

FOR OFFICE USE ONLY	
Med RB:	_____
Dent Key:	_____
Eff. Date:	_____
Group #:	_____

MASTER APPLICATION FOR INSURANCE COVERAGE

Company Information:

Legal Name of Business:	Requested Effective Date:	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other
dba (if applicable)	Employer Tax ID Number (EIN):	
Type of Business:	NAICS Code:	

Billing Address: (street, city, state, zip)

Shipping Address: (if different)

Billing/Eligibility Contact:	Phone:	
	Fax:	Email:

Medical Coverage – Premiera Blue Cross

1. **Premera Network (Choose one):** Heritage Prime Heritage (Plus)

2. **Medical Plan(s):***

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> PPO 80 \$250 | <input type="checkbox"/> PPO 80 \$2000 | <input type="checkbox"/> PPO 70 \$1000 | <input type="checkbox"/> PPO 50 \$0 |
| <input type="checkbox"/> PPO 80 \$350 | <input type="checkbox"/> PPO 80 \$2500 | <input type="checkbox"/> PPO 70 \$1500 | <input type="checkbox"/> PPO 50 \$1000 |
| <input type="checkbox"/> PPO 80 \$500 | <input type="checkbox"/> PPO 80 \$3000 | <input type="checkbox"/> PPO 70 \$2000 | <input type="checkbox"/> PPO 50 \$2000 |
| <input type="checkbox"/> PPO 80 \$750 | <input type="checkbox"/> PPO 80 \$4000 | <input type="checkbox"/> PPO 70 \$2500 | <input type="checkbox"/> HSA \$1500 |
| <input type="checkbox"/> PPO 80 \$1000 | <input type="checkbox"/> PPO 80 \$5000 | <input type="checkbox"/> PPO 70 \$3000 | <input type="checkbox"/> HSA \$2500 |
| <input type="checkbox"/> PPO 80 \$1500 | <input type="checkbox"/> PPO 100 \$5500 | <input type="checkbox"/> PPO 70 \$4000 | <input type="checkbox"/> HSA \$3500 |
| | | <input type="checkbox"/> PPO 70 \$6000 | <input type="checkbox"/> HSA \$5500 |

**Groups of 10 or more enrolled employees may select up to 2 plans as permissible per the dual choice matrix. Plan combinations must be within the same network (exception: groups of 51+ enrolled employees – please contact us for a quote). A minimum of 5 employees must be enrolled in each plan.*

Prior Coverage

Will this coverage replace existing group coverage with another carrier? Yes No
(NEW GROUPS ONLY): If yes, name of carrier: _____

Life/AD&D Coverage – LifeMap Assurance Company

Optional Life/AD&D (All plans include \$10,000 Life/AD&D):
 \$15,000 \$25,000 \$50,000 (requires 5 or more enrolled) Dependent Life

Vision – VSP Vision Care Inc

Vision: Exam Plus Basic Preferred Enhanced

Dental – Delta Dental of Washington

Optional Dental: Plan I Plan II Plan III Plan IV **Orthodontia** (Available to groups of 10+): Yes No
Voluntary Dental (requires the greater of 35% participation or 5 or more enrolled): Voluntary I Voluntary II

Group Participation

Total number of employees on payroll regardless of hours worked. (Do not include COBRA participants)

• Less employees working fewer than the **minimum hours** required

• Less employees not in an **eligible class**

• Less employees who have not completed the **probationary period**

• Less employees paid via IRS Form **1099, or temporary, seasonal or substitute** employees

• Less employees waiving coverage because they are covered by **TRICARE (CHAMPUS), Medicaid or coverage through the Exchange.**

• Less employees waiving coverage because they are covered by a spouse's or parent's **similar group medical plan. (Proof of coverage required if participation falls below 75%).**

• Less employees waiving coverage because they are covered by **Medicare as primary**, at the request of the enrollee. **(Proof of coverage required if participation falls below 75%).**

• Equals total number of employees eligible to enroll

• Number of employee applications being submitted (75% participation required)

• Number of employees covered by your group under provisions of COBRA

Washington Farm Bureau Healthcare Trust - Subscription Agreement Language

Understanding of the Terms & Provisions of Participation

The undersigned Employer agrees to adhere to the terms, conditions and limitations of coverage as set forth in the health service contracts, insurance policies, service contracts, benefit booklets and certificates of insurance issued by Washington Farm Bureau Healthcare Trust or Washington Farm Bureau Healthcare Trust's respective carriers.

Sponsor – The undersigned Employer acknowledges and agrees that Washington Farm Bureau (WFB) is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. WFB may charge a service fee for services performed on behalf of Trust. Additionally, WFB may charge a membership fee for participating in the Trust. Membership fees are not used to provide health plan benefits and are not considered Trust or Plan assets.

Producers – The undersigned Employer acknowledges that it may hire a producer to represent the Employer when joining the Trust. The undersigned Employer authorizes the Trust to recognize any fee/commission arrangement between the Employer and its producer and to receive and pay such fees/commissions to the producer. Producer fees/commissions received by the Trust shall not be used to provide Plan benefits and are not considered Trust or Plan assets.

Authority of Trustees – The undersigned Employer acknowledges and agrees that all Trustees appointed under the Trust Agreement shall have all rights and powers described here under and as set forth in the Trust Agreement.

Third Party Administrator – The undersigned Employer agrees that the Trust may select one or more service providers to act as a third party administrator ("TPA") for the Trust and/or the Welfare Benefits Plans, and that such service providers may be one or more of the Member Companies.

Contributions – The undersigned Employer agrees to pay the contributions established by the Trust every month. The undersigned Employer further understands and agrees that benefits for employees shall not be provided by the Trust during any month for which contributions are not paid.

Termination – This Adoption Agreement may be terminated by the undersigned Employer, which may withdraw from participation in the Trust by giving thirty (30) days written notice of intent to withdraw to the Trustees in accordance with the Trust Agreement. Such Member Company shall have the rights and duties specified therein. This Agreement may be terminated by the Trust, in the event that the undersigned Employer (a) shall fail or refuse to pay contributions due to the Trust in accordance with the Trust Agreement, or (b) shall be in breach of any of its other obligations under the Trust Agreement of this Adoption Agreement, which breach shall not have been cured within ten (10) days after the undersigned Employer receipt of written notice thereof.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trustees and the Sponsor from any and all loss, damages or liability incurred in the course and scope of their respective duties as described in this Agreement, except those resulting from their gross negligence, willful misconduct or dishonesty. In the event that the Trustees or the Sponsor are made a party to any legal proceeding of any kind or nature arising out of their respective duties hereunder, directly or indirectly, the undersigned Employer agrees to indemnify and hold them harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting therefrom. Any damages assessed or expenses required to be paid or incurred by reason of this indemnification shall be borne equally by all Member Companies, unless it shall be determined that the damages, expenses or losses incurred result directly from the actions or inactions of a specific Member Company, its employees or producers. In such event, that specific Member Company shall be

primarily responsible for payment, with other Member Companies being responsible only in the event of the specific Member Company's inability by reason of financial insolvency to respond.

Governing Law – This Agreement shall be construed and enforced in accordance with ERISA and, to the extent applicable, the laws of the State of Washington.

Anti-Fraud Statement

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I agree that all information completed on this application is true, correct, and complete. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. I understand that the issuer will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Group after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group no longer qualifies for the Rate quoted, I understand that the issuer will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the Rate adjustment within 30 days of the date of notice by the issuer. In addition, the issuer will have the right to collect any claims payments or other damages.

Group Signature Section:

SIGNATURE & TITLE OF EMPLOYER REPRESENTATIVE

DATE

Insurance Producer Application

A business applying for insurance coverage through the Washington Farm Bureau Healthcare may appoint their own Insurance Producer to represent them as noted below.

Name of Insurance Producer: _____

Name of Producer's Agency: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

E-mail Address: _____

We hereby appoint the above named Insurance Producer as our firm's Producer of Record.

This agreement will serve as notice of cancellation of any previous Insurance Producer agreement. This new appointment will remain effective until written notice is given by either party of a change. No changes may be made retroactively.

Name of Employer

Signature of Employer Representative

Date

Name & Title (PRINTED) of Employer Representative

Coverage Underwritten by:

Medical Insurance Benefits are underwritten by:

Premera Blue Cross; 7001 220th St SW; Mountlake Terrace, WA 98043-2160

Life Insurance Benefits are underwritten by:

LifeMap Assurance Company; PO Box 1271, MS E3A; Portland, OR 97207-1271

Dental Insurance Benefits are underwritten by:

Delta Dental of Washington; 400 Fairview Avenue North, Suite 800, Seattle, WA 98109-5271

Vision Insurance Benefits are underwritten by:

VSP Vision Care Inc; 3333 Quality Drive; Rancho Cordova, CA 95670

