PREMERA HMO
PO Box 327, MS 315
Seattle, WA 981-0327

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.

A. Group

Group ID (This field is completed by Premera Blue Cross HMO.)

B. Purpose Select one.

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

C. Group information

1.	Legal employer name			
	Common employer name (Note: Required if legal name exceeds 50 characters and spaces, otherwise, optional.)			
	Physical address			
	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
	Billing contact person		Title	
	Area code & phone number	Email address		
4.	Group benefit administrator		Title	
	Area code & phone number	Email address		
5.	Group authorized contract signer	Email address		

6. Consolidated Omnibus Budget Reconciliation Act (COBRA)

Do you use a COBRA administrator? Select one.	Would you like the COBRA bill mailed to your COBRA administrator? Select one.
❍ Yes ❍ No. Skip to section C8.	❍ No. Skip to section C8. ❍ Yes. Complete section C7.

7. COBRA administrator name. This is the name of the company.

Street/PO Box		
City	State	ZIP code
COBRA contract name		
Area code & phone number	Email address	

8.

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

9. Miscellaneous information

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

❍ No
❍ Yes. Complete the following.

Legal name			
Physical address			
City	State	ZIP code	County

10. 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

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

❍ Yes
❍ No. Please list the employees not covered and the reason.

Person's name	Reason

D. Employee eligibility requirements

If your employees must work the same hours, meet the same probationary period, and will have the same benefit options available to them, complete section 1, skip section 2, then continue to sections 3, 4 and 5.

If you are differentiating your employees by class (such as managers or hourly workers) complete section 2, skip section 1, then continue to sections 3, 4 and 5.

1. All employees in one class

a. 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.

b. Probationary period information: All eligible employees are effective on the following. Select one.
Note: Probationary period can't be more than 60 days.

❍ First of the month
❍ First of the month following date of hire
❍ First of the month following or coinciding with the date of hire
❍ Next date following
❍ Exact date of hire
❍ 30 days
❍ 60 days
❍ _____ days from (enter date) _____ **Note**: Probationary period can't be more than 60 days.

c. Subgroup setup

Standard subgroups are Active and COBRA. Additional subgroups may be added to accommodate separate billing addresses. **Note**: If more than six subgroups, attach additional subgroup information.

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

2. Employees differentiated by class

a. Minimum work hours and probationary period information

Only employees in a specific class or classes who normally work the specified minimum hours per week and who 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.

b. Employee classes

New employees, (after initial enrollment of the group), will be eligible for coverage based on the following minimum work hours* and probationary period information. If all employees fall in to 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 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
		❍ 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, provided 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.	**Coverage will end – select one.** Would you like coverage to end the last day of the month for which premium is paid? Select one. ❍ Yes ❍ No. Specify other date: _____
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, please contact your Premera Blue Cross HMO sales representative.

E. Estimated employee enrollment

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

   Note: For E2 and E3 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 D) _____
   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 D) _____
   Total of section E2 _____

3. **Employee not enrolling due to other Coverage under:**
   Government Plan *(such as. Medicare, CHAMPUS/Tricare, Military)* _____
   Other group coverage _____
   Collective bargaining agreement (Union) _____
   Total of section E3 _____

4. Total number of employees eligible to enroll (section E1 – E2 – E3) _____
5. Eligible employees waiving enrollment without other coverage _____
6. Total number of eligible employees enrolling (section E4 – E5) _____
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?

- ○ No
- ○ Yes. Complete the fields below.

State or country	Number of employees

F. Employee participation and employer contribution

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

Please 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 _____/_____/_____ (month/day/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. If needed, attach additional page.

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

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

❍ 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.

G. 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

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).

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, 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.

ERISA plan number	Month ERISA plan year ends	ERISA plan administrator

H. Current coverage information

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

❍ No. Go to section H2.

❍ Yes. Complete the following.

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

2.	Are you offering a plan for a carrier other than Premera Blue Cross HMO? Select one. ❍ No. Go to section J. ❍ Yes. Please complete the names below. If HSA (Health Savings Account), please check ☐.			
	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. Please see your plan benefit for specific TMJ benefit			

I. Group materials

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	☐ Benefit booklets	Number of booklets
Group administrator	☐ Benefit booklets	Number of booklets

J. 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 X _____	Producer of record (print name)	
	Producer number	Date signed
Name of firm/agency	Email address	
Start date producer is appointed for this group		
Commission amount per employee per month (PEPM)	Split commission? ❍ Yes ❍ No	Secondary producer amount per employee per month (PEPM)
Secondary producer name		Secondary producer number

K. Group agreement to contract

A. 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 third party administration services for the Group's self-funded plan(s) 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 section K 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:

- 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

C. 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.

D. 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

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.