Sponsored by: Janke

CITY OF MARATHON, FLORIDA
RESOLUTION 2003-117

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF MARATHON, FLORIDA, AUTHORIZING THE CITY MANAGER TO ENTER INTO A CONTRACT WITH PACIFIC LIFE INSURANCE FOR EMPLOYEE LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT AND SHORT TERM DISABILITY INSURANCE

WHEREAS, at the July 8th, 2003 City Council meeting, the City Council authorized changes in Health Insurance for City of Marathon employees. During budget work sessions the City Council was still concerned with the high cost of personnel insurance expenses; and

WHEREAS, the City of Marathon's current employee benefit package set up under Moyer & Associates includes, Life/Accidental Death and Dismemberment (AD&D) insurance with a per annum benefit, Short Term Disability (STD) insurance for 13 weeks, and Long Term Disability insurance with a maximum benefit to age 65 or 2 years if over 65; and

WHEREAS, our department did an audit of Monroe County municipalities and City of Marathon private sector entities insurance benefits. The City of Key West offers Term Life insurance with a maximum benefit of $10,000. The Village of Islamorada offers Term Life insurance with a per annum maximum benefit. Both municipalities offer optional coverages at the employee's expense and no cost to the municipality. Both public entities offer Term Life insurance; and

WHEREAS, three Life/AD&D and STD quotes were solicited. One from the League of Cities which exceeds what the City is currently paying. One quote from our current carrier, Standard Insurance, and one quote from Pacific Life. See attached Exhibit "A" comparisons; and

WHEREAS, by choosing Pacific Life's Life/AD&D Insurance package at a $15,000 benefit, and STD with a 26 week benefit at 66 2/3 % of employees salary, it would be a cost savings of $867.01 per month. See Exhibit "B".

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF MARATHON, FLORIDA, that:

Section 1. Council authorizes the city manager to enter into a contract with Pacific Life Insurance for employee Life & ADD and STD in substantially the form as attached as Exhibit "C".

Section 2. This resolution shall take effect immediately upon its adoption.

PASSED AND APPROVED by the City Council of the City of Marathon, Florida, this 23rd day of September, 2003.

THE CITY OF MARATHON, FLORIDA

Randy Mearns, Mayor

AYES: Bartus, Pinkus, Repetto, Worthington, Mearns
NOES: None
ABSENT: None
ABSTAIN: None

ATTEST:

Cindy L. Ecklund
City Clerk

(City Seal)

APPROVED AS TO FORM AND LEGALITY FOR THE USE
AND RELIANCE OF THE CITY OF MARATHON, FLORIDA ONLY:

CITY ATTORNEY

Exhibit "A"

Life/Accidental Death & Dismemberment (AD&D), Short Term Disability (STD), Long Term Disability (LTD) Comparisons
League of Cities (LOC), Standard Insurance (SI), Pacific Life (PL)

Ins Type	LOC Cost	LOC Benefit	SI Cost	SI Benefit	PL Cost	PL Benefit
Life & AD&D	.68 per $1,000 of benefit per month (combined)	$10,000	$327.93 (.35 per $1,000) $28.11 (.03 per $1,000	Per annum Per annum	$355.99 total cost monthly for Life and AD&D	$15,000 $15,000
STD	.59 per $10.00 of benefit per month	13 wks /66-2/3% of gross wkly salary	.39 per $10.00 of benefits	13 wks/60% of gross wkly salary		
STD	.74 per $10.00 of benefit per month	26 wks/66-2/3% of gross wkly salary	.59 per $10.00 pf benefit per month	26 wks/60% of gross wkly salary	$232.25 total cost monthly	26 wks/66 2/3% of gross wkly salary
LTD	Does not offer	Does not offer	.75 of the monthly payroll per 100.00	60% of salary	Found nothing competitive	

9/9/03wernerc

Exhibit "B"

Pacific Life Cost Savings for Life & AD&D, STD, and LTD

What We Have Currently

Standard Life w/per annum benefit -	$327.93
Standard AD&D w/per annum benefit	$ 28.11
Standard STD 13 wks 66 2/3% of salary	$451.31
Standard LTD	$647.90
Total per month for all employees	$1,455.25

What We Are Proposing

Pacific Life & ADD w/ $15,000 benefit -	$355.99
Pacific STD w/26 wks at 66 2/3% of salary	$232.25
Total per month for all employees	$588.24

.D&D – Accidental Death & Dismemberment
STD – Short Term Disability
LTD – Long Term Disability

9/9/03wernerc

Exhibit C

Pacific Life & Annuity Company
Post Office Box 7010
Newport Beach, CA 92658-7010

Small Group Plans
Application For Coverage For Florida Employers

To be completed in **BLUE** or **BLACK** ink **ONLY**

PACIFIC LIFE & ANNUITY

EMPLOYER (CORRECT LEGAL NAME):	FEDERAL EMPLOYER ID NUMBER (EIN):
DBA (BUSINESS AS (DBA)):	TELEPHONE NO.: ( )
MAILING ADDRESS: CITY STATE ZIP CODE	FAX NO.: ( )
STREET ADDRESS: COUNTY:	E-MAIL ADDRESS:
CITY: STATE ZIP CODE	NUMBER OF YEARS AT PRESENT LOCATION:
TYPE OF BUSINESS (CHECK ONE): ☐ SOLE PROPRIETORSHIP ☐ PARTNERSHIP ☐ CORPORATION ☐ NON-PROFIT CORP. ☐ SUB-CHAPTER S CORP. ☐ LLC/LLP	DATE BUSINESS ENTITY FORMED:
DESCRIBE NATURE OF BUSINESS:	SIC CODE:
AUTHORIZED COMPANY REPRESENTATIVE NAME/TITLE:	REQUESTED EFFECTIVE DATE:

Subject to approval of this application, proposed Employer hereby requests and endorses the following selection of coverages, options and benefits as its Employee Benefit Health and Welfare Plan. The Employer understands that all employees participating in its Plan must enroll for all the coverages and options shown below as elected by the Employer. Employer also understands that plan changes requested by the Employer, once coverage becomes effective, are limited to once a year on the Employer's anniversary date.

GROUP LIFE INSURANCE

If elected, $15,000 minimum Life Benefit required for A, B, C or E.

☐ A. Equal amount of _____ for all employees.
☐ B. One Times Annual Earnings (including $15,000 minimum).
☐ C. 25+ Covered Employees: ☐ 1x to $100,000 ☐ 2x to $150,000
☐ Dependent Life Coverage
☐ E. Class Schedule (complete below)

SHORT TERM DISABILITY (STD) INCOME INSURANCE

If elected, choose A, B, or C. Not to exceed 66 2/3% of Weekly Earnings.

☐ A. Equal amount for all employees: Available from $100 to $500 in $50 increments ($500 maximum). Amount: $ ____
☐ B. Times Earnings (minimum $100 - maximum $500)
☐ C. Class Schedule (complete below)

CLASS NO.	DESCRIPTION OF EMPLOYEE CLASS (BY JOB TITLES)	LIFE BENEFIT	STD BENEFIT
1.			
2.			
3.			

NOTE: Minimum Life and AD&D benefit of $15,000 per employee. Life and AD&D benefits are reduced to 65% at age 65; to 45% at age 70 and to 30% at age 75. Short Term Disability Income benefits are reduced to 65% at age 65 and terminate at age 70.

GROUP MEDICAL PLANS

☐ **INCENTIVE CARE PPO**
PPO Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,000
PPO Coinsurance: ☐ 70% ☐ 80% ☐ 90%

WAITING PERIOD
☐ For All Employees **OR** ☐ For Subsequent Employees Only
☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 6 Months
Eligible first of the month following waiting period.

☐ **PPO NETWORK SELECTED:** _____
If network differs by work location, give details.
_____
_____

OPTIONAL COVERAGES

☐ **$300 ADDITIONAL ACCIDENT**

☐ **PREGNANCY**

☐ **CLASSIC DENTAL** (Requires 5+ covered employees for stand alone)
Plan: ☐ 1 ☐ 2 ☐ 3
Deductible: ☐ $25 ☐ $50 ☐ $100
Prior dental plan inforce: ☐ Yes* ☐ No *If Yes, are you applying for the reduced waiting period for major dentistry? ☐ Yes ☐ No

☐ **OCCUPATIONAL COVERAGE** If electing, give names of Officers, Partners, Proprietors: _____
_____
_____

EMPLOYER INFORMATION

1. Is your business known by a name other than the one(s) listed on the front of this application? ☐ Yes ☐ No

   If "Yes," other name(s): _____

2. Do any employees work at a location other than the one(s) listed on the front of this application? ☐ Yes ☐ No

   Address(es) of other location(s): _____

3. What is the name of your Worker's Compensation carrier? _____

4. Does your business file an Employer's Quarterly Wage and Contribution Report? ☐ Yes ☐ No
   A copy of the most current report is required.

5. NOTE: All eligible employees hired on or before the employer's requested effective date are eligible for coverage and must be included in the count of eligible employees. Evidence of Insurability is required on all employees hired on or before the employer's effective date, regardless of group size.

   A. Please indicate in the boxes below the number of employees, by category, employed 50% of the business working days during the time periods indicated:

	Full-Time	Part-Time	Temporary	Seasonal	Union	Commission	Contract	TOTAL
Preceding Calendar **Year**								
Preceding Calendar **Quarter**								

   B. Total number of employees **currently** working for your business .....

   C. Total number of employees applying for coverage (including Life-only applicants) .....

   D. Total number of employees in Waiting Period (enrollment forms for employees in waiting periods which end in less than 3 months must be included) .....

6. Any employee/dependent currently hospitalized or disabled (including disability due to a work-related injury)? ☐ Yes ☐ No

   If "Yes," name of individual(s): _____

7. Is your firm subject to TEFRA legislation [i.e. 20 or more employees (both full and part-time) working for 20 or more consecutive weeks in **either** the current **or** prior calendar year]? ☐ Yes ☐ No

8. Is your firm subject to COBRA legislation [i.e. 20 or more employees (both full and part-time) employed at least 50% of the business days during the preceding calendar year]? ☐ Yes ☐ No

   If "Yes," please answer the following questions:

   -- Any employee/dependent currently on a continuation of benefits under COBRA? ☐ Yes ☐ No

   -- If "Yes," name of individual(s): _____

   -- Has any employee/dependent experienced a qualifying event (i.e., employment termination, reduction in work hours due to disability, divorce, etc.) under COBRA within the last 90 days and not yet elected to continue coverage? ☐ Yes ☐ No

   -- If "Yes," name of individual(s) and qualifying event dates: _____

9. Are any of your employees related by blood or marriage? ☐ Yes ☐ No

   If "Yes," please provide names and relationships: _____

10. Are any of your employees/dependents currently on a continuation of benefits under state law? ☐ Yes ☐ No

    If "Yes," name of individual(s): _____

11. Has your firm ever been insured under either this Plan or another Pacific Mutual, Pacific Life, PM Group or Pacific Life & Annuity group health plan? ☐ Yes ☐ No

    If "Yes", policy or employer number: _____ When? _____

12. Will your present group insurance terminate prior to or on the requested effective date? ☐ Yes ☐ No
    If "Yes," provide the following and include a copy of your current premium statement(s).

    A) Name of prior carrier/HMO: _____ B) Phone Number: _____

    C) Prior Policy / Employer Number: _____ D) Effective Date: _____

    E) Date coverage will terminate: _____ F) Number of covered employees on termination date: _____

    G) Reason for termination: _____

13. What percentage of the employee premium do you contribute? ..... %

14. Is your business affiliated with any other companies (Parent companies, subsidiaries, commonly owned, related entities or partnerships)? ☐ Yes ☐ No

    If "Yes," number of full-time employees in Parent companies, subsidiaries, commonly owned, related entities or partnerships .....

SUBSCRIPTION AGREEMENT
TO THE MULTI-PROTECTION TRUST-UTAH

MPORTANT -- READ CAREFULLY BEFORE SIGNING

'he undersigned Employer, engaged primarily in the industry described in the Small Group Plans Application For Coverage, applies for enrollment in the iroup insurance plan established thereunder, and hereby adopts and subscribes to the terms of the Trust Agreement establishing the Multi-Protection 'rus' ' "ah. For purposes of this Agreement, the insurance company, Pacific Life & Annuity Company, shall hereafter be referred to as the Insurance ;ar. he Administrative Representative for the Trust, Pacific Life & Annuity Company, Medical Products, Small Group, Administration Department, shall ereafter be referred to as PL&A's Small Group Dept.

. The Employer agrees to follow all terms, provisions, conditions and limitations of said Trust Agreement and all amendments thereto. The undersigned Employer, on behalf of itself and its participating employees and dependents is bound by and agrees to follow all terms, provisions, conditions and limitations contained in the Master Group Insurance Contract, established for, and issued to, the policyholder of the Multi-Protection Trust-Utah (the Trustee, Key Trust Company of the West). The Employer further agrees, on behalf of itself and its participating employees and dependents, to cooperate in the verification of compliance with the terms, provisions, conditions and limitations set forth in the Master Group Insurance Contract and the Certificate Booklet.

. The Employer agrees to pay the required contributions monthly, said contributions being comprised of insurance premium and administrative fees. The contributions must be made in the form of a check drawn against the account of the business, payable to the Multi-Protection Trust-Utah at the address so designated by PL&A's Small Group Dept. The Employer understands that the contribution is payable on the first day of each respective month and will become delinquent if not received by PL&A's Small Group Dept. by the 15th day of the month for which the contribution is due. The Employer further understands that a delinquent status is cause for termination from the Trust, effective the last day of the calendar month for which complete contributions have been received.

. The Employer agrees to make timely notification to PL&A's Small Group Dept. of any employee terminations, status changes or other material changes which serve to modify the statements contained in this application or render the Employer ineligible for continued participation in this Trust. Timely notification shall be defined as being no more than 31 days past the actual date of such changes.

. The Employer understands that all new employees are eligible for participation in this plan on the first day of the month following completion of the elected waiting period and coverage will become effective on that date if the enrollment form is received by PL&A's Small Group Dept. before the employee's eligibility date. (When evidence of insurability is required, the application must be approved before coverage becomes effective.)

. The Employer understands that under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Employer is the named fiduciary for the plan of benefits provided by the Multi-Protection Trust-Utah on behalf of the employees of the business. These fiduciary responsibilities include, but are not limited to, remitting tributions on the employees' behalf when due and notifying employees of effective dates of coverage, effective dates of changes in coverage, termination of coverage and conversion privileges. The Insurance Carrier assumes the responsibility as claim review fiduciary for the plan.

The Employer understands that the Insurance Carrier is not responsible for complying with any state or federal laws or regulation which affect benefits that must be provided by employers to their employees.

. The undersigned Employer understands that the Administrative Representative conducts periodic audits to assure that eligibility, participation and contribution requirements are being met by all Employers on a continuing basis. Further, the Employer agrees to cooperate with the Administrative Representative in the event of an audit with respect to said Employer's Employee Benefit Plan. Specific cooperation includes, but is not limited to, providing payroll documentation, copies of business licenses or Wage and Contribution Reports. Failure to cooperate upon request of the Administrative Representative may result in termination or cancellation of coverage at the option of the Administrative Representative.

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

THE UNDERSIGNED EMPLOYER certifies that it has read all sections of the Application for Coverage and the Subscription Agreement and fully understands and agrees to abide by all requirements and conditions stated therein. The Employer agrees to follow all terms, provisions, conditions and limitations contained n the Master Group Insurance Contract under which coverage is provided and understands that coverage shall not commence until this application has been approved by the Insurance Carrier and notice of approval has been provided to the undersigned Employer.

MPLOYER NAME (PLEASE PRINT):

MPLOYER SIGNATURE:

X

AME AND TITLE:

DATE APPLICATION COMPLETED:

TE WHERE SIGNED:

THE INSURANCE CARRIER RESERVES THE RIGHT TO DECLINE ANY NEW BUSINESS APPLICATION WHICH, IN THE COMPANY'S OPINION, DOES NOT MEET SOUND UNDERWRITING STANDARDS OR WHICH WOULD AFFECT THE FINANCIAL STABILITY OF THE TRUST, EXCEPT WHERE PROHIBITED BY LAW.

EMPLOYEE ELIGIBILITY REQUIREMENTS An eligible employee is any full-time, permanent employee actively engaged in the conduct of the business of a covered Employer for at least 25 or more hours per week at the regular place of business. An eligible employee must have a W-4 form on file with the employer and appear on the payroll with the appropriate federal and state tax deductions made. An independent contractor is considered an eligible employee if he/she is included in the employer's benefit plan and the employee's full-time employment and eligibility can be documented by 1099's and 1040's. A corporate officer is also considered an employee, and, therefore, must fulfill the same requirements as an eligible employee. Partners or proprietors who work at least the same minimum number of hours required for their eligible employees every week and file the appropriate tax forms, are considered eligible for coverage. If an employee's spouse or child qualifies as an employee, he/she must be covered as an employee and not as a dependent.

PA CIPATION REQUIREMENTS The minimum participation requirements for group enrollment and continued participation in the Plan are:

Number of Eligible Employees	Required Employee Enrollment	Required Dependent Enrollment of Employees With Eligible Dependents
Less than 6	100%	100%
6, 7, or 8	All Less 1	50%
9, 10, 11, or 12	All Less 2	50%
13, 14, or 15	All Less 3	50%
16 or More	75% of All Eligible Employees	50%

Employees and dependents who are covered under creditable coverage are considered eligible for coverage but may be excluded from the number of eligible employees and dependents before the participation requirements are calculated if they do not elect Pacific Life & Annuity coverage. However, when an employer sponsors multiple plans, employees and dependents covered under the other employer-sponsored plan are counted.

EMPLOYER CONTRIBUTION REQUIREMENT The minimum employer contribution requirement is 50 percent of the employee premium for the lowest cost plan the employer offers.

PREEXISTING CONDITIONS LIMITATION A "Preexisting Condition" is a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months immediately preceding the covered person's enrollment date. Except as stated below, pregnancy is not considered a preexisting condition. No medical benefits are provided for a preexisting condition unless the charge is incurred after the covered person has been insured for 12 consecutive calendar months (18 months for late enrollees) under the Pacific Life & Annuity plan chosen by the employer. For groups with less than two employees, the 6, 12, and 18 month periods described above are changed to 24 months and pregnancy is considered a preexisting condition for enrollees with no prior creditable coverage.

PREEXISTING CONDITION WAITING PERIOD CREDIT Preexisting Conditions Waiting Period Credit or "Portability" credits the time a person was covered under prior "creditable coverage" towards the 12, 18, or 24 month insured time period specified in the Preexisting Conditions Limitation above. Preexisting Conditions Waiting Period Credit is available to all employees and their covered dependents who: (a) become eligible under this plan within 63 days of termination of their prior "creditable coverage," and; (b) apply within the applicable enrollment period. Prior "creditable coverage" means: 1) a group medical plan; 2) medical insurance coverage; 3) Part A or Part B of title XVIII of the Social Security Act (Medicare); 4) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; 5) Chapter 55 of title 10, United States Code (CHAMPUS); 6) a medical care program of the Indian Health Service or of a tribal organization; 7) a state health benefits risk pool; 8) a health plan offered under chapter 89 of title 5, United States Code (FEHBP); 9) a public health plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals; or 10) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

PRODUCER'S STATEMENT I hereby certify that I hold a valid Life, Accident and Health License issued by the state in which the employer's principal place of business is located, and that all of the information contained herein is correct, to the best of my knowledge, and I know nothing unfavorable about this firm or individuals applying for insurance that has not been disclosed. Furthermore, I certify that: (1) The firm is a bona fide business establishment and meets all eligible employer requirements as described in the sales brochure; (2) Participation and Eligibility requirements have been explained and are being met; (3) I have advised the Employer not to terminate any existing coverage until receiving notice that the coverage being applied for by the Application and Subscription Agreement is accepted; (4) Preexisting Conditions Limitation and Pre-Service Review requirements have been fully explained to, and understood by, the Employer identified in this document; (5) I will not disclose any health or financial information of the applicants to anyone other than PL&A.

☐ PRODUCER TO BE PAID, OR
☐ FIRM TO BE PAID, OR ☐ SPLIT*

IF SPLIT*, INDICATE COMMISSION PERCENTAGES:
* First producer must receive a minimum of 10% commission and first producer only will receive MVP credit and correspondence for the employer.
FIRST PRODUCER_____% SECOND PRODUCER_____%

THE ADMINISTRATION KIT WILL BE SENT TO YOU TO DELIVER TO THE EMPLOYER UNLESS YOU INDICATE OTHERWISE HERE:
☐ SEND ADMINISTRATION KIT DIRECTLY TO THE EMPLOYER.

PRODUCER'S NAME:	SOCIAL SECURITY NO. OR TAX ID.:	INSURANCE LICENSE NO./STATE: / EXPIRATION DATE:	IF PACIFIC LIFE AGENT — SAID CODE: / AGENCY:
MAILING ADDRESS: CITY STATE ZIP CODE			TELEPHONE NO.: ( )
STREET ADDRESS: CITY STATE ZIP CODE			FAX NO.: ( )
SIGNATURE OF WRITING PRODUCER: X		DATE COMPLETED:	E-MAIL ADDRESS:
SECOND PRODUCER'S NAME OR FIRM'S NAME:	SOCIAL SECURITY NO. OR TAX ID.:	INSURANCE LICENSE NO./STATE: / EXPIRATION DATE:	IF PACIFIC LIFE AGENT — SAID CODE: / AGENCY:
MAILING ADDRESS: CITY STATE ZIP CODE			TELEPHONE NO.: ( )
STREET ADDRESS: CITY STATE ZIP CODE			FAX NO.: ( )
SIGNATURE OF WRITING PRODUCER: X		DATE COMPLETED:	E-MAIL ADDRESS:
SMA NAME:			SMA AGENCY:

SALES OFFICE USE ONLY	SALES OFFICE:	REP #:	COMM SCHD:	ORIGIN CODE:	EMPLOYER NO.:	EFFECTIVE DATE:	MEDICAL ☐ YES ☐ NO	NO. INSURED LIVES:	COPIES TO: L&C: