WASHINGTON FARM BUREAU Healthcare

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:	❑ Corporation ❑ Partnership ❑ Proprietorship ❑ 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: Fax:	Email:

Medical Coverage – LifeWise Health Plan of Washington

❑ PPO 80 | $500
❑ PPO 80 | $750
❑ PPO 80 | $1000
❑ PPO 80 | $1500
❑ PPO 80 | $2000
❑ PPO 80 | $2500
❑ PPO 80 | $3000
❑ PPO 80 | $4000
❑ PPO 80 | $5000
❑ PPO 100 | $5500

❑ PPO 70 | $1500
❑ PPO 70 | $2000
❑ PPO 70 | $2500
❑ PPO 70 | $3000
❑ PPO 70 | $4000
❑ PPO 70 | $5000
❑ PPO 70 | $6000

❑ PPO 50 | $1000
❑ PPO 50 | $2000
❑ HSA $1600
❑ HSA $2500
❑ HSA $3500
❑ HSA $5500

Dual Choice: Groups of 10 or more enrolled employees may select up to 2 plans as permissible per the dual choice matrix. A minimum of 2 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 (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

Late Fee Policy – *Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of $20 or 1.5% of the amount owed, whichever is greater. The fee will be added to the next month's billing statement. Unpaid balances may be referred to collections. The employer will be responsible for any fees, attorney fees or other fees, associated with the collections process.*

Payment Options: ❑ Electronic Funds Transfer (EFT)* ❑ Other (Check or Online Payment)

**If you choose EFT as your payment option you must also complete the EFT form*

WFB Membership – *A membership with Washington Farm Bureau is required to obtain coverage through Washington Farm Bureau Healthcare. If your group is not currently a member, please complete a WFB Membership Application. Membership must be maintained to continue coverage under the plan. Membership fees are not used to provide plan benefits and are not consider plan assets. Any membership fees received by the Washington Farm Bureau Healthcare will be forwarded to the Washington Farm Bureau.*

Current WFB Member: ❑ No ❑ Yes, Membership Number: _____

Partner Association Member: ❑ No ❑ Yes, Partner Association Name: _____

Note: A WFB Membership is also required for Partner Association groups.

COBRA and FMLA

	COBRA Administration: Regardless of size, all groups insured by Washington Farm Bureau Healthcare are eligible for COBRA. Rehn & Associates will administer COBRA for all WFBH lines of coverage at no additional cost.
❑ **Yes** ❑ **No**	**FMLA:** Did your company employ 50 or more full and/or part-time employees during each of the 20 calendar weeks in the current or preceding calendar year, and is it subject to federal TEFRA laws?
_____	**Affordable Care Act Required Information:** Please enter the average number of employees that were employed by your company during the prior calendar year (January – December). This count should include: full-time, part-time, seasonal, and union employees that work inside or outside the state of Washington and employees in any state from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.

Eligibility and Enrollment

Participation Requirement	■Minimum 75% Employee Participation of all eligible employees	
Employer Contribution	Employee: %	Dependent: %

Eligible Employees are required to work _____ hours per week
(Minimum Requirement: 20 hours per week, administered on a non-discriminatory basis, based on conditions of employment)

Eligible Employee Classifications:

Class 1:_____Eligibility Requirements (other than hours):_____

Class 2:_____Eligibility Requirements (other than hours):_____

Probationary period should be effective on the 1st of the month following or coinciding with:

Class 1: ❑ Date of Hire* ❑ 30 Days ❑ 60 Days – not to exceed 90 Days

Class 2: ❑ Date of Hire* ❑ 30 Days ❑ 60 Days – not to exceed 90 Days

Eligibility Look Back Measurement/Stability Period:

Has your company adopted a look back measurement/stability period under the ACA for the employee classification referenced above?

❑ Yes ❑ No

If Yes, the Measurement Period is ___ months and the Stability Period is ___ months. Please confirm that this measurement period is being applied due to a good faith uncertainty about whether the employee meets the eligibility criteria referenced above: ❑ Yes

***If 'Date of Hire' (DOH) is selected above, choose how DOH will be administered**

❑ Effective date will always be 1st of month following DOH, even if DOH is the 1st of the month

❑ Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

NEW GROUPS ONLY - Is probationary period waived on group's initial enrollment?

❑ Yes (Probationary period applies only to future full-time employees)

❑ No (Probationary period applies to all current and future full-time employees)

For employees transferring from part-time to full-time status, the probationary period specified should apply

❑ Retroactive to the original date of hire **OR** ❑ Beginning on the date transferred to full-time status

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. (P**roof 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.

Temporomandibular Joint Disorder (TMJ) - When selecting a LifeWise Health Plan of Washington plan, coverage for Temporomandibular Joint Disorder (TMJ) will be offered under the medical plan or stand-alone dental plan. Please see your plan benefit for specific TMJ benefit coverage.

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:
LifeWise Health Plan of Washington; 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