Resolution 2024-192

A Resolution Approving The Zurich American Insurance Company's Supplemental Medical Expense Policy

The Board of Trustees of Franklin Township, Franklin County, Ohio, met in person in a Special Meeting at 12:00 p.m. on Wednesday, December 11, 2024. The trustee marked below made a motion for the adoption of the following Resolution:

☐ ***Leezer*** ☐ ***Fleshman*** ☐ ***Blevins***

BE IT RESOLVED that effective January 1, 2025, the Board of Trustees of Franklin Township, Franklin County, Ohio approves and authorizes to contract with the Zurich American Insurance Company's Supplemental Medical Expense Policy for all benefitted Township employees. The policy is a zero (0) deductible medical benefit that will reduce Franklin Township's medical insurance expenses.

BE IT FURTHER RESOLVED that all formal actions of this Board concerning and relating to this Resolution were passed in an open meeting of the Board, and that all deliberations of this Board and any of its committees that resulted in such formal action were in a meeting open to the public, in compliance with all legal requirements including Section 121.22 of the Ohio Revised Code.

BE IT FURTHER RESOLVED that this Resolution shall be declared an emergency and be in full force and effective immediately upon its adoption.

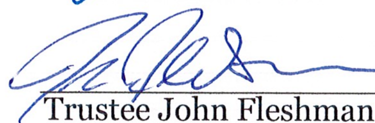
The following trustee marked below seconded the motion:

☐ ***Leezer*** ☑ ***Fleshman*** ☐ ***Blevins***

Roll was called for the adoption of the Resolution, and the vote was as follows:

Leezer: ☐ YES/ ☐ NO ***Fleshman***: ☐ YES/ ☐ NO ***Blevins***: ☐ YES/ ☐ NO

Trustee James Leezer



Trustee John Fleshman

Trustee Mike Blevins

Adopted: December 11, 2024

Application
Group Supplemental Medical Expense Policy

ZURICH®

Zurich American Insurance Company
1299 Zurich Way
Schaumburg, Illinois 60196

APPLICANT INFORMATION

Applicant's Legal Name: Franklin Township Tax ID #: ______
Street Address: 2193 Frank Road City: Columbus State: OH Zip Code: 43223
Mailing Address: ______ City: ______ State: ______ Zip Code: ______
Telephone: 614-279-9411 Website: www.franklin-townshipohio.gov
Contact Person: ______ Email: ______

Are Subsidiaries/Affiliates to be covered? ☐ Yes ☒ No If Yes, please provide a list of complete names and addresses of all to be covered. ______
Number of years in business: 20+
Public or Privately Owned: ______
Nature of Business: Local Government
Number of eligible employees: ______
Number of enrolled employees: ______
Number waiving coverage: ______

Pay Period: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Requested Effective Date: 1/1/2025 Open Enrollment Period: 12/1/24-12/15-24

This request is for: ☒ New Coverage ☐ Replacement Coverage
If replacing existing coverage, indicate:
Name of Carrier: ______
Coverage Type: ______
Policy Number(s): ______ Date(s) of Replacement: ______

Class(es) of Employees (check one):

☐ All employees working a minimum of 30 hours per week after ______ days active service who are covered under the Applicant's **Health Benefit Plan**.

☐ All employees working a minimum of ______ hours per week after ______ days active service who are covered under a **Health Benefit Plan**.

Please select BENEFIT OPTIONS
(All Coverages/ Benefits are subject to terms, conditions, exclusions and other provisions in the Policy)

BENEFIT PERIOD: ☐ Plan Year ☒ Calendar Year
POLICY DEDUCTIBLE: ☐ Applies ☐ Does not Apply

☒ **Policy Deductible (Traditional)**

Per Covered Person: $0

Per Family* $0

Applies to: ☒ Inpatient and Outpatient Benefits
☐ Inpatient Benefits Only
☐ Outpatient Benefits Only

Waived for Accident: ☐ Yes ☒ No

*The "Per Family" Policy Deductible may be satisfied by one or more Covered Person. Benefits for a Covered Person will be payable after the Covered Person has met the "Per Covered Person" Policy Deductible or after the "Per Family" Policy Deductible has been met, whichever occurs first.

☐ **Policy Deductible (High Deductible – Health Savings Account "HSA" Compatible)**

Per Covered Person: $_____

Per Family* $_____

Applies to: ☒ Inpatient and Outpatient Benefits
☐ Inpatient Benefits Only
☐ Outpatient Benefits Only

Waived for Accident: ☐ Yes ☒ No

*If more than one person is covered under the Insured's Certificate, the "Per Family" Policy Deductible must be satisfied before any benefits are payable for a Covered Person. The "Per Family" Policy Deductible may be satisfied by one or more Covered Persons.

☐ **Policy Deductible (High Deductible – Health Savings Account "HSA" Non-Compatible)**

Per Covered Person: $_____

Per Family* $_____

Applies to: ☒ Inpatient and Outpatient Benefits
☐ Inpatient Benefits Only
☐ Outpatient Benefits Only

Waived for Accident: ☐ Yes ☒ No

*If more than one person is covered under the Insured's Certificate, the "Per Family" Policy Deductible must be satisfied before any benefits are payable for a Covered Person. The "Per Family" Policy Deductible may be satisfied by one or more Covered Persons.

SUPPLEMENTAL MEDICAL COINSURANCE: ☒ Applies ☐ Does not Apply

Per Covered Person: 100%

Applies to: ☒ Inpatient and Outpatient Benefits
☐ Inpatient Benefits Only
☐ Outpatient Benefits Only

Waived for Accident: ☐ Yes ☒ No

BENEFITS

☐ **Inpatient Benefits**

Maximum Benefit per Covered Person: $______ per Benefit Period

Maximum Benefit per family: ______ times the Maximum Benefit per Covered Person per Benefit Period

☒ **Combined Inpatient and Outpatient Benefits**

Maximum Benefit per Covered Person: $6000 per Benefit Period

Maximum Benefit per family: 2 times the Maximum Benefit per Covered Person per Benefit Period

ADDITIONAL BENEFITS

☐ **Doctor's Office Visits**

Maximum Benefit per Covered Person: $______ per visit, up to ______ visits, per Benefit Period

Maximum Benefit per family: $______ per visit, up to ______ times the number of visits per Covered Person per Benefit Period

☐ **Outpatient Benefits I**

Maximum Benefit per Covered Person: $______ per Injury or Sickness per Benefit Period

Maximum number of occurrences per family: ______ Outpatient occurrences per family per Benefit Period

☐ **Outpatient Benefits II**

Maximum Benefit per Covered Person: $______ per Benefit Period

Maximum Benefit per family: ______ times the Maximum Benefit per Covered Person per Benefit Period

INSURANCE AGENT INFORMATION

Name: Brian Lenzo
Agency: HUB International

Address: 611 S. Sandusky Street
City: Delaware
State: OH
Zip Code: 43215

Telephone: 800-558-5658
Email: brian.lenzo@hubinternational.com

Standard Commission: ☒ Yes ☐ No ☐ Other _____% Name of Licensed Agent: _____

We reserve the right to modify the rates or plan benefits or to decline to bind coverage if participation requirements are not met by initial enrollment.

For any insurance paid in part, or wholly, by individual **Insureds**, the Applicant will support enrollment activities and allow all eligible persons an opportunity to enroll. No brochures or any material referencing the requested insurance will be published without the prior written approval of the Insurance Company.

The Applicant represents the information contained in this Application is true and correct and forms the basis of the requested insurance. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the Applicant.

I understand this Application is for a Supplemental Medical Expense Insurance Plan. The insurance provided is not Major Medical or Comprehensive Medical coverage, and does not satisfy an individual's obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA).

I understand and acknowledge that no coverage will take effect for any person who is not also covered by the Policyholder's Health Benefit Plan in effect at the time of the proposed Effective Date for this coverage. This underlying Health Benefit Plan must include Coinsurance and/or Deductible amounts.
The applicant hereby applies for Supplemental Medical Expense Policy and:

1. Represents that the answers included in this Application have been reviewed and are true and complete; and
2. Understands and agrees that the insurance applied for shall not become effective until the Application is approved by the Company and the initial premium deposit is received; and
3. Agrees that if the insurance applied for is approved by the Company, the applicant will pay all premiums due after the effective date of the insurance.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

This application shall be made part of the Policy, if issued.

☐ By checking this box, the applicant acknowledges that the applicant is electronically signing this form. Furthermore, in order to conduct business electronically with the **Company**, the applicant acknowledges that the electronic signature is the same as the handwritten signature for purposes of validity, enforceability, and admissibility.

Completed by: ______________________________ Title: _____

Signature: ______________________________ Date: _____

Signature of Licensed Agent______________________________ Date: _____