

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**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> PPO 80   \$250   | <input type="checkbox"/> PPO 70   \$1000 | <input type="checkbox"/> PPO 50   \$0    |
| <input type="checkbox"/> PPO 80   \$500   | <input type="checkbox"/> PPO 70   \$1500 | <input type="checkbox"/> PPO 50   \$1000 |
| <input type="checkbox"/> PPO 80   \$750   | <input type="checkbox"/> PPO 70   \$2000 | <input type="checkbox"/> HSA \$1700      |
| <input type="checkbox"/> PPO 80   \$1000  | <input type="checkbox"/> PPO 70   \$2500 | <input type="checkbox"/> HSA \$2500      |
| <input type="checkbox"/> PPO 80   \$1500  | <input type="checkbox"/> PPO 70   \$3000 | <input type="checkbox"/> HSA \$3500      |
| <input type="checkbox"/> PPO 80   \$2000  | <input type="checkbox"/> PPO 70   \$4000 | <input type="checkbox"/> HSA \$5500      |
| <input type="checkbox"/> PPO 80   \$2500  | <input type="checkbox"/> PPO 70   \$5000 |  |
| <input type="checkbox"/> PPO 80   \$3000  | <input type="checkbox"/> PPO 70   \$6000 |  |
| <input type="checkbox"/> PPO 80   \$4000  | <input type="checkbox"/> PPO 70   \$8000 |  |
| <input type="checkbox"/> PPO 80   \$5000  |  |  |
| <input type="checkbox"/> PPO 100   \$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

**Employee Assistance Program (Available to All Enrolled Employees) - First Choice Health**

**Basic Plan:**  Up to 3 in-person assessment sessions per issue/per person/per year.



**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.

**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 220<sup>th</sup> St SW; Mountlake Terrace, WA 98043-2160**  
**Life Insurance Benefits are underwritten by:**  
**USable Life; P.O. Box 1650 Little Rock, AR 72223**  
**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**  
**Employee Assistance Program Benefits are underwritten by:**  
**First Choice Health.; 400 Westlake Avenue North, Suite 1500, Seattle, WA 98109**

