



**Washington Business, Association and
Chambers of Commerce Trust
Employer Adoptive Agreement
2010**

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:
Plan Selections	
<p><u>Medical Underwritten by Regence BlueShield:</u></p> <p><input type="checkbox"/> PPO 250+ <input type="checkbox"/> PPO 500+ <input type="checkbox"/> PPO 500 <input type="checkbox"/> PPO 750 <input type="checkbox"/> PPO 1000 <input type="checkbox"/> PPO 1500 <input type="checkbox"/> PPO 2000 <input type="checkbox"/> PPO 2500 <input type="checkbox"/> HSA 1500 <input type="checkbox"/> HSA 2500 <input type="checkbox"/> HSA 3500</p> <p><i>Only available to Groups currently enrolled on these plans:</i></p> <p><input type="checkbox"/> PPO 200 <input type="checkbox"/> Selections 100 <input type="checkbox"/> Selections 80</p> <p><i>Please refer to the WBACC Underwriting Guidelines for dual choice options.</i></p>	<p><u>Vision Underwritten by Vision Service Plan:</u></p> <p><input type="checkbox"/> 12/12/24 Vision Plan <input type="checkbox"/> 24/24/24 Vision Plan</p> <p><u>Legal Plan Underwritten by Caldwell Legal Services:</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><u>Dental Underwritten by Washington Dental Service:</u></p> <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</p> <p><i>Available to employer groups with 5 or more employees.</i></p>	<p><u>Dental Underwritten by Willamette Dental:</u></p> <p><input type="checkbox"/> Managed Care Dental – High Option <input type="checkbox"/> Managed Care Dental – Low Option</p> <p><i>Available to employer groups with 2 or more employees.</i></p>
<p><u>Life and Accidental Death & Dismemberment Underwritten by Regence Life and Health*:</u></p> <p>\$15,000 Life/AD&D included with all medical plans.</p> <p>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.</p>	<p><u>Life and Accidental Death & Dismemberment Options:</u></p> <p><input type="checkbox"/> \$25,000 Life/AD&D <input type="checkbox"/> \$50,000 Life/AD&D – Requires 15+ employees</p> <p>Dependent Life - \$5,000 Spouse/\$2,000 child(ren)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

***Life required**

Eligibility and Participation Requirements								
<p>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.</p> <p>Number of hours to be eligible: _____ hours.</p>	<p>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: <input type="checkbox"/> Date of Hire <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> Other: _____</p>							
<p>New Groups Only The probationary period specified in the category to the right applies to (Check one box): <input type="checkbox"/> Current and Future Eligible Employees <input type="checkbox"/> Future Eligible Employees Only</p>	<p>For employees transferring from part-time to full-time status, the probationary period above should apply: <input type="checkbox"/> Retroactive to the original date of hire or, <input type="checkbox"/> Beginning on the date of transfer</p>							
<p>Definition of Eligible Dependent Eligible dependents must be a legally married spouse and/or a legally dependent child under age 25. Qualified Domestic Partners are also eligible dependents.</p>	<p>Employer Contribution Please list the employer paid portion of the premium for each category (minimum 75% for employee, 100% if a restricted industry):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><u>Medical</u></td> <td style="width: 50%;"><u>Dental</u></td> </tr> <tr> <td>Employee: _____%</td> <td>Employee: _____%</td> </tr> <tr> <td>Dependent: _____%</td> <td>Dependent: _____%</td> </tr> </table>		<u>Medical</u>	<u>Dental</u>	Employee: _____%	Employee: _____%	Dependent: _____%	Dependent: _____%
<u>Medical</u>	<u>Dental</u>							
Employee: _____%	Employee: _____%							
Dependent: _____%	Dependent: _____%							
<p>"24 hour / on-the-job" injuries or illnesses are not covered except for Regence subscribers who are legally exempt from State Industrial Insurance.</p>								
COBRA/OBRA/TEFRA/FMLA Eligibility								
<p>COBRA Employer?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	<p>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.</p> <p>If yes, by checking the box to the left the employer authorizes Trusteed Plans Services Corporation (TPSC) to administer COBRA on terminating employees.</p>						
<p>TEFRA Employer?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>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.</p>						
<p>FMLA Employer?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>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.</p>						
<p>OBRA Employer?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>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.</p>						
Prior Coverage Information								
<p>Will this coverage replace existing group coverage with another carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of other carrier(s)</p>								
Employee Participation Requirements								
<p>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.</p>								
<p>A. Total Number of full-time and part-time employees (Do not include COBRA participants).</p>								
<p>B. Number of employees working fewer than the minimum hours</p>	-							
<p>C. Number of employees not in an eligible class</p>	-							
<p>D. Number of employees who have not completed the probationary period</p>	-							
<p>E. Subtotal of A. minus B. minus C. minus D.</p>	=							

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. 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. 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 producer as our company's producer of record.

Signature Section

Employer Representative (please print)	
Employer Representative Signature	Date:
Producer Signature	Date:
Agency Name	

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

Regence BlueShield
1800 9th 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

Page 4