WBBA — WASHINGTON BIOTECHNOLOGY & BIOMEDICAL ASSOCIATION

WBBA
January 2010 - December 2010
Participation Agreement

Program Management Provided By
Wells Fargo Insurance Services

Company Information

Company Name:	dba (if applicable):	Effective Date:

Employer Tax ID (EIN)#:	☐ Corp. ☐ Partnership	☐ Proprietor ☐ Other	Business Nature: ____________ SIC: ____________

Group Benefits Administrator:	Billing Contact:
Phone: ( ) - Fax: ( ) -	Phone: ( ) - Fax: ( ) -
Street Address: City State Zip	Billing Address: City State Zip
Benefits Administrator Email (important if electing Wellness):	Billing Representative Email:

Base Product Selections

Compulsory benefits are Medical, the 3 Visit EAP Model and $10,000 Basic Life and AD&D coverage (Life only available for 5+ groups)

Medical Plans

Underwritten by Premera Blue Cross:

☐ Plan A $0 Ded. 0/50% $20 Copay
☐ Plan B $200 Ded. 0/50% $15 Copay
☐ Plan C $250 Ded. 10/50% $20 Copay
☐ Plan D $300 Ded. 20/50% $20 Copay
☐ Plan E $500 Ded. 20/50% $25 Copay
☐ Plan F $750 Ded. 20/50% $25 Copay
☐ Plan G $1,000 Ded 20/50%
☐ Plan HSA $1,700 Ded. 20/50%
☐ Plan I $2,000 Ded. 20/50% $30 Copay
☐ Plan HSA $2,500 Ded. 20/50%

NOTE: If an HSA Plan is selected, please indicate the employer contribution percentage (0% - 80%) ___________ % to the HSA Fund

Wellness Plan Pricing* ☐ Yes ☐ No

*50% of the participants must complete the Personal Health Assessment. Employer must incent participants with a $75 cash benefit. A participant is defined as a covered employee and/or spouse. Employer has 90 days from plan anniversary date to provide verification of the participation requirement. When this program is selected, a Wellness Welcome Kit will be delivered within 30 days of the effective date. ONLY AVAILABLE WITH PREMERA MEDICAL PLANS.

Underwritten by Group Health Options, Inc.:

☐ Alliant Plus Health Plan 5 ☐ Alliant Select Health Plan 10

Life Plans

Underwritten by Unum
☐ Plan 1 $10,000 Basic Life and AD&D (groups 5+ only)

Employee Assistance Plan

The Wellspring Group
☒ 1-3 Visit Model

Buy-Up Product Selections

Dental Plans

Underwritten by Washington Dental Service: Delta Dental PPO Plans
☐ Plan A 00352 100/90/50%, $1,000 max $25 Ded.
☐ Plan B 00776 100/90/50%, $2,000 max, $50 Ded.
☐ Plan C 00777 100/80/50% $1,500 max, $50 Ded.
☐ Plan D 00778 100/80/50%, $2,000 max, $50 Ded.
☐ Plan E 00353 90/70/50%, $1,000 max, $50 Ded.
☐ Option 1 50% to $1,000 Ortho
☐ Option 2 50% to $2,000 Ortho

Life Plans

Unum (10+ Employees)
☐ Plan 2 $50K Basic Life & AD&D ☐ Plan 3 1 x times salary not to exceed $100K ☐ Plan 4 1 x times salary not to exceed $200K
☐ Supplemental Life and AD&D

Vision Hardware Plan

Underwritten by Vision Service Plan
(Available to groups >5 employees)
☐ Plan B ☐ Safety Glasses Option 1 ☐ Safety Glasses Option 2

Employee Assistance Plan (Buy-Up Option)

☐ 1-6 Visit Model

Cafeteria Plan: ☐ Section 125 ☐ Section 132 ☐ Premium Only ☐ HRA

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.
☐ All full-time Employees working a minimum of ___________hours per week (not less than 20)
☐ All part-time Employees working a minimum of ___________hours per week (not less than 20)
☐ All Employees working in a specific class(es), working a minimum of ________hours per week *
*If the last box is checked, please specify class, such as hourly, salaried, covered or not covered by collective bargaining, etc.:
____

Probationary Period Information:

Coverage for newly hired/eligible will become effective the first of the month following the completion of the probationary period.
☐ Date of Hire ☐ 1 month ☐ 2 months ☐ 3 months ☐ Other: ______________________

Employees Differentiated by Class:

Only employees in a specific class of classes who work the specified minimum hours per week that have met the probationary period are eligible. Complete the minimum work hours and probationary period information for each designated class of employee.

Eligibility and Participation Requirements (Continued)

☐ Management	☐ Salaried	☐ Hourly	☐ Part-time	☐ Full-time	☐ Other
Minimum Hours ___	Minimum Hours ___	Minimum Hours ___	Minimum Hours ___	Minimum Hours ___	Minimum Hours ___
1st of the month following	1st of the month following	1st of the month following	1st of the month following	1st of the month following	1st of the month following
☐ Date of Hire	☐ Date of Hire	☐ Date of Hire	☐ Date of Hire	☐ Date of Hire	☐ Date of Hire
☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days
☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days
☐ 90 days	☐ 90 days	☐ 90 days	☐ 90 days	☐ 90 days	☐ 90 days
☐ Other ______	☐ Other ______	☐ Other ______	☐ Other ______	☐ Other ______	☐ Other ______

Waive Probationary Period: new groups only
For employees transferring from part-time to full-time status, the probationary period above should apply

☐ Retroactive to the original date of hire
☐ Beginning at the date of transfer

Domestic Partner Coverage: Domestic Partner coverage is optional on all plans on the group level. Domestic Partner Affidavits are required with enrollment form during open enrollment.
☐ No Domestic Partner Eligibility
☐ Yes, Domestic Partner Eligibility

Pre and Post Doctoral Eligibility:
☐ No Pre- and/or Post- Doctoral Fellows
☐ Yes, Pre- and/or Post- Doctoral Fellows

Employer Contribution and Employee Participation Requirements:

The employer must contribute the minimum percentages shown below toward the cost of coverage and must meet the minimum participation requirements. Minimum Contribution/Participation Requirements:
75% Employee Contribution- 75% Employee Participation 100% Employee Contribution- 100% Employee Participation

Medical		Dental	
Employee:	______%	Employee:	______%
Dependent:	______%	Dependent:	______%

Employee Enrollment

Total number of employees on payroll regardless of hours worked: ____________(A)

Employees not eligible to enroll:
- Working less than the min. hrs: ________
- Temporary or seasonal: +________
- In probationary period: +________
- Not in a covered class: +________ = ______(B)

Employees not enrolling due to coverage under:
- Medicare, CHAMPUS/Tricare, Military: _______
- Other group coverage +_______
- Union +_______= ______(C)

Total number of eligible employees (A)-(B)-(C) = ______ (D)
Eligible employees waiving enrollment without other coverage: ______ (E)
Total number of eligible employees enrolling (D)-(E)= ______

Current Medical Plan Information (New Groups Only)

Is this plan intended to replace any existing coverage? ☐ Yes ☐ No
If yes, complete the following:
Name of prior medical carrier ________________________ Original Effective Date: _________ Term Date: ____________
Name of prior dental carrier ________________________ Original Effective Date: _________ Term Date: ____________

COBRA/TEFRA/OBRA/FMLA Designation

We strongly urge you to consult with legal counsel in answering the following questions. The summaries below are not intended to be or to replace legal advice on your particular group. It is the group's responsibility to inform the carrier immediately if facts change which would cause the group's answers below to change.

COBRA Employer?
☐ Yes ☐ No

*COBRA Administered by BSI?
☐ Yes ☐ No

*Separate application required

Helpful Hint: Generally, thee laws apply to any non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year. "Employees" are full-time and part-time common-law employees. Self-employed workers as defined in IRC §401(c)(1), corporate directors, or independent contractors should not be counted unless they qualify as common-law employees. "Employees" may also include leased employees who qualify as common-law employees. Please COBRA regulations at 26 CFR §54.4980b-2 Q/A 5 for guidance on counting part-time employee as a fraction of a full-time employee.

Rates- REQUIRED

	Employee	Emp/Sp	Emp/Sp/1Child	Emp/Sp/2Child	Emp/1Child	Emp/2Child
Medical Plan 1:	$	$	$	$	$	$
Medical Plan 2:	$	$	$	$	$	$
Dental Plan:	$	$	$	$	$	$
Vision Hardware:	$	$	$	$	$	$
Basic Life/AD&D:	$	$	$	$	$	$
EAP:	$	$	$	$	$	$

Endorsed Carrier Contact Information

Carrier	Contact
Premera BlueCross	7001 220th Street S.W.; Mountlake Terrace, WA 98043-2124; Customer Service – 800.722.1471
Group Health Options, Inc.	320 Westlake Avenue N., Suite 100; Seattle, WA 98109-5233; Customer Service – 888.901.4636
Washington Dental Service	9706 4th Avenue N.E., P.O. Box 75983; Seattle, WA 98175-0983; Customer Service – 800.554.1907
Vision Service Plan	3333 Quality Drive; Rancho Cordova, CA 95670; Customer Service – 800.877.7195
Unum Life Insurance Company	1111 3rd Avenue, Suite 2300; Seattle, WA 98101; Customer Service – 800.421.0344
Wellspring Family Services	1900 Rainier Avenue South; Seattle, WA 98144; Customer Service – 800.553.7798

Understanding of the Terms of Selection and Participation

The undersigned Employer understands that any change to the selections made on the Participation Agreement for Insurance Coverage shall occur only at the renewal date and are subject to approval by the applicable carrier(s).

The undersigned Employer agrees at all times to adhere to the established rules and procedures of the applicable carrier(s) as set forth including, but not limited to the terms, conditions and limitations described in the initial Underwriting and Administrative Guidelines, billing and administrative guidelines, and other applicable administrative guidelines. The undersigned Employer understands that 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.

The undersigned Employer acknowledges and agrees that full payment of premium to the applicable carrier(s) is due on the first day of the month for which coverage is purchased, that any payment of premium received by the applicable carrier(s) after the 10th day of the month is late and the applicable carrier(s) will impose late charges and interest in the amount established in the Underwriting and Administrative Guide, and further that any premium received by the applicable carrier(s) more than 30 days after the due date will be returned to the undersigned Employer and the Employer's group life and health insurance coverage under the applicable carrier(s) will be terminated as of the last day of the last month for which full payment was timely received.

The undersigned Employer acknowledges and agrees that once its application has been approved and accepted by the applicable carrier(s), any request to rescind its application must be made in writing and must be received by the applicable carrier(s) not later than the close of business on the last business day at least 48 hours before the effective date of coverage under the applicable carrier(s). If a proper request to rescind is not received timely, the applicable carrier(s) will not refund any premiums or deposits and the coverage will be in effect as approved and accepted by the applicable carrier(s).

Fraud and HIPAA Statements

FRAUD STATEMENT:

I have provided these answers as part of the application procedure required by the WBBA Benefit Program to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Premera BlueCross will rely on each answer in making coverage and rating determinations. If Premera BlueCross 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 Premera BlueCross will have the right to adjust the rates.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. 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.

HIPAA STATEMENT:

I acknowledge and understand my health plan may request or disclose health information about persons who are eligible for benefits coverage and are listed on the enrollment forms for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health Information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist, or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or other group health plan. Health Information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes.

Signature Section

Producer Agreement to Contract

You, the Producer(s), certify that you have met with the group submitting this agreement and that you have fully explained its contents. You have discussed coverage, eligibility, any pre-existing condition waiting periods, the effect of misrepresentations, termination provisions and subscription charge billing administration.

Producer Signature	Date
Producer of Record (Print Name)	Name of Firm
Producer E-mail Address	Effective Date Producer is Appointed for this Group

Group Agreement to Contract

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 Associated Employers Trust and the trust's carriers' plan booklets and contracts. We agree to maintain our membership in the Associated Industries. With my signature, I also hereby appoint the above named Producer as our company's Producer of record.

I understand there is no coverage in effect until The Trust accepts this Application, premium is deposited, and an effective date of coverage is established. Final rates are subject to the execution of the Group Subscriber Agreement/ Group Policy. If this Application is not accepted, the premium deposit will be refunded. THE PARTICIPATING EMPLOYER UNDERSTANDS AND AGREES THAT THE EMPLOYER SHOULD KEEP PRIOR COVERAGE IN FORCE UNTIL NOTIFIED OF ACCEPTANCE IN WRITING. IT IS UNDERSTOOD AND AGREED THAT NO PRODUCER HAS THE AUTHORITY TO: a. modify this Application; b. waive the answer to any question; c. bind us in any way by giving or receiving any date which is not written on this Application; or d. bind us by making any promise or representation

Group Representative's Signature	Date
Group Representative (Print Name)	Title