for its employees and, if accepted, agrees to be bound by all of the terms, provisions, conditions and limitations of the Plan.

This application does not constitute acceptance in the Plan. The Employer should maintain current coverage in force until acceptance and an effective date of coverage have been received from the Plan.

<b>PART I. EMPLOYER INFORMATION</b>				
Name	Telephone Number	Fax Number		
Street Address	City	County	State	Zip
Name of Insurance Contact Person		Federal Tax I.D. Number		
<p>Has the Employer previously been covered under the Plan? If "yes", when was coverage discontinued? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Total number of employees (both full-time and part-time) _____</p> <p>Number of part-time employees (less than 20 hours per week) _____</p> <p>Number of employee working at least 20 hours per week _____</p> <p>Number of full-time employees applying for coverage* _____</p> <p>Number of full-time employees waiving medical coverage* _____</p> <p>Number of full-time employees with eligible dependents* _____</p> <p>Number of full-time employees applying for dependent coverage* _____</p> <p>* Please see Part III - Participation Requirements.</p>				
<p>Are any employees of affiliates or subsidiaries to be covered? If so, please complete a separate application <input type="radio"/> Yes <input type="radio"/> No for each affiliate and subsidiary and attach to this Application.</p> <p>Is the Employer subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or similar <input type="radio"/> Yes <input type="radio"/> No law? NOTE COBRA is only applicable to Employers employing 20 or more employees on at least 50% of the business days during the preceding calendar year.</p> <p>If "yes", each person on COBRA must complete an "Employee Life/Medical and Optional Dental Application Form" and any other forms required to be completed by full or part-time employees.</p>				
<b>PART II. REQUESTED BENEFITS</b>				
DENTAL <input type="radio"/> VISION <input type="radio"/> LIFE <input type="radio"/>				
<b>PART III. PARTICIPATION REQUIREMENTS</b>				
<p>Upon initial application to the Plan and at all times during participation in the Plan, the Employer shall:</p> <ol style="list-style-type: none"> <li>1. Maintain a membership in good standing in the California Independent Grocers Association ("Association");</li> <li>2. Maintain a minimum Plan participation level of not less than 100% of all eligible employees (excluding employees who submit proof of other insurance (carrier binders) under the group insurance program of another employer);</li> <li>3. Submit with this application and annually thereafter a <b>current DE/6</b> (or Schedule C, if you don't have any employees); Stores with Union employees must provide a copy of their most recent submission to the Trust;</li> <li>4. Provide ninety (90) days prior written notice of intention to withdraw from participation in the Plan;</li> <li>5. Submit to the Plan the names of all employees not actively at work on the effective date of the Employer's initial participation in the Plan;</li> <li>6. Submit to the Plan the names of all employees or dependents who are currently receiving plan benefits from the prior insurance carrier under COBRA, or who are eligible to elect COBRA coverage.</li> </ol>				

#### PART IV. AGREEMENT

The undersigned Employer has read, understands and agrees that:

1. This Application and the individual employee enrollment forms are a part of the contract with the Plan, and that any material misrepresentation, omission or misstatement of information may result in immediate termination of participation or rescission of coverage, retroactive to the date of this application, or both;
2. Participation in the Plan is subject to written approval of this application by GIF, and no liability is created or assumed by the Plan until this application has been so approved. If this application is not approved for any reason, the sole obligation of the Plan will be to refund any payments made by Employer at the time of application;
3. Employer is solely responsible for compliance with the provisions of COBRA and the Family Medical Leave Act of 1993, and hereby acknowledges that the Plan shall bear no liability in the event Employer fails to comply;
4. Insurance coverage provided by the Plan is subject to all of the provisions of any group insurance policy issued to the Plan;
5. The GIF, shall have the right to inspect employer's payroll and personnel records which may have a bearing on or are a basis for any insurance coverage requested, placed in force, or maintained;
6. A condition of participation in the Plan is the timely payment of premium contributions, as specified by GIF, If the total premium is not received by GIF, by the 5th and cleared by the 10th of the month following the premium statement issued by GIF, GIF, will (1) send a notice to each employee of Employer who is enrolled in the Plan informing the employee that their coverage in the Plan will lapse in 30 days because the premium has not been paid by Employer, and (2) suspend claims processing in regard to Employer. In any case where a notice is issued pursuant to the previous sentence, as a condition to continued participation in the Plan, Employer shall timely pay two months of premiums in advance, as opposed to one month of premiums in advance, which shall be set forth by GIF, in the monthly premium statement issued by GIF, and if Employer fails to timely pay two months of premiums in advance, Employer's participation in the plan may be terminated.
7. Employer shall be solely responsible for providing accurate and timely information to GIF with in 30 days of eligibility or change, regarding Plan enrollment; employee and dependent status changes; and employee elections of continuation coverage under COBRA or conversion. GIF must be notified immediately of employee terminations. The Plan shall bear no responsibility to Employer, any insured person or any third party as a result of Employer's failure to provide accurate and timely information;
8. The Plan shall have no liability to pay benefit claims in excess of Plan assets;
9. The Plan retains the right at all times, upon 30 days written notice to Employer, to amend or modify the provisions of the Plan or to terminate the Plan in its entirety without the consent or approval of Employer or any insured person;
10. If on the effective date of coverage under the Plan, an employee is not actively at work and regularly scheduled to work at least 20 hours per week, or any dependent is confined in a hospital or institution, is disabled, is receiving Social Security disability benefits, or is unable to carry on the activities of a person of like age and sex in good health, coverage for such employee or dependent shall be deferred until such employee or dependent qualifies for coverage in accordance with the terms of the plan or any insurance policy issued to the Plan.

Certain benefits under this Plan may contain individual medical underwriting requirements and mandatory pre-certification of certain medical services all of which have been disclosed to me and which I have disclosed to my employees. Failure to comply with any of these requirements shall result in either denial of coverage, denial of claims or the payment of additional deductibles.

I certify that the undersigned is a member of the California Independent Grocers Association and I hereby apply for participation in and agree to the terms of the Plan.

Date: \_\_\_\_\_

\_\_\_\_\_  
[Name of Member]

By: \_\_\_\_\_  
[Signature]

Its: \_\_\_\_\_  
[Title]

Revised: 05/03