

Med RB: _____

Den RB: _____

Effective Date: _____

Group #: _____

MASTER APPLICATION AND AGREEMENT FOR INSURANCE COVERAGE

Company Information		
Legal Name of Business:	Requested Effective Date:	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other
dba (if applicable):	Employer Tax ID Number (EIN):	
Type of Business:	NAICS Code:	
Billing Address: (street, city, zip)		
Shipping Address: (if different)		
Billing Contact (<input type="checkbox"/> Contact for SIMON portal invitation?):	Phone:	Email:
Eligibility Contact (<input type="checkbox"/> Contact for SIMON portal invitation?):	Phone:	Email:

Prior Premera Medical Coverage
Will this coverage replace existing group coverage with Premera? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Coverage – Premera Blue Cross																				
1. Premera Network (Choose one): <input type="checkbox"/> Heritage Prime <input type="checkbox"/> Heritage Plus																				
2. Medical Plans(s)*: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Tech Premier</td> <td><input type="checkbox"/> Tech 80 \$250</td> <td><input type="checkbox"/> Tech 80 \$1,500</td> <td><input type="checkbox"/> HSA \$1,500</td> </tr> <tr> <td><input type="checkbox"/> Tech 90 \$200</td> <td><input type="checkbox"/> Tech 80 \$350</td> <td><input type="checkbox"/> Tech 80 \$2,500</td> <td><input type="checkbox"/> HSA \$3,000</td> </tr> <tr> <td><input type="checkbox"/> Tech 90 \$350</td> <td><input type="checkbox"/> Tech 80 \$500</td> <td><input type="checkbox"/> Tech 80 \$3,000</td> <td><input type="checkbox"/> HSA \$4,500</td> </tr> <tr> <td><input type="checkbox"/> Tech 90 \$500</td> <td><input type="checkbox"/> Tech 80 \$750</td> <td><input type="checkbox"/> Tech 80 \$4,000</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tech 90 \$750</td> <td><input type="checkbox"/> Tech 80 \$1,000</td> <td><input type="checkbox"/> Tech 80 \$2,000</td> <td></td> </tr> </table> <p><i>*Groups of 10 or more enrolled employees may select up to 2 plans as permissible per the dual choice matrix. Plan combinations must be within the same network. Heritage Prime and Heritage Plus plans may not be combined. A minimum of 5 employees must be enrolled in each plan.</i></p>	<input type="checkbox"/> Tech Premier	<input type="checkbox"/> Tech 80 \$250	<input type="checkbox"/> Tech 80 \$1,500	<input type="checkbox"/> HSA \$1,500	<input type="checkbox"/> Tech 90 \$200	<input type="checkbox"/> Tech 80 \$350	<input type="checkbox"/> Tech 80 \$2,500	<input type="checkbox"/> HSA \$3,000	<input type="checkbox"/> Tech 90 \$350	<input type="checkbox"/> Tech 80 \$500	<input type="checkbox"/> Tech 80 \$3,000	<input type="checkbox"/> HSA \$4,500	<input type="checkbox"/> Tech 90 \$500	<input type="checkbox"/> Tech 80 \$750	<input type="checkbox"/> Tech 80 \$4,000		<input type="checkbox"/> Tech 90 \$750	<input type="checkbox"/> Tech 80 \$1,000	<input type="checkbox"/> Tech 80 \$2,000	
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<input type="checkbox"/> Tech 90 \$750	<input type="checkbox"/> Tech 80 \$1,000	<input type="checkbox"/> Tech 80 \$2,000																		

Dental – Premera Blue Cross
Optional Dental: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Decline
Orthodontia (Available to groups of 10+): <input type="checkbox"/> Yes <input type="checkbox"/> No

Vision – VSP Vision Care, Inc.
Vision: <input type="checkbox"/> Exam Plus <input type="checkbox"/> Basic <input type="checkbox"/> Preferred <input type="checkbox"/> Enhanced <input type="checkbox"/> Decline

Life and Disability Coverage – Metropolitan Life Insurance Company

Basic Life/AD&D (Life plan required with all medical plans):

☐ Plan A (\$25,000) ☐ Plan B (\$50,000) ☐ Plan C (\$100,000) ☐ Plan D (\$250,000)

Supplemental Life and AD&D: ☐ Yes ☐ No (*No minimum employee participation requirement*)

Short Term Disability: ☐ Yes (*salary information required*) ☐ No

Minimum 2 full-time employees: 60% of weekly salary; 26-week duration. All plans Non-Contributory.

☐ **STD Plan 1:** \$2500 wkly benefit; 0/7 Day Elimination Period ☐ **STD Plan 2:** \$2000 wkly benefit; 7/7 Day Elimination Period
☐ **STD Plan 3:** \$ 1750 wkly benefit; 7/7 Day Elimination Period ☐ **STD Plan 4:** \$1250 wkly benefit; 14/14 Day Elimination Period

Long Term Disability: ☐ Yes (*salary information required*) ☐ No

Minimum 2 full-time employees: 60% of weekly salary; 180-day EP, 90-day EP Option if Stand-alone. All plans Non-Contributory.

☐ **LTD Plan 1:** \$10,000 max; Benefit to SSNRA ☐ **LTD Plan 2:** \$8,000 max; Benefit to SSNRA
☐ **LTD Plan 3:** \$6,000 max; Benefit to SSNRA ☐ **LTD Plan 4:** \$5,000 max; 5-Year Benefit Duration
☐ **LTD Plan 5:** Stand-alone – No STD Coverage: 90-Day EP, \$8,000 max; Benefit SSNRA

EAP Plan – Wellspring Family Services

3 visits included in medical plan

WTIA Membership

A membership with WTIA is required to obtain coverage through WTIA Employee Benefit Trust. Please submit the WTIA Membership Application along with dues payment. Membership must be maintained to continue coverage under the plan. Membership fees are not used to provide plan benefits and are not consider plan assets. Any membership fees received by the WTIA Employee Benefit Trust will be forwarded to the WTIA.

Current Member: ☐ Yes ☐ No

Late Fee Policy – Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of 5% of the amount owed. The fee will be added to the next month's billing statement. Unpaid balances may be referred to collections. The employer will be responsible for any fees, attorney fees or other fees, associated with the collections process.

Payment Options: ☐ Electronic Funds Transfer (EFT)
(You must fill out the EFT form) ☐ Online ☐ Check

NEW GROUPS – *A binder check is not required for groups that elect EFT for payment. Binder checks are required for online and check payment options.*

COBRA and FMLA

COBRA Administration: Regardless of size, all groups insured by Washington Technology Industry Association Employee Benefit Trust are eligible for COBRA. Benefit Solutions, Inc. will administer COBRA for all WTIA lines of coverage at no additional cost.

☐ Yes ☐ No **FMLA:** Did your company employ 50 or more full and/or part-time employees during each of the 20 calendar weeks in the current or preceding calendar year, and is it subject to federal TEFRA laws?

Affordable Care Act Required Information: Please enter the average number of employees that were employed by your company during the prior calendar year (January – December). This count should include: full-time, part-time, seasonal, and union employees that work inside or outside the state of Washington and employees in any state from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.

Eligibility and Enrollment	
Participation and Contribution Requirements	<ul style="list-style-type: none"> • Minimum 75% Employee Participation of all eligible employees • Minimum 75% Employer Contribution of Employee Coverage
Employer Contribution	Class 1: Employee: _____% Dependent: _____% Class 2: Employee: _____% Dependent: _____%
Eligible Employees are required to work _____ hours per week. (Minimum Requirement: 20 hours per week, administered on a non-discriminatory basis, based on conditions of employment.)	
Employee Classifications: (20+ employees required for addition of Class 2) Class 1: _____ Eligibility Requirements (other than hours): _____ Class 2: _____ Eligibility Requirements (other than hours): _____	
Probationary period should be effective on the 1st of the month following: Class 1 <input type="checkbox"/> Date of Hire* <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days – not to exceed 90 Days Class 2 <input type="checkbox"/> Date of Hire* <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days – not to exceed 90 Days	
*If “Date of Hire” (DOH) is selected above, choose how DOH will be administered. <input type="checkbox"/> Effective date will always be 1 st of month following DOH, even if DOH is the 1 st of the month <input type="checkbox"/> Effective date will be 1 st of month following DOH, with the exception of when the DOH is the 1 st of the month	

Eligibility and Enrollment (continued)
Eligibility Look Back Measurement/Stability Period: Has your company adopted a look back measurement/stability period under the ACA for the employee classification referenced above? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, the Measurement Period is _____ months and the Stability Period is _____ months. Please confirm that this measurement period is applied due to a good faith uncertainty about whether the employee meets the eligibility criteria referenced above: <input type="checkbox"/> Yes
(NEW GROUPS ONLY): Is probationary period waived on group’s initial enrollment? <input type="checkbox"/> No (Probationary period applies to all current and future full-time employees) <input type="checkbox"/> Yes (Probationary period applies only to future full-time employees)
For employees transferring from part-time to full-time status, the probationary period specified should apply: <input type="checkbox"/> Retroactive to the original date of hire OR <input type="checkbox"/> Beginning on the date transferred to full-time status

Group Participation (Do not leave any blanks, if the answer is “zero” please put “0”)	
Total Number of employees on payroll regardless of hours worked. (Do NOT include COBRA participants)	+ _____
• Less employees working fewer than the minimum hours required	- _____
• Less employees not in an eligible class	- _____
• Less employees who have not completed the probationary period	- _____
• Less employees paid via IRS Form 199, or temporary, or seasonal, or substitute employees	- _____
• Less employees waiving coverage because they are covered by a spouse’s or parent’s similar group medical plan. (Proof of coverage required if participation falls below 75%.)	- _____
• Less employees waiving coverage because they are covered by Medicare as primary , at the request of the Medicare enrollee. (Proof of coverage required if participation falls below 75%.)	- _____
• Equals total number of employees eligible to enroll	= _____
• Number of employee applications being submitted (75% participation required)	_____
• Number of employees covered by your group under provisions of COBRA	_____

Adoption of Trust, Appointment of Trustee & Understanding of the Terms of the Selection & Participation

Understanding of the Terms & Provisions of Participation

The undersigned Employer agrees to adhere to the terms, conditions and limitations of coverage as set forth in the Trust Agreement, health service contracts, insurance policies, service contracts, benefit booklets and certificates of insurance issued by the WTIA Employee Benefit Trust ("Trust") or the WTIA Employee Benefit Trust's respective carriers.

Sponsor – The undersigned Employer acknowledges and agrees that Washington Technology Industry Association (WTIA) is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. WTIA may also charge a service, license or other sponsorship fee for participating in the Trust. Additionally, WTIA may charge a membership fee for participating in the Trust. Membership fees are not used to provide health plan benefits and are not considered Trust or Plan assets.

Producers – The undersigned Employer acknowledges that it may hire a producer to represent the Employer when joining the Trust. The undersigned Employer authorizes the Trust to recognize any fee/commission arrangement between the Employer and its producer to receive and pay such fees/commissions to the producer. Employer producer fees/commissions received by the Trust shall not be used to providing Plan benefits and are not considered Trust or Plan assets.

Authority of Trustees – The undersigned Employer acknowledges and agrees that all Trustees appointed under the Trust Agreement shall have all rights and powers described here under and as set forth in the Trust Agreement.

Third Party Administrator – The undersigned Employer agrees that the Trust may select one or more service providers to act as a third-party administrator ("TPA") for the Trust and/or the Welfare Benefits Plans, and that such service providers may be one or more of the Member Companies.

Contributions – The undersigned Employer agrees to pay the contributions established by the Trust. The undersigned Employer further understands and agrees that benefits for employees shall not be provided by the Trust during any month for which contributions are not paid.

Termination – This Adoption Agreement may be terminated by the undersigned Employer, which may withdraw from participation in the Trust by giving thirty (30) days written notice of intent to withdraw to the Trustees in accordance with the Trust Agreement. Such Member Company shall have the rights and duties specified therein. This Agreement may be terminated by the Trust, in the event that the undersigned Employer (a) shall fail or refuse to pay contributions due to the Trust in accordance with the Trust Agreement, or (b) shall be in breach of any of its other obligations under the Trust Agreement of this Adoption Agreement, which breach shall not have been cured within ten (10) days after the undersigned Employer receipt of written notice thereof.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trustees and the Sponsor from any and all loss, damages or liability incurred in the course and scope of their respective duties as described in this Agreement, except those resulting from their gross negligence, willful misconduct or dishonesty. In the event that the Trustees or the Sponsor are made a party to any legal proceeding of any kind or nature arising out of their respective duties hereunder, directly or indirectly, the undersigned Employer agrees to indemnify and hold them harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting there from. Any damages assessed or expenses required to be paid or incurred by reason of this indemnification shall be borne equally by all Member Companies, unless it shall be determined that the damages, expenses or losses incurred result directly from the actions or inactions of a specific Member Company, its employees or producers. In such event, that specific Member Company shall be primarily responsible for payment, with other Member Companies being responsible only in the event of the specific Member Company's inability by reason of financial insolvency to respond.

Governing Law – This Agreement shall be construed and enforced in accordance with ERISA and, to the extent applicable, the laws of the State of Washington.

Anti-Fraud Statement

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I agree that all information completed on this application is true, correct, and complete. 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. 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. In addition, the issuer will have the right to collect any claims payments or other damages.

Group Signature Section_____
Signature & Title of Employer Representative_____
Date**Insurance Producer Application**

A business applying for insurance coverage through the Washington Technology Industry Employee Benefit Trust may appoint its own Insurance Producer to represent them as noted below:

Name of Insurance Producer: _____

Name of Producer's Agency: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: Fax Number: _____

E-Mail Address: _____

- ☐ We request the above-named producer be given access to our records in the online enrollment system, SIMON. *(Employer must complete separate SIMON authorization form. Our third-party administrator will send the form to your SIMON portal contact.)*

We hereby appoint the above-named Insurance Producer as our firm's Producer of Record. This agreement will serve as notice of cancellation of any previous Insurance Producer agreement. This new appointment will remain effective until written notice is given by either party of a change. No changes may be made retroactively.

Name of Employer_____
Signature of Employer Representative_____
Date_____
Name & Title (PRINTED) of Employer Representative**Coverage Underwritten By:****Medical & Dental Insurance Benefits:** Premera Blue Cross, 7001 220th St SW, Mountlake Terrace, WA 98043-2160**Vision Insurance Benefits:** VSP Vision Care, Inc., 3333 Quality Drive, Rancho Cordova, CA 95670**Life Insurance Benefits:** Metropolitan Life Insurance Co., 200 Park Avenue, New York, NY 10166**Employee Assistance Program:** WellSpring Family Services, 1900 Rainier Ave S, Seattle, WA 98020