

SONNY A. HENNING INSURANCE

9671 CASTLE WOODS COVE, INDIANAPOLIS, IN 46280 FAX 888-766-8288
TOLL FREE 1-888-SONNY-32 (888-766-6932)

Thank you for your interest in our Health Plans. I have attached a more detailed description for the quoted program.

Please print the attached file and complete all application forms per the instructions. Paperwork and checks must be returned to:

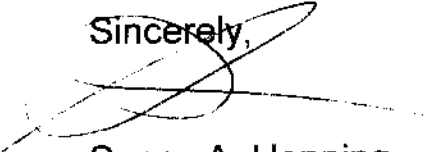
**SONNY A. HENNING
SONNY HENNING INSURANCE
9671 CASTLE WOODS COVE
INDIANAPOLIS, IN 46280**

Please include a check, payable to the name instructed on the attached and be sure to include any requested tax documentation. **In addition, please include a check, payable to Sonny Henning Insurance in the amount of \$50.00 as a one time processing and handling fee.**

All forms must be received by the 15th of the month for a 1st of the month effective date.

If you have any questions, please feel free to call, toll free, at your convenience **1-888-SONNY-32 (1-888-766-6932)**.

Sincerely,



Sonny A. Henning
SAH:ms
Attachments

**BE SURE TO REMEMBER US FOR ALL YOUR LIFE AND
HEALTH INSURANCE NEEDS, INCLUDING LIFE, HEALTH,
DISABILITY, LONG TERM CARE AND OTHER SENIOR
PRODUCTS.**

HOW TO GET STARTED?

JUST FOLLOW THE SIMPLE INSTRUCTION BELOW AND MAIL
ALL PAPERWORK AND CHECKS TO :

SONNY HENNING INSURANCE
9671 CASTLE WOODS COVE
INDIANAPOLIS, IN 46280

ULTRACARE-PPO **NO GATEKEEPER** **NY&NJ**

**(UTILIZES THE MULTIPLAN NETWORK FOR NEW YORK
AND HORIZON PPO NETWORK FOR NEW JERSEY)**

WWW.MULTIPLAN.COM OR
WWW.HORIZONHEALTHCARE.COM

- COMPLETE PARTICIPATION STATEMENT
- COMPLETE C.W.F. HEALTH BENEFITS PLAN
- COMPLETE MEMBERSHIP DEDUCTION FORM
- COMPLETE COLLECTIVE BARGAINING AGREEMENT
- COMPLETE C.W.F. HEALTH HISTORY COVERAGE FORM
- COMPLETE C.W.F. ULTRACARE HEALTH PLAN ENROLLMENT FORM

**INLCUDE ONE CHECK FOR THE FIRST MONTH'S PREMIUM
PLUS THE ANNUAL ADMINISTRATION FEE OF \$40,
PAYABLE TO INTERNATIONAL BENEFIT ADMINSTRATORS**

PLUS

**A ONE TIME PROCESSING FEE OF \$50.00, PYABALE TO
SONNY HENNING INSURANCE.**

PARTICIPATION STATEMENT

COMPANY NAME _____

I CONFIRM THAT THE ABOVE NAMED COMPANY IS COMPLYING WITH DIVERSIFIED EMPLOYEES' UNION, LOCAL 4 REQUIREMENTS PURSUANT TO ERISA. THE FOLLOWING EMPLOYEES COVERED BY THE COLLECTIVE BARGAINING AGREEMENT WITH LOCAL 4, ARE EMPLOYED AS A FULL-TIME BASIS WORKING AT LEAST (30) HOURS PER WEEK.

<u>EMPLOYEE NAME</u>	<u>EMPLOYEE NAME</u>
1) _____	13) _____
2) _____	14) _____
3) _____	15) _____
4) _____	16) _____
5) _____	17) _____
6) _____	18) _____
7) _____	19) _____
8) _____	20) _____
9) _____	21) _____
10) _____	22) _____
11) _____	23) _____
12) _____	24) _____

I HEREBY REPRESENT AND AGREE THAT ALL ANSWERS AND STATEMENTS IN THIS STATEMENT ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE SAID ANSWERS AND STATEMENTS FROM THE BASIS UPON WHICH PARTICIPATION WILL BE MADE EFFECTIVE AND OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS ABOUT EMPLOYMENT HISTORY COULD RESULT IN DENIAL OF PARTICIPATION IN THE DIVERSIFIED EMPLOYEE'S UNION, LOCAL 4. I AFFIRM THAT THE FOREGOING STATEMENTS ARE TRUE UNDER THE PENALTIES OF PERJURY.

SIGNATURE OF OWNER

PRINT NAME

TITLE: _____ DATE: _____

WITNESS: _____ PRINT NAME: _____

CWF HEALTH BENEFITS PLAN

PLEASE PRINT

NAME (PRINT) _____ SOC. SEC. NO. _____
(LAST) (FIRST)

ADDRESS: _____

DATE OF BIRTH: _____ HOME PHONE # _____

() MARRIED () SINGLE NO. OF DEPENDENTS UNDER AGE 18 _____ () INDIVIDUAL () FAMILY

EMPLOYED BY: _____

EFFECTIVE DATE: _____

PRIOR CARRIER: _____ FROM: _____ TO: _____

DEPENDENTS

FIRST NAME DATE OF BIRTH RELATIONSHIP SOCIAL SECURITY #

SIGN HERE: _____ DATE: _____

MEMBERSHIP FEE DEDUCTION AUTHORIZATION

I HEREBY AUTHORIZE AND DIRECT MY EMPLOYER TO DEDUCT FROM MY WAGES AND PAY OVER TO DIVERSIFIED EMPLOYEE'S UNION, LOCAL 4, THE AMOUNT OF (\$12.00) PER MONTH AS AND FOR MEMBERSHIP FEES IN CONNECTION WITH THE UNION'S REPRESENTATION OF MY INTERESTS. I FURTHER AUTHORIZE LOCAL 4, TO REPRESENT ME WITH MY EMPLOYER.

THIS AUTHORIZATION SHALL NOT BE REVOCABLE FOR A PERIOD OF ONE YEAR FROM THE DATE HEREOF. IT SHALL THEREAFTER CONTINUE IN FULL FORCE AND EFFECT FOR SIMILAR PERIODS UNLESS REVOKED BY ME BY NOTICE IN WRITING TO THE UNION AND TO THE EMPLOYER.

PARTICIPATING EMPLOYEE _____ PARTICIPATING EMPLOYEE'S SIGNATURE _____
(PRINT NAME)

SOCIAL SECURITY #: _____

ADDRESS: _____

EMPLOYER: _____

ADDRESS: _____

DATE: _____ EMPLOYER'S TELEPHONE#: _____

AGREEMENT

This undersigned Employer hereby agrees to accept and adopt all terms and conditions contained in the collective bargaining agreement which is currently in Effect and any successor collective bargaining agreement by and between LOCAL 621 and BMI.

The undersigned Employer acknowledges that by signing the Agreement, it agrees to all terms of the above referenced collective bargaining agreement, including all economic terms contained therein.

The undersigned Employer acknowledges that it has received a copy of the collective bargaining agreement referenced above.

Accepted and Agreed:

Date:

C.W.F. ULTRA-CARE

Health Plan

Social Security # _____ - _____ - _____

Employee Enrollment Information

Last Name:				First Name:				Sex: M <input type="checkbox"/> F <input type="checkbox"/>		
Street Address:				Apt.:	City:		State:		Zip:	
Where you ever a CWF Member? No <input type="checkbox"/> Yes <input type="checkbox"/>	Date of Birth: →		Mo.	Day	Yr.	Telephone:		Work:		
Marital Status? <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Date of Event: →		Mo.	Day	Yr.	Are you covered by any other Health Insurance? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes indicate: Ins. Co. Name: _____ Address: _____ Policy # _____ Effective Date ____/____/____		Is your spouse covered by any other Health Insurance? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes indicate: Ins Co. Name: _____ Address: _____ Policy # _____ Effective Date ____/____/____		
Provider Network: Check one →	Network Multiplan <input type="checkbox"/>		Network Beech Street <input type="checkbox"/>							

**If you are applying for coverage for your spouse and/or children, please list each one below- see Election of Coverage for eligibility*

In Case of Emergency Please Contact
Name _____ Relation _____
Telephone # _____ Work _____

Last Name	First Name	Soc. Sec. Num.	Sex	Relationship	Birth Date Mo. Day. Year	Check if over 19 & Disabled	Network Physician Name or Number
Spouse:				<input type="checkbox"/> Wife <input type="checkbox"/> Husband			
Dependants				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

Please indicate Additional Dependants of a Duplicate Sheet

ELECTION OF COVERAGE AND AUTHORIZATION*

The applicant in consideration of participation in the Plan hereby covenants to indemnify and hold harmless the third-party administrator, its agents, owners, successors and or assigns for any claims that may arise by the participation of the plan

I am applying for coverage myself, my spouse, any ineligible unmarried children under 19 years of age and unmarried children between the ages of 19 and 23 who are full time students at an accredited educational institution and receive at least half of their support from me and/or my spouse. I elect to enroll myself and my family members, if any, with the Medical Group / Network Physician associated with the Combined Welfare Fund.

On behalf of myself and each eligible Family Member, I hereby authorize all physicians, nurses, hospitals and other providers who or which have at any time either before or after we became covered by C.W.F., provided any diagnosis, treatment, or any other service to any of us, to furnish to C.W.F. and our Medical Group / Network Physician all information and records relating thereto.

I understand that pre-existing conditions will not be covered during the first 12 months of the contract. A pre-existing condition is any condition for which I / We received medical advice, diagnosis, care, or treatment during the first 6 months preceding my/our C.W.F. coverage effective date, any condition manifesting itself in symptoms which would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment or a pregnancy existing on the C.W.F. effective date

If I am required to contribute to the premium for my coverage, I hereby authorize my employer to deduct such contributions in advance from wages due me and remit same to C.W.F.

All information provided above is true and complete to the best of my knowledge. A copy of this application will be placed in my C.W.F. medical record.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation

All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage.

Applicant must sign here: _____ Date: _____

To be completed by Employer/Contractor Group

Name of Group		Group Number	
Effective Date	Date Submitted to CWF	Approved By	CWF Use Only
			Processed by _____ Date _____

COMBINED WELFARE FUND

HEALTH HISTORY COVERGE FORM

SUBSCRIBER: To complete the enrollment process, information on any prior health insurance coverage you and/or your dependents have had in the last 12 months is required. Please attach the "Certificate of Coverage" from your prior health plan(s) or complete the following. Within the past 12 months I have had (check one)

No prior coverage One insurance carrier Multiple insurance carriers

1. INSURANCE CARRIER NAME _____ DATE COVERAGE BEGAN _____	POLICY/SUBSCRIBER NUMBER _____ DATE COVERAGE ENDED _____	TYPE OF POLICY <input type="checkbox"/> GROUP <input type="checkbox"/> FAMILY <input type="checkbox"/> INDIVIDUAL
2. INSURANCE CARRIER NAME _____ DATE COVERAGE BEGAN _____	POLICY/SUBSCRIBER NUMBER _____ DATE COVERAGE ENDED _____	TYPE OF POLICY <input type="checkbox"/> GROUP <input type="checkbox"/> FAMILY <input type="checkbox"/> INDIVIDUAL
DEPENDENT NAME _____ _____ _____		
YES	NO	GIVE DETAILS TO QUESTIONS ANSWERED "YES" IN THE SPACES PROVIDED BELOW
		Has anyone been treated for serious illness, hospitalized, or had surgery during the past five (5) years? (Including but not limited to examples: cancer, diabetes, cardiovascular disease, AIDS, substance abuse, renal disease, mental illness, etc.) If yes please explain.
		Has anyone been treated for an illness that required any kin of surgery or outpatient procedure during the past 12 months? If yes, please explain
		Has anyone undergone open-heart surgery or received significant cardiac testing at anytime? (Including but not limited to examples: cardiac catheterization, angioplasty, bypass graft, pacemaker, valve replacement, etc.) If yes, please explain.
		Has anyone had a claim of \$5,000 or more in the past 12 months? Do you foresee any claims in excess of \$5,000 occurring within the next 12 months? (Including but not limited to examples: pregnancy, etc.)
		Does anyone have continuing claims due to mental or physical disorders or for prescribed drugs such as anti-reject drugs, growth hormones, steroids, insulin, cardiac medications, AZT, drugs for mental nervous conditions, or any other maintenance medications? If yes, please explain.
		Has anyone been treated for the same condition more than once during the past 12 months? If yes, please explain.
DETAILS		

If additional space is needed for dependents, please complete a separate sheet of paper.
To the best of my knowledge. The information provided above is true and complete. I.E. I understand that failure to complete this form may result in denied claim payment for services.

PRINT NAME OF SUBSCRIBER _____ SIGNATURE OF SUBSCRIBER _____ DATE _____

Combined Welfare Fund

\$250,000 Incurred Annual Maximum Multiplan network/Beech-Street Network Summary of Benefits Plan

Co-insurance Maximum	\$3,500 single \$7,000 Family	Per Visit	**After \$1,000 Per Member or \$3,000 Per Family
Primary Care Visit		In Network	Out of Network**
Office Visits		\$20.00 Co-Pay	70%
Diagnostic Services <input type="checkbox"/> X-ray & Labs		\$15.00 Co-Pay	70%
Specialty Care		In Network	Out of Network**
Chiropractic Services 14 Per Year		\$25.00 Co-Pay	70%
Pre-Natal & Post-Natal Care		\$20.00 Co-Pay	70%
Durable Medical Equipment		\$20.00 Co-Pay	70%
Mental Health 14 Per Year		\$20.00 Co-Pay	70%
Outpatient Alcohol & Substance Abuse Treatment 28 Per Year		\$20.00 Co-Pay	70%
Diabetes (Supplies & Education)		\$20.00 Co-Pay	70%
Outpatient Therapy - Speech, Physical Occupational & Repertory		\$20.00 Co-Pay	70%
Preventive Care		In Network	Out of Network**
Routine Physical 1 Per Year		\$20.00 Co-Pay	70%
Routine OBGYN		\$20.00 Co-Pay	70%
Routine Infant Care (Including Immunizations)		\$20.00 Co-Pay	70%
Routine Foot Care 14 Per Year		\$20.00 Co-Pay	70%
Routine Mammogram		\$50.00 Co-Pay	70%
MRI *		\$50.00 Co-Pay	70%
Cat-Scan *		\$50.00 Co-Pay	70%
Hospitalization¹		In Network	Out of Network**
One Deductible for all Hospital Care		\$5,000 Deductible	After \$5,000 Deductible 70%
Out Patient Surgery*		\$5,000 Deductible	70%

Summary of Benefits

Emergency Room *	\$100.00 Co-Pay	70%
Home Health Care *	\$20.00 Co-Pay	70%
Ambulance to E/R	\$100.00 Total	70% all charges after \$100

***Pre-Cert Required**

Prescription Plan***

Co-Pay Per Prescription		<i>In Network</i>	<i>Out of Network**</i>
<i>Prescription Type</i>	Generic	\$10.00	N/A
	Brand	\$25.00	N/A
	Non-Formulary	Discount	N/A

Mail Order Program 35-90 day supply

<i>Prescription Type</i>	Generic	\$20.00	N/A
	Brand	\$50.00	N/A
	Non-Formulary	Discount	N/A

*** - Annual Maximum Benefit for Prescriptions is \$2,500 Per Policy

Dental Coverage

	<i>In Network</i>	<i>Out of Network**</i>
Covered at a reduced member fee schedule	Covered only per Provider List	N/A

Prescription Eyewear and Supplies

Limits		<i>In Network</i>	<i>Out of Network**</i>
Eye Exam Lenses Select Frames	1 Voucher only every 24 months	Call Fund for Voucher	N/A

1 Note: Please call the Combined Welfare Fund at the following number for Eligibility, Pre-certifications, and Vouchers for Prescription Eyewear and supplies at 718-847-7726.