VIGILANT℠
benefits for employers

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

Managing General Agent: DiMartino Associates
1501 Fourth Avenue, Suite 2400, Seattle, WA 98101

MASTER APPLICATION FOR ANCILLARY INSURANCE COVERAGE

COMPANY INFORMATION		
Legal Name of Business:	Requested Effective Date:	Employer Tax ID Number (EIN):
Doing Business As (DBA):	NAICS Code:	SIC Code:

Physical Business Address (No PO Box or PMB):

Mailing Address (if different from Physical Business Address):

Billing/Eligibility Contact:	Phone: Fax:	Email:

OptiFlex MEDICAL – OptiFlex Medical coverage is required in order to enroll in Trust ancillary coverage. A separate Group Master Application must be completed in order to enroll in OptiFlex medical coverage. All lines of coverage require common enrollment.

Medical Coverage (Required): ☐ An application for OptiFlex medical coverage has been completed

OptiFlex Plan Choice: _____

Vigilant Membership – A membership with Vigilant is required to obtain coverage through Vigilant Manufacturers' Trust. Please submit a Vigilant Membership Application along with dues payment. Membership must be maintained to continue coverage under the plan.

Current Member: ❑ Yes ❑ No

EFT PAYMENT REQUIREMENT - Monthly premium payments must be made via Electronic Funds Transfer (EFT).
Please complete an EFT form and submit it along with the OptiFlex Master Application.
A binder check for the first month's premium is NOT required.

LIFE/AD&D COVERAGE – LifeMap Assurance Company - *$10,000 Life/AD&D coverage is required*.

Life/AD&D Plans: ☐ $15,000 ☐ $25,000 ☐ $50,000 (only available for groups of 5 or more enrolled employees) ☐ Depedent Life $5,000/SP | $2,500/CH

VISION – VSP

Vision Coverage: ☐ Exam Plus ☐ Basic ☐ Preferred ☐ Enhanced

DENTAL – Delta Dental of Washington

Dental Coverage: ☐ Plan I ☐ Plan II ☐ Plan III ☐ Plan IV
☐ Orthodontia - only available to groups of 10 or more enrolled employees

CDHP Administration - Benefit Solutions, Inc. - *You may select more than one option; separate application is required.*

CHDP Administration: ☐ HSA ☐ HRA ☐ FSA ☐ DCAP ☐ Premium Only Plan

COBRA ADMINISTRATION – Benefit Solutions Inc.

☐ Yes ☐ No	**COBRA:** Is your company subject to federal COBRA laws in the current CALENDAR year based on employing 20 or more full-time equivalent employees for at least 50% of the workdays in the preceding CALENDAR year? **NOTE TO RENEWING GROUPS:** Although you need to confirm your COBRA status on the application, since COBRA eligibility runs calendar year, BSI cannot change your status effective as of your renewal.
☐ Yes ☐ No	**COBRA Administration:** If you answered YES to the above, would you like to authorize Benefit Solutions, Inc. to administer COBRA on terminating employees? **If so, please complete a BSI COBRA Administration Agreement.**
_____	**Affordable Care Act Required Information:** Please enter the average number of employees that were employed by your company during the prior CALENDAR year. 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 & ENROLLMENT – Must Match Medical

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: 20 hours per week, administered on a non-discriminatory basis, based on conditions of employment)

Eligible Employee Classifications:

Class 1: _____ Class 2: _____

Class 3: _____ Class 4: _____

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

Class 1: ☐ Date of Hire* ☐ 30 Days ☐ 60 Days Class 2: ☐ Date of Hire* ☐ 30 Days ☐ 60 Days

Class 3: ☐ Date of Hire* ☐ 30 Days ☑ 60 Days Class 4: ☐ Date of Hire* ☐ 30 Days ☐ 60 Days

***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.

Is probationary period waived on group's initial enrollment? (NEW GROUPS ONLY):

☐ Yes ☐ No

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

INSURANCE PRODUCER APPLICATION

A business applying for insurance coverage through Vigilant may appoint their own Insurance Producer to represent them as noted below.

Name of Insurance Producer: _____

Name of Producer's Brokerage/Agency: _____

Street Address: _____

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

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 Manufacturers' Trust or Vigilant Manufacturers' 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 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 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 certify that all information completed on this form 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**

COVERAGE UNDERWRITTEN BY

Life/AD&D: LifeMap Assurance Company™, 100 SW Market Street, Portland, OR 97201; PO Box 1271, MS E3A
Dental: Delta Dental of Washington, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
Vision: VSP, 600 University Street, Suite 2004, Seattle, WA 98101