# Washington Business, Association and Chambers of Commerce Trust
## Employer Adoptive Agreement
## 2009

Risk Level:

Group Number:

Package Number:

| Company Name: | Effective Date: |
|---|---|
| Nature of Business: ______________________________<br>Standard Industrial Code: Tax ID #: | Endorsing Chamber: ______________________________<br>Effective date of Chamber Membership: ______________<br>Chamber of Commerce Membership must be maintained to retain WBACC Trust Eligibility. |
| Group Benefits Administrator: | Billing Contact: |
| Phone:<br>( ) Fax: ( ) | Phone:<br>( ) Fax: ( ) |
| Company Address (Street, City, State, Zip) | Billing Address (Street, City, State, Zip) |
| | |
| | |
| Benefits Administrator Email: | Billing Contact Email: |

### Plan Selections

**Medical Underwritten by Asuris Northwest Health:**

☐ PPO 200 ☐ PPO 400 ☐ PPO 500a ☐ PPO 500b

☐ Advance 200 ☐ Advance 500 ☐ Advance 750

☐ Advance 1000

☐ HSA

*Please refer to the WBACC Underwriting Guidelines for dual choice options.*

**Vision Underwritten by Vision Service Plan:**

☐ 12/12/24 Vision Plan – Plan B

☐ 24/24/24 Vision Plan – Plan A

**Legal Plan Underwritten by Caldwell Legal Services:**

☐ Yes

☐ No

**Dental Underwritten by Washington Dental:**

☐ PPO 1- $1,000 annual maximum

☐ PPO 2 -$2,000 annual maximum

☐ Orthodontics

☐ Enhanced PPO - $1,500 annual maximum

☐ Enhanced PPOb - $1,000 annual maximum *(Dental stand-alone option)*

*Available to employer groups with 5 or more employees*

**Dental Underwritten by Willamette Dental:**

☐ Managed Care Dental – High Option

☐ Managed Care Dental – Low Option

*Available to employer groups with 2 or more employees*

**Life and Accidental Death & Dismemberment Underwritten by Regence Life and Health*:**

$15,000 Life/AD&D included with all medical plans.

Reductions:

All Life & AD&D benefits reduce from the original amount to 65% at age 65, 50% at age 70, 30% at age 75, 20% at age 80 and terminate at retirement.

**Life and Accidental Death & Dismemberment Options:**

☐ $25,000 Life/AD&D

☐ $50,000 Life/AD&D – Requires 15+ employees

**Dependent Life -** $5,000 Spouse/$2,000 child(ren)

☐ **Yes**

☐ **No**

***Life Required**

## Eligibility and Participation Requirements

**Definition of Eligible Employee**
Eligible Employees must be regular (not seasonal or temporary) active employees on company payroll working a minimum of 20 hours per week to be eligible for coverage.

Number of hours to be eligible: _____ hours.

**Eligibility Probationary Period**
Coverage for newly hired/eligible employees will become effective the first of the month on or following the completion of the probationary period indicated below:
☐ Date of Hire ☐ 30 days ☐ 60 days ☐ 90 days
☐ Other: _____

**New Groups Only**
The probationary period specified in the category to the right applies to (Check one box):
☐ Current and Future Eligible Employees
☐ Future Eligible Employees Only

**For employees transferring from part-time to full-time status, the probationary period above should apply:**
☐ Retroactive to the original date of hire or,
☐ Beginning on the date of transfer

**Definition of Eligible Dependent**
Eligible dependents must be a legally married spouse and/or a legally dependent child under age 25. **Qualified Domestic Partners** can also be eligible dependents. If you decline to offer domestic partner coverage to your employees, please check here:
☐ Decline

**Employer Contribution**
Please list the employer paid portion of the premium for each category (minimum 75% for employee, 100% if a restricted industry):

| Medical | | Dental | |
|---|---|---|---|
| Employee: | _____% | Employee: | _____% |
| Dependent: | _____% | Dependent: | _____% |

"24 hour / on-the-job" injuries or illnesses are not covered except for Regence subscribers who are legally exempt from State Industrial Insurance.

## COBRA/OBRA/TEFRA/FMLA Eligibility

| | | |
|---|---|---|
| COBRA Employer? | ☐ Yes<br>☐ No<br><br>☐ | An employer is subject to COBRA during the current calendar year if the company employed 20 or more full or part-time employees on more than 50% of its typical business days in the preceding calendar year.<br><br>If yes, by checking the box to the left the employer authorizes Trusteed Plans Services Corporation (TPSC) to administer COBRA on terminating employees. |
| TEFRA Employer? | ☐ Yes<br>☐ No | An employer is subject to TEFRA if the company employed 20 or more employees, including part-time, on each working day of 20 or more weeks in the current or preceding calendar year. TEFRA eligibility will be assumed for all participating member companies of the WBACC who are enrolled in Regence BlueShield regardless of group size; however, it will be the responsibility of the member to inform Medicare of their status so that claims will be properly adjudicated. |
| FMLA Employer? | ☐ Yes<br>☐ No | An employer is subject to FMLA if the company employed 50 or more employees for each working day of 20 or more calendar weeks in the current or preceding calendar year. |
| OBRA Employer? | ☐ Yes<br>☐ No | An employer is subject to OBRA if the company has 100 or more full or part-time employees for at least 50% of the work days of the preceding year. |

## Prior Coverage Information

Will this coverage replace existing group coverage with another carrier? ☐ Yes ☐ No If yes, name of other carrier(s)

## Employee Participation Requirements

For any group size, a minimum of 75% of eligible employees must participate; 90% if a restricted industry. Refer to carrier contracts for detailed information.

| | |
|---|---|
| A. Total Number of full-time and part-time employees (Do not include COBRA participants). | |
| B. Number of employees working fewer than the minimum hours | - |
| C. Number of employees not in an eligible class | - |
| D. Number of employees who have not completed the probationary period | - |
| E. Subtotal of A. minus B. minus C. minus D. | = |
| F. Number of employees submitting valid waivers of coverage | - |
| G. Total number of eligible employees (E. minus F.) | = |
| H. Total number of enrolled employees | |
| I. Total number of employees covered under COBRA or 6-month extension. | |

## Signature Section

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Group after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group no longer qualifies for the Rate quoted, I understand that the issuer will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the Rate adjustment within 30 days of the date of notice by the issuer. For the protection of all of our members, fraud or misrepresentation of material fact by the Group for the purposes of defrauding the issuer may result in the issuer taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, the issuer will have the right to collect any claims payments or other damages.

I also agree to be bound by the terms, conditions, and provisions of coverage as set forth by the WBACC and the program carriers' plan booklets and contracts. With my signature, I also hereby appoint the below named broker/agent as our company's broker/agent of record.



*****Send payments payable to WBACC Trust by the 20th of the month prior to coverage effective date. *****

| Signature Section | |
|---|---|
| **Employer Representative (please print)** | |
| **Employer Representative Signature** | **Date:** |
| **Broker Signature** | **Date:** |
| **Brokerage/Agency Name** | |

## Release of Protected Health Information

Due to HIPAA privacy laws, information regarding the plan can only be released to the individuals listed below. Please provide the name of those authorized to receive protected health information (PHI) in regard to Billing/Eligibility.

Individual's Name

___________________________________

___________________________________

___________________________________

___________________________________

___________________________________

___________________________________

___________________________________

___________________________________

___________________________________

___________________________________

Employer Name: ________________________________________________________

Plan Administrator Name: __________________________________________________

Plan Administrator Signature: ________________________________Date: ____________

Asuris Northwest Health
528 E Spokane Falls Blvd, Suite 301
Spokane, WA 99202

Regence Life & Health
PO Box 1271
Portland, OR 97207-1271

Willamette Dental
6950 NE Campus Way
Hillsboro, OR 97124

Vision Service Plans
600 University Street, Suite 2004
Seattle, WA 98101

Washington Dental Service
9706 4th Ave NE
Seattle, WA 98115

Caldwell Legal
PO Box 245778
Sacramento, CA 95824-5778