PREMERA HMO

Employer Group Application

PO Box 327, MS 315
Seattle, WA 98111-0327

Application is made to Premera Blue Cross HMO (hereafter referred to as "Premera", "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 can't be enrolled prior to our receipt date of this completed and signed application.

A. Purpose Select one.

❍ New group. Complete this application and submit with enrollment forms prior to the effective date of coverage. ❍ Other _____	
Start date MM/DD/YYYY From: _____ To: _____	Annual contract renewal month

B. Group information

1.	**Legal name**				
	Common employer name **Note**: Required if legal name exceeds 43 characters and spaces, otherwise, optional.				
	Physical address (No PO Box/PMB)				
	City		State	ZIP code	County
2.	**Mailing address**	Select one. ❍ Same as physical address ❍ Separate address, complete below			
	Street/PO Box				
	City		State	ZIP code	County
3.	**Billing address**	Select one. ❍ Same as physical address ❍ Separate address, complete below			
	Street/PO Box				
	City		State	ZIP code	County
4.	**Billing contact person**			Title	
	Phone – include area code		Email address		
5.	**Group benefit administrator**			Title	
	Phone – include area code		Email address		
6.	Group authorized contract signer		Email address		

7. **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

Do you use a COBRA administrator? Select one.

❍ Yes.

Would you like the COBRA bill mailed to your COBRA administrator? Select one.

❍ Yes. Complete section B8.

❍ No

❍ No. Skip to section B9.

8.

COBRA administrator name. This is the name of the company.		
Street/PO Box		
City	State	ZIP code
COBRA contact name		
Phone – include area code	Email address	

9.

Employer Identification Number (EIN)	North American Industry Classification System (NAICS #)
Type of Business	Standard Industrial Classification (SIC #)

10. **Miscellaneous information**

Is the group a subsidiary of or affiliated with another company or headquartered outside Washington state? Select one.

❍ Yes. Complete the following.

❍ No

Legal name			
Physical address			
City	State	ZIP code	County

11.

In the past 36 months has the group or any affiliated entity filed for protection or operated under federal or state bankruptcy laws? Select one.

❍ Yes

❍ No

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? Select one.

❍ Yes

❍ No

12.

Is worker's compensation coverage provided for all employees? Select one.

❍ Yes

❍ No. List the employees not covered and the reason.

Person's name	Reason

C. Eligibility requirements

1. Subgroup setup

Standard subgroups are Active and COBRA.

Note: If your census includes subgroups other than Active and COBRA list them below. If there are more than six subgroups, attach additional subgroup information.

Subgroup Name	Subgroup contact name (if different)	Subgroup billing address (if different)

2. Employee classes

New employees, after initial group enrollment, will be eligible for coverage based on the following minimum work hours* and probationary period information. If all employees fall into one class, notate "all employees" in the first line and make the hour and probationary period selections.

Note: Probationary period cannot be more than 60 days following the member's eligibility date. If there are more than 6 Classes, attach additional class information.

*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.

Class description	Minimum hours	Probationary period option 1	Probationary period option 2	Probationary period option 3
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _______________	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other ________
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _______________	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other ________
		❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _______________	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other ________

	Class description	Minimum hours	Probationary period option 1	Probationary period option 2	Probationary period option 3
			❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 days ❍ 60 days ❍ Other _____
			❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 Days ❍ 60 days ❍ Other _____
			❍ Exact date of hire	First of the month following: Select one. ❍ Date of hire ❍ 30 days ❍ 60 days ❍ Other _____	Next day following: Select one. ❍ 30 Days ❍ 60 days ❍ Other _____

3. **Waive probationary period – select one.**

❍ Yes. Waive the probationary period on all current qualifying employees, regardless of their hire date, providing it is on or before the effective date of the group.

❍ No. Apply the probationary period to all employees. Use the employee's original date of hire and apply the group's probationary period to determine their effective date.

4. **Would you like coverage to end on the last day of the month for which premium is paid? Select one.**

❍ Yes

❍ No. Specify the other date MM/DD/YYYY _____

5. **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 or COBRA coverage to state-registered domestic partners, contact your Premera Blue Cross HMO sales representative.

D. Estimated employee enrollment

1. **Total number of employees on payroll regardless of hours worked** _____

   Note: For D2 and D3 count each employee in only ONE category.

2. **Employees not eligible to enroll:**

   Employees who work less than the minimum hours per week (as specified in section C) _____

   Employees who are temporary or seasonal _____

   Employees who are in a probationary period _____

   Employees who are not in a covered class (employees not eligible in section C) _____

   Total of section D2 _____

3. **Employees not enrolling due to other coverage under:**

   Government Plan: Medicare, CHAMPUS/Tricare, Military. _____

   Other group coverage _____

   Collective bargaining agreement (Union) _____

   Total of section D3 _____

4. Total number of employees eligible to enroll (section D1 – D2 – D3) _____

5. Eligible employees waiving enrollment without other coverage _____

6. Total number of eligible employees enrolling (section D4 – D5) _____

7. Total number of retirees eligible for benefits _____

8. Total number of COBRA/Continuation of coverage subscribers _____

9. Calculated actual % of participation (Completed by PBC) _____

Do you have eligible employees outside Washington state?

○ Yes. Complete the fields below.

○ No

State or country	Number of employees

E. Employee participation and employer contribution

1. **Minimum employee and dependent participation requirements**

Refer to underwriting assumptions to verify minimum participation requirements are being met.

2. **Employer contribution requirements – TO BE COMPLETED BY EMPLOYER**

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. Start date of contribution (the group effective date). MM/DD/YYYY _____/_____/_____
2. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee and dependent coverage.

Note: If you differentiate contributions by class of employee, those same classes must be represented here. If needed, attach an additional page.

	Medical	Vision
Employee		
Spouse/domestic partner		
Dependent child (1 child)		
Dependent children (2 or more)		

3. **Employer contribution changes – impact on grandfathering. Select one.**

- ❍ Employer contribution toward the cost of any tier of coverage has not been decreased by more than 5 percentage points since March 23, 2010
- ❍ Employer Contribution toward the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010

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

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

F. 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 group. It is the group's responsibility to inform Premera Blue Cross HMO immediately if facts change that would cause the group's answers below to change.

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? Select one.

- ❍ Yes. This plan will pay primary to Medicare as required by federal law.
- ❍ No. There are under 20 employees.

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).

Is the group subject to COBRA? Select one.

❍ 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. 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.

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?

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

❍ No. Under 100 employees.

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.

Is the group subject to Employee Retirement Income Security Act (ERISA)? Select one.

❍ Yes

❍ No. Specify the legal reason for exemption. Select one.

- ❍ Government or public plan
- ❍ Church plan
- ❍ Other, specify: _____

ERISA plan number	Month ERISA plan year ends	ERISA plan administrator

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.

G. Current coverage information

1. **Is this Premera Blue Cross HMO plan intended to replace any existing coverage? Select one.**

❍ Yes. Complete the following.

❍ No. Go to section G2.

Name(s) of current medical carrier(s)	Proposed termination date MM/DD/YYYY
Name(s) of current vision carrier(s)	Proposed termination date MM/DD/YYYY
Name(s) of current dental carrier(s)	Start date of coverage MM/DD/YYYY
	Proposed termination date MM/DD/YYYY
Does your current dental coverage include orthodontia? Select one. ❍ Yes ❍ No	If yes, start date of orthodontia coverage MM/DD/YYYY

2. **Are you offering a plan for a carrier other than Premera Blue Cross HMO? Select one.**

❍ Yes. Complete the names below. If it is a Health Savings Account (HSA), check ☐.

❍ No. Go to section H.

Name(s) of other medical carrier(s)	HSA	Name(s) of other dental carrier(s)	Name(s) of other vision carrier(s)
	☐		
	☐		
	☐		

3. When selecting a Premera Blue Cross HMO plan, coverage for Temporomandibular Joint Disorder (TMJ) will be offered under the medical plan or stand-alone dental plan. See your plan benefit for specific TMJ benefit coverage.

H. Group materials

Electronic copies of benefit booklets are available online at premera.com. Indicate if you would like printed copies sent, leave blank if no copies are requested. Printed copies should be sent to:

Producer	Number of booklets
Group administrator	Number of booklets

I. Producer agreement to contract

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 premium billing administration.

Producer signature	Producer of record (print name)	
X_____	Producer number	Date signed MM/DD/YYYY
Name of firm/agency	Email address	

Start date producer is appointed for this group MM/DD/YYYY

Commission: ☐ _____% Per employee per month (PEPM) ☐ $ _____

Split commission?

❍ Yes

❍ No

Commissions are split between the primary and secondary producers as follows:

Primary _____% Secondary _____%

Secondary producer name	Secondary producer number

J. Group agreement to contract

1.

You, (the group named in Section A of this application), understand and agree to the following:
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
- We receive the initial month's premium

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 Healthcare Contract, including premiums, 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 the Producer agreement to contract 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.

2.

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:

- View benefit detail
- Inquire about eligibility
- Reinstate terminated members
- Invoices: inquire about or request invoices
- View group demographic information
- Order ID cards for an individual or whole family
- Members: search for members, enroll or cancel a member

Do you elect and authorize Premera Blue Cross HMO to provide such information to the producer and their staff? Select one.

❍ Yes
❍ No

3.

New non-grandfathered groups with a plan start date in the middle of the calendar year can ask Premera Blue Cross HMO to apply credit toward members' out-of-pocket maximum on the group's new Premera Blue Cross HMO plan. When the group provides the data, Premera Blue Cross HMO will credit the members' coinsurance, copays, and deductible amounts required by the group's prior plan that the members paid in the same calendar year as the group's start date under the new Premera Blue Cross HMO plan.

4.

I affirm that this group has a physical location outside Clark County in Washington state, and I am authorized to sign on behalf of the group.

Signature of group representative	Group's representative (print name)	
X _____	Title	Date signed MM/DD/YYYY

Note: A person who, with intent to injure, defraud, or deceive, knowingly makes a false or fraudulent statement or representation in or with reference to an application for insurance, may be prosecuted under state law.