PREMERA HMO
P.O. Box 327
MS 315
Seattle, WA 98111-0327

Group Master Application

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

Group ID: _____
(Completed by Premera HMO)

1. PURPOSE

☐ New Group: Complete this application and submit with enrollment forms 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 (Required if Legal Name exceeds 50 characters and spaces)

_____

Physical Address _____

City _____ State _____ ZIP_____ County _____

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

Street/ P.O. _____

City _____ State_____ ZIP_____ County _____

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

Street/ P.O. _____

City _____ State_____ ZIP_____ County _____

Billing Contact Person _____ Title _____

Phone No. (_____) _____ -_____

Email Address _____

D. Group Benefit Administrator _____ Title _____

Phone No. (_____) _____ -_____

Email Address _____

An Independent Licensee of the Blue Cross Blue Shield Association

E. Group Authorized Contract Signer

Name _____

Email Address _____

F. Do you use a COBRA Administrator?

☐ Same as Billing Address and Contact Person (sections 2C and 2D)

☐ No

☐ Yes, complete section 2G:

G. COBRA Administrator

Street/ P.O. _____

City _____ State _____ ZIP _____ County _____

COBRA Administrator Contact Person _____ Title _____

Phone No. (____) ____ - _____

Email Address _____

H. Employer Identification Number (EIN) _____ NAICS # _____

Type of Business _____ SIC # _____

I. 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 _____

J. 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 the group or any affiliated entity filed for protection or operated under Federal/State Bankruptcy laws?

☐ No ☐ Yes

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

_____

_____

_____

_____

3. EMPLOYEE ELIGIBILITY REQUIREMENTS

If all of your employees must work the same hours, meet the same probationary period, and will have the same benefit options available to them, complete section A, skip section B, then continue to sections C, D and E.

If you are differentiating your employees by class (i.e., Managers, Hourly, etc.) complete section B, skit section A, then continue to sections 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.

*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

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2. Probationary Period Information All eligible employees are effective on the:

- ☐ 1st of the month
- ☐ 1st of the month following date of hire
- ☐ 1st of the month following or coinciding with the date of hire
- ☐ Next Date following
- ☐ Exact date of hire
- ☐ 20 days
- ☐ 60 days
- ☐ _____days from (enter date) *_____ ***Note:** Probationary period can't be more than 60 days.

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.

*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: ☐ Date of hire ☐ 30 days ☐ 60 days ☐ Exact date of hire	☐ 1st of the month following: ☐ Date of hire ☐ 30 days ☐ 60 days ☐ Exact date of hire	☐ 1st of the month following: ☐ Date of hire ☐ 30 days ☐ 60 days ☐ Exact date of hire	☐ 1st of the month following: ☐ Date of hire ☐ 30 days ☐ 60 days ☐ Exact date of hire	☐ 1st of the month following: ☐ Date of hire ☐ 30 days ☐ 60 days ☐ Exact date of hire	☐ 1st of the month following: ☐ Date of hire ☐ 30 days ☐ 60 days ☐ 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).
- ☐ Waive the probationary period for rehired employees
- ☐ Apply to probationary period to all rehired employees

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 or COBRA coverage to state-registered domestic partners, please contact your Premera HMO sales representative.

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 4A)	_____
2.	Employees who are temporary or seasonal	_____
3.	Employees who are in a probationary periods	_____
4.	Employees who are in a covered class (employees not specified as eligible in section 3A)	_____
	Total of section 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 of section 4C _____

D. Total number of employees eligible to enroll (sections 4A – 4B – 4C) _____

E. Eligible employees waiving enrollment without other coverage _____

F. Total number of eligible employees enrolling (sections 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 of the State of Washington?

☐ No ☐ Yes, complete the table below

State/Country	Number of Employees

J. Calculated Actual % of participation
(completed by Premera HMO) _____

5. EMPLOYEE PARTICIPATION AND EMPLOYER CONTRIBUTION

A. Minimum Employee & Dependent Participation Requirements
Please refer to underwriting assumptions to verify minimum participation requirements are being met.

B. 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. Effective date of contribution_____(month/date/year)

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.

	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.

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 HMO 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 HMO plan intended to replace any existing coverage?

☐ No, continue to section 7B ☐ Yes, complete the following sections:

1. Name(s) of current Medical carrier(s)		Proposed termination date	___/___/_____ (mm/dd/yyyy)
2. Names(s) of current Vision carrier(s)		Proposed termination date	___/___/_____ (mm/dd/yyyy)
3. Name(s) of current Dental carrier(s)		Effective date of coverage	___/___/_____ (mm/dd/yyyy)
		Proposed termination date	___/___/_____ (mm/dd/yyyy)
4. Does your current dental coverage include orthodontia? ☐ No ☐ Yes		If yes, effective date of orthodontia coverage	___/___/_____ (mm/dd/yyyy)

B. Are you offering a plan for a carrier other than Premera HMO?

☐ No, skip 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		

C. When selecting a Premera HMO 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.

8. GROUP MATERIAL

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

Printed copies should be sent to:

Producer	☐ Contract	☐ Benefit Booklet(s)	Number of booklets _____
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 _____ /_____/_____(mm/dd/yyyy)

Producer of Record (print name) _____ Producer Number _____

Email Address _____ Name of Firm/Agency _____

Effective Date Producer is Appointed for this Group Date _____/_____ / _____ (mm/dd/yyyy)

Commission: ☐ PEPM ☐ %

B. ☐ Split Commission

Secondary Producer Name_____ Secondary Producer Number_____

Commissions are split between the primary and secondary producer as follows: Primary____% Secondary____ %

10. GROUP AGREEMENT TO CONTRACT

A. You, the group named in section 2 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; 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	• Inquire on Invoice	• Order ID Cards for an Individual or Whole Family	
• Request Invoice	• Inquire on Eligibility	• View Group Demographic Information	
• Search for a Member	• Enroll a Member	• Cancel a Member	• View Benefit Detail

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

C. New non-grandfathered groups with a plan effective date in the middle of the calendar year can ask Premera HMO to apply credit toward members' out-of-pocket maximum on the group's new Premera HMO plan. When the group provides the data, Premera 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 effective date under the new Premera HMO plan.

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

Signature of Group's Representative

_____ Date ____/____/_____ (mm/dd/yyyy)

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.