

Rate Band: \_\_\_\_\_

Eff. Date: \_\_\_\_\_

Group #: \_\_\_\_\_

**MASTER APPLICATION FOR INSURANCE COVERAGE**

**Company Information:**

Legal Name of Business:	Employer Tax ID Number (EIN):	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other
dba (if applicable)	Requested Effective Date:	
Type of Business:	Next Renewal Date:	NAICS Code:
Billing Address: (street, city, state, zip)		SIC Code:
Shipping Address: (if different)		
Billing/Eligibility Contact:	Phone: Fax:	Email:

**Medical Coverage – Regence BlueCross BlueShield of Oregon**

**PPO Plan A Series:**     PPO | \$500     PPO | \$1,000     PPO | \$1,500     PPO | \$2,000     PPO | \$2,500     PPO | \$3,500  
 PPO | \$5,000

**PPO Plan B Series:**     PPO | \$500     PPO | \$1,000     PPO | \$1,500     PPO | \$2,000     PPO | \$2,500     PPO | \$3,500  
 PPO | \$5,000

**PPO Plan D HSA:**     HSA | \$1,500     HSA | \$2,500     HSA | \$3,500     HSA | \$5,000

**ACO Plan M (Tuality/Adventist)**     ACO | \$500     ACO | \$1,000     ACO | \$2,000     ACO | \$5,000

**Prior Coverage**    Will this coverage replace existing group coverage with another carrier?     Yes     No  
**(NEW GROUPS ONLY):** If yes, name of carrier: \_\_\_\_\_

**EAP – Reliant Behavioral Health (RBH)**

**Optional EAP:**     3-Visit Model     6-Visit Model

**Life & AD&D – LifeMap Assurance Company**

**Optional Life/AD&D:**     Plan A (\$10,000)     Plan B (\$15,000)     Plan C (\$25,000)

**Vision – VSP**

**Optional Vision:**     Plan 1     Plan 2     Plan 3

**Dental – Moda Health (ODS)**

**Optional Dental:**     Plan 1000     Plan 1500     Plan 2000    **Orthodontia Rider**  Yes  No

**Regence Required Domestic Partner Eligibility – Please Check One**

- This plan will allow coverage for Certified Domestic Partners *only*
- This plan will allow coverage for *both* Certified and Non-Certified Domestic Partners

**Payment Options – if you choose EFT as your payment option you must also complete the EFT form**

**Pay Via:**     Electronic Funds Transfer (EFT)     Other

**Vigilant Membership** – A membership with Vigilant is required to obtain coverage through Vigilant Group Benefits Trust. Please complete the attached Vigilant Membership Application. Membership must be maintained to continue coverage under the plan.

**Current Member:**     Yes     No

**COBRA, Worker's Compensation, & ACA Information**

**COBRA Administration:** Regardless of size, all groups insured by Vigilant Group Benefits Trust are eligible for COBRA. Benefit Solutions, Inc. will administer COBRA for all VGBT lines of coverage at no additional cost.

Yes  No

**Worker's Compensation:** Does your group have Worker's Compensation coverage?

If yes, name of carrier: \_\_\_\_\_

**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, union employees, out of state employees, and employees from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.

**Eligibility and Enrollment****Participation and Contribution Requirements**

Minimum 75% Employee Participation of all eligible employees

Minimum 50% Employer Contribution for Employee Coverage

**Employer Contribution**

Employee: \_\_\_\_\_ %

Dependent: \_\_\_\_\_ %

**Eligible Employees are required to work \_\_\_\_\_ hours per week**

(Minimum Requirement: 17.5 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): \_\_\_\_\_

Class 3: \_\_\_\_\_ 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

Class 3:  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 1<sup>st</sup> of month following DOH, even if DOH is the 1<sup>st</sup> of the month

Effective date will be 1<sup>st</sup> of the month following DOH, with the exception of when the DOH is the 1<sup>st</sup> 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 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 completing waiving coverage because they are covered by **TRICARE (CHAMPUS)** - \_\_\_\_\_

• 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 Medicare 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 \_\_\_\_\_

## Vigilant Group Benefits 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 Vigilant Group Benefits Trust or Vigilant Group Benefits Trust's respective carriers.

**Sponsor** – The undersigned Employer acknowledges and agrees that Vigilant is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. Vigilant shall be entitled to reimbursement for any out-of-pocket expenses directly related to its marketing support and activities from Trust assets. Vigilant may also charge a service fee for services performed on behalf of the Trust.

**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 there from. 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 Oregon.

### Anti-Fraud Statement

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify 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 Vigilant Group Benefits Trust may appoint their own Insurance Producer to represent them as noted below.

Name of Insurance Producer: \_\_\_\_\_

Name of Producers Brokerage/Agency: \_\_\_\_\_

Regence Producer Number: \_\_\_\_\_

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:  
Regence BlueCross BlueShield of Oregon; 200 SW Market Street; Portland, OR 97201**  
**Dental Insurance Benefits are underwritten by:  
Moda Health; 601 SW 2<sup>nd</sup> Ave; Portland, OR 97204**  
**Life and AD&D Insurance Benefits are underwritten by:  
LifeMap Assurance Company; PO Box 1271, MS E3A; Portland, OR 97207**  
**Employee Assistance Plan Insurance Benefits are underwritten by:  
Reliant Behavioral Health; 1220 SW Morrison Street #600; Portland, OR 97205**  
**Vision Insurance Benefits are underwritten by:  
VSP Vision Care Inc; 3333 Quality Drive; Rancho Cordova, CA 95670**



Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

