P.O. Box 91060
Seattle, WA 98111-9160

PREMERA BLUE CROSS

GROUP MASTER APPLICATION

51 OR MORE ELIGIBLE EMPLOYEES

Application is made to Premera Blue Cross (hereafter referred to as "we," "us," or "our") for a new Health Care Contract, the provisions of which shall be made available to all eligible classes of employees.

Your group cannot be enrolled prior to our receipt date of this completed and signed application, which must be accompanied by the initial subscription charge payment. This application and subscription charge payment must be received no less than 10 days prior to the requested effective date.

GROUP ID _____

(Completed by Premera Blue Cross)

1. PURPOSE

☐ New Group: Complete this application and submit with enrollment forms, and the first month's payment prior to the effective date of coverage.

☐ Renewal: Complete this application and Benefit Selection Report in its entirety.

☐ Other

Effective Date: From: To: Annual Contract Renewal Month

2. GROUP INFORMATION

A. Legal Name

Common Name ***Note:*** *Required if Legal Name exceeds 50 characters and spaces, otherwise, optional.*

Physical Address

City State ZIP County

B. Mailing Address ☐ Same as Physical Address ☐ Separate Address, complete the following:

Street/ P.O.

City State ZIP County

C. Billing Address ☐ Same as Mailing Address ☐ Same as Physical Address ☐ Separate Address, complete the following:

Street/ P.O.

City State ZIP County

Billing Contact Person ☐ Mr. ☐ Mrs. ☐ Ms. Title

Phone No. ( ) - Fax No. ( ) - E-mail Address

D. Group Contact Person ☐ Mr. ☐ Mrs. ☐ Ms. Title

Phone No. ( ) - Fax No. ( ) - E-mail Address

E. Do you use a COBRA Administrator? ☐ No ☐ Yes, complete the following: ☐ Same as Billing Address and Contact Person (same contact as section 2C & 2D)

COBRA Administrator Billing Address

City State ZIP County

COBRA Administrator Contact Person ☐ Mr. ☐ Mrs. ☐ Ms. Title

Phone No. ( ) - Fax No. ( ) - E-mail Address

F. Employer Identification Number (EIN)

Type of Business SIC # NAICS #

G. Is the group a subsidiary of or affiliated with another company or headquartered outside the State of Washington? ☐ No ☐ Yes, complete the following:

Legal Name

Physical Address

City State ZIP County

H. In the past 36 months has the group or any affiliated entity filed for protection or operated under Federal/State Bankruptcy laws? ☐ No ☐ Yes

In the past 36 months has any creditor filed or threatened to file a petition requesting the group or any affiliated entity to be put into bankruptcy? ☐ No ☐ Yes

I. Is worker's compensation coverage provided for all employees? ☐ Yes ☐ No, please list employees not covered and reason:

An Independent Licensee of the Blue Cross Blue Shield Association

3. EMPLOYEE ELIGIBILITY REQUIREMENTS

If all of your employees must work the same hours, meet the same probationary period and will have the same benefits options available to them, complete section **A** (omit **B**), then continue to **C**, **D** and **E**.

If you are differentiating your employees by class (i.e., Managers, Hourly, etc.) complete section **B** (omit **A**), then continue to **C**, **D** and **E**.

A. All Employees in One Class

1. Minimum Work Hours

All employees who normally work a minimum of _____ hours* per week and have satisfied the probationary period are eligible.

**Note: Employees must work at least 20 hours per week to qualify for health coverage. The group may choose to set the minimum number of work hours per week higher for employees to be eligible.*

2. Probationary Period Information

All eligible employees are effective on the:

☐ 1st of the month following **Or** ☐ Next day following:

☐ 30 days ☐ 60 days ☐ ____ Number of days from (enter date)* _____

**Note: Probationary period cannot be more than 60 days.*

☐ 1st of the month following date of hire ☐ Exact date of hire

B. Employees Differentiated by Class

Minimum Work Hours and Probationary Period Information

Only employees in a specific class or classes who normally work the specified minimum hours per week that have met the probationary period are eligible.

Complete the minimum work hours* and probationary period information for each designated class of employee. If you have differentiated your benefit coverage selection by class of employee on your Benefit Coverage Selection Worksheet – those same classes must be represented

***Note:** Employees must work at least **20 hours** per week to qualify for health coverage. The group may choose to set the minimum number of work hours per week higher for employees to be eligible.*

☐ **Management (M)**	☐ **Salaried (S)**	☐ **Hourly (H)**	☐ **Part-time (P)**	☐ **Full-time (F)**	☐ **Other (O) Please specify** _____
Minimum hours ____	Minimum hours ____	Minimum hours ____	Minimum hours ____	Minimum hours ____	Minimum hours ____
☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:
☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire
☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days
☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days
☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire

C. Waive Probationary Period—to be completed by New Groups Only

☐ Waive the probationary period on all current qualifying employees.

☐ Apply the probationary period to all employees (current qualifying employees must satisfy the balance of the above probationary period).

D. Coverage will end:

☐ Last day of the month for which subscription charge is paid

☐ Other _____

E. Domestic Partners

Domestic Partner coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state-registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation coverage.

If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners, please contact your Premera sales representative. If your group is self-funded, please contact your sales representative for your options.

4. EMPLOYEE ENROLLMENT

A. Total number of employees on payroll regardless of hours worked _____

Note: *For **4B** and **4C** count each employee in only **ONE** category.*

B. Employees not eligible to enroll

1. Employees who work less than the minimum hours per week *(as specified in section **3A**)* _____

2. Employees who are temporary or seasonal _____

3. Employees who are in a probationary period _____

4. Employees who are not in a covered class *(employees not specified as eligible in **3A**)* _____

Total 4B _____

C. Employees not enrolling due to coverage under:

1. A Government plan *(e.g., Medicare, CHAMPUS/Tricare, Military)* _____

2. Other group coverage _____

3. A collective bargaining agreement *(Union)* _____

Total 4C _____

D. Total number of employees eligible to enroll *(section **4A - 4B - 4C**)* _____

E. Eligible employees waiving enrollment without other coverage _____

F. Total number of eligible employees enrolling *(section **4D - 4E**)* _____

G. Total number of retirees eligible for benefits _____

H. Total number of COBRA/Continuation of Coverage subscribers _____

I. Do you have eligible employees employed outside the State of Washington?

☐ No ☐ Yes, complete the following table:

State/Country	Number of Employees

J. Calculated Actual % of participation *(Completed by Premera Blue Cross)* _____

5. EMPLOYEE PARTICIPATION AND EMPLOYER CONTRIBUTION

A. Minimum Employee & Dependent Participation Requirements — TO BE COMPLETED BY PREMERA

Minimum eligible employee participation requirement is % Minimum eligible dependent participation requirement is %

B. Employer Contribution Requirements – TO BE COMPLETED BY EMPLOYER

Please Note: *Waivers of coverage are NOT allowed for eligible employees of non-contributory groups. If dependent coverage is also non-contributory, no waivers of coverage are allowed.*

1. Effective date of Contribution: (month / day / year)

2. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee and dependent coverage:

Please Note: *If you differentiate contributions by class of employee, those same classes must be represented here.*

	Medical	Dental	Vision
Employee:			
Spouse / Domestic Partner:			
Dependent Child (1 child)			
Dependent Children (2 or more)			

C. Employer Contribution Changes – Impact on Grandfathering

☐ Employer Contribution towards the cost of any tier of coverage has **not** been decreased by more than 5 percentage points since March 23, 2010

☐ Employer Contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010

Note: *If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.*

Please Note: *We reserve the right to review payroll records or comparable reports to ensure that eligibility and enrollment requirements are met.*

6. FEDERAL REQUIREMENTS

Helpful Hint: We strongly urge you to consult legal counsel in answering the questions below. The summaries below are not intended to be or to replace legal advice on your particular group. It is the group's responsibility to inform Premera immediately if facts change which would cause the group's answers below to change.

A. Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a spouse's) current employment status who have Medicare due to age?

1. ☐ Yes. This plan will pay primary to Medicare as required by federal law.

☐ No. Under 20 employees.

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

Helpful Hint: *These laws do not apply to any employer who did not employ 20 employees or more for each working day in each of 20 or more calendar weeks in either the current **or** preceding calendar year. For these small group plans, Medicare pays primary to the group plan.*

"Employees" include all full-time and part-time employees as well as those employees on disability and subject to FICA taxes. Also count leased employees if they would be counted as employees under §414(n)(2) of the Internal Revenue Code (IRC), and count employees employed by an "affiliated service group" under IRC §414(m) or by employers considered to be a "single employer" under IRC §52(a) or (b).

B. Is the group subject to COBRA?

☐ Yes

☐ No. Give the legal reason for exemption: _____

Helpful Hint: *Generally, these laws apply to any non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year.*

"Employees" are full-time and part-time common-law employees. Self-employed workers as defined in IRC §401(c)(1), corporate directors, or independent contractors should not be counted unless they qualify as common-law employees. "Employees" may also include leased employees who qualify as common-law employees. Please see COBRA regulations at 26 CFR § 54.4980B-2 Q/A 5 for guidance on counting a part-time employee as a fraction of a full-time employee.

C. Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a family member's) current employment status who have Medicare due to disability?

1. ☐ Yes. This plan will pay primary to Medicare as required by federal law.

☐ No. Under 100 employees.

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

Helpful Hint: *Generally, these laws apply to any employer that employed at least 100 employees on 50% or more of its working days in the preceding calendar year. See the helpful hint in **6A** above for a definition of "employee" for this purpose.*

D. Is the group subject to ERISA?

☐ Yes. Enter the month the ERISA plan year ends: Month _____

☐ No. Give the legal reason for exemption: ☐ Government or Public Plan ☐ Church Plan

☐ Other, please specify: _____

Helpful Hint: *Generally, ERISA applies to all employer health plans except governmental, public or church plans. Non-profit status alone does not exempt an employer from ERISA.*

7. CURRENT COVERAGE INFORMATION

A. Is this Premera Blue Cross plan intended to replace any existing coverage? ☐ No, go to section **7B** ☐ Yes, complete the following:

1. **Name(s) of current Medical carrier(s)** _____ Proposed termination date _____

2. **Name(s) of current Dental carrier(s)** _____ Effective date of dental coverage _____

Proposed termination date _____

Does your current dental coverage include orthodontia? ☐ No ☐ Yes If Yes, effective date of orthodontia coverage _____

3. **Name(s) of current Vision carrier(s)** _____ Proposed termination date _____

B. Are you offering a plan from a carrier other than Premera Blue Cross? ☐ No, go to section **8** ☐ Yes, more than one carrier's plan is offered:

Name(s) of other Medical carrier(s)		Name(s) of other Dental carrier(s)	Name(s) of other Vision carrier(s)
Indicate if other plan is an HSA.	HSA? ☐ No ☐ Yes		
	☐ No ☐ Yes		
	☐ No ☐ Yes		

8. GROUP MATERIALS

Important note: Electronic copies of benefit booklets are available online at www.premera.com. Please indicate if you would like printed copies sent.

Printed copies should be sent to: Producer: ☐ Contract ☐ Benefit Booklet(s)
Group Administrator: ☐ Contract ☐ Benefit Booklet(s) Number of booklets: _____

9. PRODUCER AGREEMENT TO CONTRACT

A. You, the producer(s), certify that you have met with the group submitting this agreement and that you have fully explained its contents. You have discussed coverage, eligibility, the effect of misrepresentations, termination provisions and subscription charge billing administration.

Producer Signature | Date

Producer of Record (*Print Name*) | Producer Number

E-mail Address | Name of Firm/Agency

Effective Date Producer is Appointed for this Group

Commission: ☐ PEPM ☐ % ☐ Scale

B. ☐ Split Commission

Secondary Producer Name | Secondary Producer Number

Commissions are split between the primary and secondary producer as follows (e.g., 50% / 50%): Primary % / Secondary %

10. GROUP AGREEMENT TO CONTRACT

You, the group named in section **2** of this application, understand and agree to the following.

A. This application becomes part of the contract to provide health care coverage after:

- The application is signed by you;
- The application is received and approved by us; and
- We receive the initial month's subscription charges.

You may not assign this contract without our written consent. Any attempt to do so will not have any binding effect on us. You agree to promptly deliver materials and notifications, including benefit booklets, received from us to all covered employees. You also agree to provide notification regarding the plan's special enrollment rights to all eligible employees before their enrollment. You attest to have read this application, and certify that all statements are true and complete. You agree to the terms and obligations stated in this application. It is understood that provisions of the Health Care Contract, including subscription charges, may be amended or changed from time to time, upon our notice to you. All prior applications, to the extent that you have not made changes to them in this application, remain in full force and effect. The producer listed in section **9** will remain effective until written notice is given by either party. We are authorized to pay, on your behalf, commission, if any, for which you are liable to the above named producer.

B. You may elect to allow the producer listed above to act as a group benefit administrator beginning on the group's effective date. This means that the producer/administrator will be able to access membership and billing functions, and obtain information about group members via the Web on behalf of the group. These functions may include, but are not limited to:

- Reinstate Terminated Members
- Request Invoice
- Search for a Member
- View Benefit Detail
- Inquire on Invoice
- Inquire on Eligibility
- Enroll a Member
- Order ID Cards for an Individual or Whole Family
- View Group Demographic Information
- Cancel a Member

Do you elect and authorize Premera Blue Cross to provide such information to the producer? ☐ No ☐ Yes

C. I affirm that this group has a physical location in the State of Washington, and I am authorized to sign on behalf of the group.

Signature of Group's Representative | Date

Group's Representative *(Print Name)* | Title

Please note: *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.*

TRACKING INFORMATION—TO BE COMPLETED BY PREMERA BLUE CROSS

Date Received by Sales | Information Complete ☐ Yes ☐ No | Date Missing Information Received

Account Manager/Sales Executive | Extension | Rep. Code

Sales Support Contact | Extension | Sales Distribution