P.O. Box 3048, MS 732
Spokane, WA 99220-3048

PREMERA | BLUE CROSS

SMALL GROUP MASTER APPLICATION

(Average of *50* or fewer employees during the previous calendar year)

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.

CLEAR ALL FIELDS

GROUP ID _____

(Completed by Premera Blue Cross)

1. REQUESTED EFFECTIVE DATE

2. GROUP INFORMATION

A. Legal Name

Common Name ***Note:*** *Required if Legal Name exceeds 43 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

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

Phone No. Fax No. E-mail Address

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

Phone No. Fax No. E-mail Address

F. Is the group subject to COBRA? ☐ Yes ☑ No

If subject to COBRA, do you use a COBRA Administrator? ☐ No ☑ Yes, complete the following: ☐ Same as Billing Address and Contact Person

COBRA Administrator Billing Address

City State ZIP County

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

Phone No. Fax No. E-mail Address

G. Employer Identification Number (EIN) NAICS # SIC #

3. CURRENT COVERAGE INFORMATION

Is this plan intended to replace any existing group coverage? ☐ No, go to next section ☑ Yes, complete the following:

A. **Name of current Medical carrier** _____

B. **Name of current Dental carrier** _____

4. GROUP ELIGIBILITY

A. Did the group employ an average of 50 or fewer employees during the previous calendar year? ☑ No ☐ Yes *

**Employee count should include: all full-time, part-time employees, seasonal employees, union employees, employees from any affiliated companies, partners, business owners, corporate officers, and employees who work outside the State of Washington. Your employee count should NOT include contracted 1099 individuals. If you were not in business during the previous year, please base your average number of employees on the current calendar year.*

B. Is the company's headquarters located outside the State of Washington? ☐ No ☑ Yes

5. EMPLOYEE ELIGIBILITY REQUIREMENTS

A. Minimum Work Hours and Probationary Period Information

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 the information under **All** below, otherwise please complete the applicable sections. **You can have no more than 3 classes.**

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.*

☐ **All (one class)**	☐ **Management**	☐ **Salaried**	☐ **Hourly**	☐ **Part-time**	☐ **Full-time**
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

B. Waive Probationary Period

Do you want to waive the probationary period for all current qualifying employees for this enrollment period?

☐ No ☐ Yes

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	Class 1	Class 2		Class 1	Class 2
Medical Plan Contribution for Employees:			Dependents:		
Dental Plan Contribution for Employees:			Dependents:		

6. EMPLOYER CONTRIBUTION AND EMPLOYEE PARTICIPATION REQUIREMENTS

A. Minimum Contribution / Participation Requirements

Group Size	Employer Contribution for Employees	Employee Participation	Employer Contribution for Dependents	Dependent Participation
Medical: Up to 3 Employees	100%	100%	No required level	Optional
Medical: Up to 3 Employees	50%	75%	50%	75%
Medical: 4 – *50* Employees	75%	75%	No required level	Optional
Medical: 4 – *50* Employees	50%	75%	50%	25%
Dental / Non-Voluntary: 5 – *50* Employees	50%	Greater of 5 Enrolled Employees or 50% Enrolled Employees	No required level	Optional
Dental / Voluntary: 5 – *50* Employees	0% – 49%	Greater of 5 Enrolled Employees or 30% Enrolled Employees	No required level	Optional

B. *HRA and HSA Employer Contributions*

To comply with Federal requirement regarding plan actuarial value, certain Health Reimbursement Arrangement (HRA) and Health Savings Accounts (HSA) plans require a specified annual employer contribution to a HRA or HSA funding account. ***By selecting these plans, the employer agrees to fund the accounts to the levels specified in Section 1B of the Group Master Application Benefit Selections form.*** *The employer further agrees that the HRA account, if chosen, will be established through Connect Your Care and the HSA account, if chosen, will be established through UMB Bank. The employer agrees they will not establish other HRA or HSA funding arrangements.*

By checking the box below, the employer attests that if HRA or HSA plans with mandatory contributions are selected, they agree to fund the HRA or HSA to the amounts stated in the Group Master Application Benefit Selections form and will not establish or make any contributions to any other employee's HRA or HSA account.

☐ I am selecting an HRA or HSA plans with required employer contributions and agree to the funding account requirements as stated in this application.

☐ I am selecting a PPO, HRA or HSA plan with no required employer contributions. I agree not to make a contribution to any HRA or HSA account.

7. EMPLOYEE ENROLLMENT

A. Total number of Employees on payroll regardless of hours worked: _____

Note: *Count each employee in only ONE category.*

		Medical	Dental
B.	Employees not eligible to enroll:		
	Employees working less than the minimum number of hours per week, are in a probationary period, temporary or seasonal, not in a covered class:		
C.	Employees not enrolling due to coverage under:	**Medical**	**Dental**
	A Government plan (e.g., Medicare, CHAMPUS/Tricare, Military) or other group coverage.		
D.	Total number of employees eligible to enroll **Total*** ***** *(Employees on payroll), subtract (Employees not eligible to enroll), subtract (Employees not enrolling due to other coverage)*		
E.	Eligible employees waiving enrollment without other group coverage *(Waiver form required)* ***Note:*** *Individual Coverage is not a valid waiver*		
F.	Total number of eligible employees enrolling **Total*** ***** *(Total number of employees eligible to enroll), subtract (Employees waiving enrollment without other group coverage)*		

G. Do you have eligible employees in Hawaii? ☑ No ☐ Yes

Please note: *If a group does not meet the requirements above, the group may enroll during the designated open enrollment period. Employees who reside in the state of Hawaii are not eligible for coverage.*

8. 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 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 8A above for a definition of "employee" for this purpose.

C. 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.

9. GROUP MATERIALS

Important note: *Benefit booklets are delivered electronically and are available online at* ***www.premera.com****. One copy of the benefit booklet will be sent to the Group Administrator and the Producer.*

A. Do you want additional printed copies of the benefit booklet to be sent to the Group Administrator?

☐ No ☑ Yes Number of booklets:

10. 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 subscription charge billing administration.

General Agency Affiliation: **Connexion Insurance Solutions** ☐ **ProPoint Business Solutions** ☐ **S4 Benefits** ☑

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

11. GROUP AGREEMENT TO CONTRACT

You, the group named in the GROUP INFORMATION section 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 waiting period and 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 complete application consists of this document and the completed Group Master Application Benefit Selections form.
The producer listed in the Producer Agreement to Contract section 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 Blue Cross to provide such information to the producer? ☐ No ☑ Yes

C. As required by RCW 48.43.005(33), to qualify for group coverage as a group of one, a self-employed individual or sole proprietor must: (1) have been employed by the same employer or small group for at least twelve months prior to this application; and, (2) have derived at least seventy-five percent of income from a trade or business for which the appropriate Internal Revenue Service forms have been filed for the previous tax year. A self-employed individual or sole proprietor in an agricultural trade or business must have derived at least fifty-one percent of income from the trade or business for which the appropriate Internal Revenue Service forms have been filed for the previous tax year.

D. New groups, with a plan effective date in the middle of their plan year, can request the cost-sharing (e.g. deductible, coinsurance and copay) amounts accrued prior to the plan effective date be credited to their new plan.

E. I affirm the contribution and participation requirements in EMPLOYER CONTRIBUTION AND EMPLOYEE PARTICIPATION REQUIREMENTS are followed. *(Applicable to groups renewing outside open enrollment).*

F. 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.*