

FOR OFFICE USE ONLY	
Med RB:	_____
Dent Key:	_____
Eff. Date:	_____
Partner Assoc:	_____
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:	SIC Code:

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

Shipping Address: (if different)

Billing/Eligibility Contact:	Phone:	Email:
	Fax:	

Medical Coverage – Premera 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 \$500 | <input type="checkbox"/> PPO 80 \$2500 | <input type="checkbox"/> PPO 70 \$1500 | <input type="checkbox"/> PPO 50 \$1000 |
| <input type="checkbox"/> PPO 80 \$750 | <input type="checkbox"/> PPO 80 \$3000 | <input type="checkbox"/> PPO 70 \$2000 | <input type="checkbox"/> PPO 50 \$2000 |
| <input type="checkbox"/> PPO 80 \$1000 | <input type="checkbox"/> PPO 80 \$4000 | <input type="checkbox"/> PPO 70 \$2500 | <input type="checkbox"/> HSA \$1500 |
| <input type="checkbox"/> PPO 80 \$1500 | <input type="checkbox"/> PPO 80 \$5000 | <input type="checkbox"/> PPO 70 \$3000 | <input type="checkbox"/> HSA \$2500 |
| | <input type="checkbox"/> PPO 100 \$5500 | <input type="checkbox"/> PPO 70 \$4000 | <input type="checkbox"/> HSA \$3500 |
| | <input type="checkbox"/> PPO 100 \$8000* | <input type="checkbox"/> PPO 70 \$5000 | <input type="checkbox"/> HSA \$5500 |
| | | <input type="checkbox"/> PPO 70 \$6000 | |

Dual Choice: 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 2 employees must be enrolled in each plan.

**NOTE: PPO 100/8000 plan NOT available as dual choice option.*

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 (Enrollment Must Match Medical) – 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 (Enrollment Must Match Medical) – VSP Vision Care Inc

Vision: Exam Plus Basic Preferred Enhanced

Dental (Uncommon Enrollment Allowed) – Delta Dental of Washington

Group Dental (requires 2+ employees and 51% employee participation): 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.

Changes – The undersigned Employer acknowledges that this Agreement may only be changed at contract renewal or as mutually agreed between the Employer and Trust, and subject to the insurance carrier's approval. The undersigned Employer agrees to notify the Trust when there is a change to the Employer's name, address, phone number, contact person, or ownership status.

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 Plans, and that such service providers may be a member of the WFB.

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 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 terminate this Agreement. Such Employer shall have the rights and duties specified in the Trust Agreement. This Agreement may be terminated by the Trust, in the event that the undersigned Employer (a) fails or refuses to pay contributions due to the Trust, or (b) shall be in breach of any of its other obligations under the Trust Agreement.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trust, its Trustees and the Sponsor from any and all loss, damages or liability resulting from the undersigned Employer's negligence, misrepresentation, breach of contract or dishonesty. In the event that the Trust, its Trustees or the Sponsor are made a party to any legal proceeding arising from the undersigned Employer's negligence, misrepresentation, breach of contract or dishonesty, the undersigned Employer agrees to indemnify and hold them harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting therefrom.

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

