



**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: _____ Standard Industrial Code: _____ Tax ID #: _____	Endorsing Chamber: _____ Effective date of Chamber Membership: _____ Chamber of Commerce Membership must be maintained to retain WBACC Trust eligibility.
Group Benefits Administrator:	Billing Contact:
Phone: ( ) _____ Fax: ( ) _____	Phone: ( ) _____ Fax: ( ) _____
Company Address (Street, City, State, Zip)	Billing Address (Street, City, State, Zip)
Benefits Administrator Email:	Billing Contact Email:
<b>Plan Selections</b>	
<p><b><u>Medical Underwritten by Regence BlueShield:</u></b></p> <input type="checkbox"/> PPO 200 <input type="checkbox"/> PPO 400 <input type="checkbox"/> PPO 500a <input type="checkbox"/> PPO 500b <input type="checkbox"/> HSA <input type="checkbox"/> FourFront 200 <input type="checkbox"/> FourFront 500 <input type="checkbox"/> FourFront 750 <input type="checkbox"/> FourFront 1000 <input type="checkbox"/> Selections 100 <input type="checkbox"/> Selections 80	<p><b><u>Vision Underwritten by Vision Service Plan:</u></b></p> <input type="checkbox"/> 12/12/24 Vision Plan <input type="checkbox"/> 24/24/24 Vision Plan
<p><i>Please refer to the WBACC Underwriting Guidelines for dual choice options.</i></p> <p><b><u>Dental underwritten by Regence BlueShield:</u></b></p> <input type="checkbox"/> High Option Dental <input type="checkbox"/> Low Option Dental <i>Available to employer groups with 5 or more employees.</i>	<p><b><u>Legal Plan Underwritten by Caldwell Legal Services:</u></b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<p><b><u>Dental underwritten by Willamette Dental:</u></b></p> <input type="checkbox"/> Managed Care Dental – High Option <input type="checkbox"/> Managed Care Dental – Low Option <i>Available to employer groups with 2 or more employees.</i>	<p><b><u>Dental underwritten by Washington Dental Service:</u></b></p> <input type="checkbox"/> PPO 1 <input type="checkbox"/> Enhanced PPO <input type="checkbox"/> PPO 2 <input type="checkbox"/> Enhanced PPOb ( <i>Dental stand-alone option</i> ) <input type="checkbox"/> Orthodontics <i>Available to employer groups with 5 or more employees.</i>
<p><b><u>Life and Accidental Death &amp; Dismemberment Underwritten by Regence Life and Health*:</u></b></p> <p>\$15,000 Life/AD&amp;D included with all medical plans.</p> <p>Reductions: All Life &amp; AD&amp;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.</p>	<p><b><u>Life and Accidental Death &amp; Dismemberment Options:</u></b></p> <input type="checkbox"/> \$25,000 Life/AD&D <input type="checkbox"/> \$50,000 Life/AD&D – Requires 15+ employees <p><b>Dependent Life - \$5,000 Spouse/\$2,000 child(ren)</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> 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.

**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

**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

**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: \_\_\_\_\_

**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

**Employer Contribution**

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

<u>Medical</u>	<u>Dental</u>
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	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.
	<input type="checkbox"/>	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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 calendar 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.

**Signature Section**

<b>Employer Representative (please print)</b>	
<b>Employer Representative Signature</b>	<b>Date:</b>
<b>Broker Signature</b>	<b>Date:</b>
<b>Brokerage/Agency Name</b>	

**Release of Protected Health Information**

Due to HIPAA privacy laws, information regarding the plan can only be released to those 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: \_\_\_\_\_

Regence BlueShield  
800 9<sup>th</sup> Avenue  
Seattle, WA 98101

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

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

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

Caldwell Legal  
PO Box 245778  
Sacramento, CA 95824-5778

Willamette Dental  
6950 NE Campus Way  
Hillsboro, OR 97124