



## Washington Business, Association and Chambers of Commerce Trust Employer Adoptive Agreement 2007

Risk Level:

Group 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>Asuris Northwest Health - Medical Plans</u></b></p> <p><input type="checkbox"/> PPO 1   <input type="checkbox"/> PPO 2   <input type="checkbox"/> PPO 3   <input type="checkbox"/> PPO 4   <input type="checkbox"/> PPO 5</p> <p><input type="checkbox"/> Advance \$500   <input type="checkbox"/> Advance \$1,000</p> <p><input type="checkbox"/> HSA   <input type="checkbox"/> Traditional 50/50</p> <p><i>Please refer to the WBACC Underwriting Guidelines for dual choice options.</i></p>	<p><b><u>Vision Service Plan – Vision Benefit</u></b></p> <p><input type="checkbox"/> 12/12/24 Vision Plan</p> <p><input type="checkbox"/> 24/24/24 Vision Plan</p> <p><b><u>Caldwell Legal Services - Legal Benefit</u></b></p> <p><input type="checkbox"/> Legal Plan</p>
<p><b><u>Washington Dental Service - Dental Plans</u></b></p> <p><input type="checkbox"/> 690A - \$1,000 maximum benefit - 5+ employees   <input type="checkbox"/> 691 - Incentive Plan \$1,000 maximum benefit - 5+ employees</p> <p><input type="checkbox"/> 690B - \$2,000 maximum benefit - 5+ employees   <input type="checkbox"/> 692 - Incentive Plan \$1,000 maximum benefit - 2-4 employees</p> <p><input type="checkbox"/> Orthodontics – available only on Plans 690 and 691</p>	
<p><b><u>Regence Life and Health - Life and Accidental Death and Dismemberment*</u></b></p> <p>Participating Employers with less than 15 eligible employees</p> <p><input type="checkbox"/> Plan I Flat Amount: _____ Option of \$10,000 to \$50,000 increments (minimum \$10,000)</p> <p><input type="checkbox"/> Plan II 1x Annual Salary rounded to the next higher \$1,000*</p> <p><input type="checkbox"/> Plan III 2x Annual Salary rounded to the next higher \$1,000* Maximum of \$50,000</p> <p><i>Evidence of insurability required for amounts in excess of \$25,000</i></p>	<p><b><u>Regence Life and Health - Life and Accidental Death &amp; Dismemberment*</u></b></p> <p>Participating Employers with at least 15 eligible employees</p> <p><input type="checkbox"/> Plan IV Flat Amount: _____ Option of \$10,000 to \$50,000 increments (minimum \$10,000)</p> <p><input type="checkbox"/> Plan V 1x Annual Salary rounded to the next higher \$1,000*</p> <p><input type="checkbox"/> Plan VI 2x Annual Salary rounded to the next higher \$1,000* Maximum of \$100,000</p> <p><i>Evidence of insurability required for amounts in excess of \$50,000</i></p>
<p><b><u>Regence Life and Health - Dependent Life Insurance</u></b> (Available to groups of any size)</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Benefit Amount: Spouse: \$5,000 Child(ren): \$2,000</p> <p>Reductions: All Life &amp; AD&amp;D benefits reduce from the original amount to 65% at age 65, 40% at age 70, 30% at age 75, 20% at age 80 and terminate at retirement</p> <p style="text-align: center;"><i>Dependent Life and Short Term Disability benefits cease upon termination of the employee's benefits</i></p>	<p><b><u>Regence Life and Health - Short Term Disability</u></b> (Available to all participating employers with at least 5 employees)</p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Benefit Amount: 60% of weekly salary to a maximum of \$250 per week. Short term benefits begin on the 1<sup>st</sup> day of accident or the 8<sup>th</sup> day of sickness.</p> <p>Options: <input type="checkbox"/> Plan I (13 weeks)   <input type="checkbox"/> Plan II (26 weeks)</p>
<p><b><u>AIG - Voluntary Personal Accident Plan</u></b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>	<p style="text-align: center;"><b>Identification Cards Delivery Request</b></p> <p><input type="checkbox"/> Deliver to Employee's Residence <input type="checkbox"/> Deliver to Employer's Office</p>

**\*Life Required.**

**Eligibility and Participation Requirements**

<p><b>Definition of Eligible Employee</b>                  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.</p>	<p><b>Eligibility Probationary Period</b>                  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"/> 30 days   <input type="checkbox"/> 60 days   <input type="checkbox"/> 90 days  <input type="checkbox"/> Other: _____  <b>For employees transferring from part-time to full-time status, the probationary period above should apply:</b>  <input type="checkbox"/> Retroactive to the original date of hire or,  <input type="checkbox"/> Beginning on the date of transfer</p>
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<p><b>Definition of Eligible Dependent</b>                  Eligible dependents must be a legally married spouse and/or a legally dependent child under age 25. <b>Qualified Domestic Partners</b> can also be eligible dependents. If you decline to offer domestic partner coverage to your employees, please check here:  <input type="checkbox"/> Decline</p>	<p><b>Employer Contribution</b>                  Please list the employer paid portion of the premium for each category (minimum 75% for employee, 100% if a restricted industry):</p> <table border="0"> <tr> <td><b>Medical</b></td> <td><b>Dental</b></td> </tr> <tr> <td>Employee: _____%</td> <td>Employee: _____%</td> </tr> <tr> <td>Dependent: _____%</td> <td>Dependent: _____%</td> </tr> </table>	<b>Medical</b>	<b>Dental</b>	Employee: _____%	Employee: _____%	Dependent: _____%	Dependent: _____%
<b>Medical</b>	<b>Dental</b>						
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 time or part time employees on more than 50% of its typical business days in the preceding calendar year.
TEFRA/OBRA Employer? Please check box to indicate you have read and confirm this policy	<input type="checkbox"/>	TEFRA and OBRA eligibility will be assumed for all participating member companies of the WBACC Trust 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.

**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 who have not completed the probationary period	-
D. Subtotal of A. minus B. minus C.	=
E. Number of employees submitting valid waivers of coverage	-
F. Total number of eligible employees (D. minus E.)	=
G. Total number of enrolled employees	
H. Total number of employees covered under COBRA or 6 month extension.	

**Signature Section**

I certify that the information on this agreement is complete and accurate. 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.

<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>	

\*\*\*Make all payments payable to Alternative Choice Insurance on or before the 20<sup>th</sup> of the Month prior to coverage effective date.\*\*\*

## 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

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Employer Name:

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Plan Administrator Name:

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Plan Administrator Signature:

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Date:

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