Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield
1800 Ninth Avenue
Seattle, Washington 98101

Send **Renewal** GMA to:
FAXSBURenewals@regence.com

Send **New Group** GMA to:
FAXSBUNewSales@regence.com

Group Master Application - For Group Size 1-50

Please complete and submit this application to our office **no later than 15 days prior to the effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate sheet of paper.

Requested Effective Date _____

SECTION A - GROUP INFORMATION			
Group's Legal Name			Group Number
Doing Business As (DBA)		Name to be used by Regence ☐ Legal ☐ DBA	Date Business Started
Federal Tax ID Number (EIN)	State Tax ID Number (UBI, **required** for WA)		Location of Business Headquarters
SIC Code and Industry Description			Company Structure ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Other _____
Name and Title of President, Owner, CEO		Group's Primary Language (if other than English)	
Physical Business Address **Required** (No PO Box or PMB)		Mailing Address (if different from Physical Business Address)	
County	Phone Number ( ) Fax Number ( )	County	Phone Number ( ) Fax Number ( )

PRIMARY GROUP CONTACT		
Name (First, MI, Last)		Title
Phone Number ( )	Fax Number ( )	E-mail Address

GROUP ADMINISTRATOR (if different from primary contact)		
Name (First, MI, Last)		Title
Phone Number ( )	Fax Number ( )	E-mail Address

SECTION A - GROUP INFORMATION (continued)

BILLING

Do you require separate billing invoices? ☐ No ☐ Yes **(If yes, please complete Additional Billing section below)**

Billing Name to be used by Regence ☐ Legal ☐ DBA	Contact and Title (if different than primary group contact)
Billing Address (include Attention line if applicable)	Phone Number ( ) Fax Number ( )

Payment Type
☐ Pay by Check ☐ Surepay (EFT) **Please submit Surepay document**

Additional Billing Name to be used by Regence	Contact and Title (if different than primary group contact)
Billing Address (include Attention line if applicable)	Phone Number ( ) Fax Number ( )

Payment Type
☐ Pay by Check ☐ Surepay (EFT) **Please submit Surepay document**

ENROLLMENT METHOD AND EMPLOYER CENTER

Enrollment Method

Please indicate your enrollment method by checking the desired option from the listing below.	**Initial Enrollment** with Regence	**Ongoing Enrollment** with Regence
Spreadsheet	☐	
Regence Online Enrollment When selecting Regence Online Enrollment, would you like to allow your employees to enroll themselves? ☐ No ☐ Yes	☐	☐
ANSI 834	☐	☐
Paper Enrollment Forms	☐	☐

Employer Center

Primary Group Administrator for Employer Center: Name (First, MI, Last)	E-mail Address	Phone Number ( )

If more than two Secondary Group Administrators for Employer Center are required, indicate the number desired _____

SECTION B - PRODUCER (AGENT) INFORMATION

Agency Name	Producer's E-mail Address	
Producer's Name	Producer's Phone Number	Producer's Number
Secondary Producer's Name	Secondary Producer's Phone Number	Secondary Producer's Number

Commission Split: Producer #1 _____ % Producer #2 _____ %

SECTION C - FEDERAL MANDATES

COBRA:

Group subject to COBRA? ☐No ☐Yes**

COBRA applies to employer groups that have employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (January - December), with the exception of federal government plans and church plans. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

**If you are subject to COBRA, do you utilize a COBRA third party administrator (TPA)? ☐No ☐Yes

If yes, who is your COBRA administrator _____

Please indicate if your COBRA TPA is providing any of these services by checking the appropriate box(es).

☐Regence billing sent directly to the TPA for COBRA participants. (Be sure to complete the additional billing information above in Section A for this TPA.)

☐TPA submits COBRA Enrollment and Dis-Enrollment directly to Regence.

OBRA:

Group subject to OBRA? ☐No ☐Yes

If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:

Group subject to TEFRA/DEFRA? ☐No ☐Yes

If the TEFRA/DEFRA status has changed within the past year, please indicate the Date of Change _____

If you employed 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

ERISA:

Group subject to ERISA? ☐No ☐Yes

If yes, is your plan year different than your renewal date? ☐No ☐Yes, list date _____

Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals covered by a health plan subject to ERISA, as well as most voluntarily established pension plans.

ERISA Plan Note: If you use the benefit booklet as a component of the summary plan description and want to investigate meeting your distribution requirement electronically, see 29 CFR §2520.104b-1(c) for the U.S. Department of Labor's electronic distribution safe harbor.

Schedule A / 5500:

Per section 104 of ERISA, your group may be required to file IRS Form 5500 (Schedule A).

Do you require information from us to help you complete your Schedule A / Form 5500? ☐No ☐Yes

If yes, this information will be provided based on your insurance contract period.

New Groups Only - Affordable Care Act Required Information:

In the previous calendar year (January - December) the average number of employees was _____. This employee count represents the calendar year of _____ (YYYY).

This count should include: full-time, part-time, seasonal, and union employees that work inside or outside the state of Washington and employees worldwide from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees. Your employee count should **not** include contracted 1099 individuals.

SECTION D - OTHER CARRIER INFORMATION

1. Does your group have current Medical/Pharmacy/Dental benefits?

   a. Medical: ☐No ☐Yes If yes, name of carrier _____ Coverage end date _____

   Is the current coverage through an Association? ☐No ☐Yes If yes, name of Association _____

   b. Pharmacy: ☐No ☐Yes If yes, name of carrier _____ Coverage end date _____

   Is the current coverage through an Association? ☐No ☐Yes If yes, name of Association _____

   c. Dental: ☐No ☐Yes If yes, name of carrier _____ Coverage end date _____

   Is the current coverage through an Association? ☐No ☐Yes If yes, name of Association _____

2. Will you be offering more than one medical/dental carrier to your employees (this option is not allowed in all instances)?

   a. Medical: ☐No ☐Yes If yes, name of carrier(s) _____

   b. Dental: ☐No ☐Yes If yes, name of carrier(s) _____

3. Does your group have Workers' Compensation coverage?

   ☐No ☐Yes If yes, name of carrier _____

SECTION E - GROUP ELIGIBILITY (for purposes of determining group classification)

1. Is the group affiliated with any other company (parent, subsidiary or other entity)? ☐No ☐Yes

   If yes, please explain _____

   Note: The Health Insurance Portability and Accountability Act of 1996 may require that all persons and/or entities treated as a controlled group or affiliated service group under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 be treated as a single employer.

2. Do you have employees employed outside the state of Washington? ☐No ☐Yes If yes, please indicate below

   Note: Employees who reside in the state of Hawaii are not eligible for coverage.

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

SECTION F - EMPLOYEE ELIGIBILITY (for purposes of determining who is eligible for group benefits)

Note: The minimum number of hours for eligibility are 20 hours in a normal work week.

1. This plan covers employees working the minimum number of hours required for coverage.

   The minimum number of hours to be eligible for coverage are _____

2. This plan covers the following: ☐Employee and Dependents
   ☐Employee Only **(No dependent coverage)**

3. Probationary Periods:

Groups may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. **All employees must be accounted for.** (If there are no classes, please enter all information in space provided for Class 1).

	Please place an X in the appropriate box below		
	Coverage is effective on the first of the month following		
	Date of Hire (see 3A below)*	30 Days	60 Days
Class 1:			
Class 2:			
Class 3:			

3A. *If Date of Hire (DOH) option is selected above, choose how Probationary Period will be administered:

☐Effective date will always be 1st of the month following DOH, even if DOH is the 1st of the month.

☐Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

3B. Is probationary period waived on group's initial enrollment: ☐No ☐Yes

3C. For employees transferring from part-time to full-time status, the probationary period specified above should apply:

☐Beginning on the date transferred to full-time status ☐Retroactive to the original date of hire

Note: Effective September 23, 2010, federal health reform prohibited employers from discrimination in favor of highly compensated individuals set forth in Internal Revenue Code section 105(h). Enforcement of this prohibition has been delayed until associated regulations or other guidance has been issued and it is unclear when that may occur. Regence is unable to determine whether a plan discriminates in a way that violates the federal reform provisions, both because guidance has not been issued and because it does not have access to information necessary to identify highly compensated individuals. Because this element of federal reform is intended to fine employers with discriminatory plans, Regence recommends that employers obtain tax and/or legal advice associated with maintaining any plan provision that may prove discriminatory.

SECTION G - EMPLOYER CONTRIBUTION ‡

Employer Contribution Level:

There is a minimum employer contribution percentage of 50% towards employee coverage and no minimum employer contribution percentage for dependents. Using the table below, please indicate whether the Employer Contribution is based by product (e.g., Bronze, Silver, Gold, Platinum, etc.) or by class (e.g., hourly/salary etc.) and enter the percentage amount that the employer will pay towards the monthly rate of the elected coverage type (medical/dental).

☐ By Product	Option 1, specify product		Option 2, specify product		Option 3, specify product	
☐ By Class	Class 1		Class 2		Class 3	
Coverage Type	Medical/Rx	Dental	Medical/Rx	Dental	Medical/Rx	Dental
Employee	%	%	%	%	%	%
Dependent	%	%	%	%	%	%

SECTION H - GROUP PARTICIPATION ‡

Participation Requirements: There is a minimum participation requirement of 100% of eligible employees (line 5 below) after consideration of valid waivers for groups with fewer than four eligible employees. For groups with greater than three eligible employees, the minimum participation is 75% of eligible employees (line 5 below) after consideration of valid waivers.

1. Total number of employees on payroll regardless of hours worked (Do not include individuals participating on COBRA or Non-COBRA Continuation of Coverage). + _____
2. Less individuals not eligible for coverage on this plan (account for each of these individuals in one of the following that best applies):
   a) Number of employees working fewer than the minimum hours (as selected in Section F - Employee Eligibility). – _____
   b) Number of employees who are fulfilling their New Hire Probationary Period (as selected in Section F - Employee Eligibility). – _____
   c) Number of employees who are seasonal, substitute or temporary. – _____
   d) Number of individuals who are paid solely via IRS Form 1099. – _____
   e) Number of employees whose class is ineligible for coverage under this plan **(applies to groups of 10 or more enrolled employees, unless union).** Please enter the description of your group's ineligible class _____ , if union, please provide a copy of the union roster. – _____
3. Equals sub-total number of employees eligible to enroll. = _____

Using the number of employees eligible to enroll (from line 3 above), continue for each type of coverage (Medical/Dental) elected:	Medical	Dental
4. Less number of employees submitting a Waiver form for **other qualifying coverage.**	–	–
5. Equals total number of employees eligible to enroll.	=	=
6. Less number of employees submitting a Waiver form because they are **declining coverage. (No other qualifying coverage).**	–	–
7. Equals number of employee applications submitted **(new groups)** / number of employees on coverage on the effective date **(renewing groups)**.	=	=
8. Employees participation percentage (line 7 divided by line 5).	%	%
9. Number of subscribers and/or their dependents covered by your group under COBRA or Non-COBRA Continuation of Coverage.		
10. Number of former and current employees and/or their dependents who are currently eligible for COBRA or Non-COBRA Continuation of Coverage but have not yet applied.		

‡Special Annual Enrollment for Groups 1-50

A special small group annual enrollment period will be offered November 15th through December 15th for a January 1st effective date to groups who do not meet the minimum contribution and/or participation rules. Minimum contribution and participation rules must be met for renewing groups.

SECTION I - BENEFITS

MEDICAL - Please make your selections here.

☐ If offered by class, specify Employee Classification _____ (Available to 25 or more enrolled employees)
☐ Employee Choice - Please use Employee Choice Rate Sheet to indicate product selections.

Medical Plan Choices

You may select two products, in addition to the Preferred product, which has been automatically selected for you.	You may select up to 5 different metal levels for your chosen product(s). **Note:** Pharmacy is embedded with the medical		Would you like to include Adult Vision benefits to the selected plans?
☒ Preferred ☐ The Everett Clinic ☐ Evergreen Health Partners ☐ MultiCare Health System ☐ UW Medicine	Regence Employee Choice	☐ Gold 500 ☐ Gold ☐ Gold+ ☐ Platinum ☐ Platinum+	☐ Adult Vision (Available with non-HSA plans only)
	Regence Employee Choice Simple	☐ Silver Simple ☐ Gold Simple	
	Regence Employee Choice Silver	☐ Silver	
	Regence Employee Choice HSA	☐ Bronze HSA ☐ Bronze HSA+ ☐ Silver HSA ☐ Silver HSA 100% ☐ Gold HSA	

DENTAL - Please make your selections here. If offered by class, please specify the additional Employee Classification _____ .

	DENTAL PLAN CHOICES (Available to 2 or more enrolled employees)	
☐ **Encore** 80/50/0	**Deductible and Annual Maximum**	
	☐ $0 Deductible Classes I - II; $500 Annual Maximum ☐ $50 Deductible Classes I - II; $500 Annual Maximum ☐ $25 Deductible Classes I - II; $750 Annual Maximum ☐ $50 Deductible Classes I - II; $750 Annual Maximum	
☐ **Expressions** 100/80/50	**Deductible and Annual Maximum**	
	☐ $25 Deductible Classes II - III; $1,000 Annual Maximum ☐ $50 Deductible Classes II - III; $1,000 Annual Maximum ☐ $25 Deductible Classes II - III; $1,500 Annual Maximum ☐ $50 Deductible Classes II - III; $1,500 Annual Maximum ☐ $25 Deductible Classes II - III; $2,000 Annual Maximum ☐ $50 Deductible Classes II - III; $2,000 Annual Maximum	
Optional Benefits	**TMJ**	**Orthodontia** (Available with Expressions Plans with 26 or more enrolled employees)
	☐ TMJ $1,000 Annual Maximum	☐ $1,000 lifetime maximum ☐ $1,500 lifetime maximum

Additional Information

SECTION J - ACKNOWLEDGMENTS AND CERTIFICATIONS

If you have any questions about the benefits and services that are covered, provided, limited or excluded under the group coverage(s) to which this application applies, please contact your Sales Representative before signing this application.

Note: The Company as used here means the group applying for coverage as indicated in Section A - Group Information of this application.

I certify that I am an officer or employee of the Company, that I am duly authorized to execute this application on behalf of the Company, and that the Company:

a) Applies for the group coverage(s) selected in Section I - Benefits and Rates of this Group Master Application.

b) Authorizes any person or other entity to release to Regence BlueShield (Regence) any information requested by Regence in connection with the processing of this application.

c) Acknowledges, where permitted by law, that Regence may choose not to approve this application and any premium received will be returned if the application for group coverage(s) is not approved.

d) Acknowledges that coverage is not in effect until Regence accepts this application, establishes an effective date of coverage and issues the group contract(s) to the Company.

e) Acknowledges that, if this application is approved by Regence, it will form a part of the group contract(s) issued by Regence and agrees that the Company will be bound by the terms and the conditions of entire group contract(s).

f) Acknowledges that eligibility standards (e.g., minimum hours, probationary period(s), etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.

g) Acknowledges that it has selected the group coverage(s) to be offered to its employees, based upon information provided by Regence, and that no producer or consultant had or has authorization to modify the terms of the offer. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.

h) Agrees to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Regence for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Regence, upon its request verifications of employee participation levels.

i) Agrees that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Regence, at no time shall any employee be permitted or required to make contributions for coverage at a rate different than the employee contribution rate represented herein.

j) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.

k) Agrees to deliver, or otherwise make available to enrollees, all Regence paper or online member documents and other coverage-related materials.

l) Agrees to make all coverage options available to all employees and dependents who satisfy eligibility requirements.

m) Acknowledges that benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and Regence in accordance with the group contract(s).

n) Acknowledges that Regence must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc).

o) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither producer's nor employees of Regence, that Regence does not provide health care services, and that Regence cannot guarantee any results or outcomes of care. We are responsible for the quality of health care you receive only as provided by law.

SECTION J - ACKNOWLEDGMENTS AND CERTIFICATIONS (continued)

p) Certifies under penalty of perjury that all statements made and information provided in this application are accurate and complete to the best of its knowledge or belief and acknowledges that Regence will rely in part on the information in this application as the basis for Regence's decision on whether to approve this application and issue any group contract(s). It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. In addition, Regence will have the right to collect any claims payments or other damages. If Regence continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that Regence will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by Regence.

q) Agrees that any controversy or claim between the Company and Regence arising out of or relating to the group contract(s), or the breach thereof, whether involving a claim in tort, contract, or otherwise, shall be subject to final resolution through binding arbitration. The Company and Regence agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs, and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in King County, Washington (WA), unless mutually agreed otherwise by the parties. If any enrollee or former enrollee (or person claiming to be an enrollee or former enrollee) makes any claim or brings any action or proceeding arising out of or relating to the group contract(s) to which Regence or the Company becomes a party, Regence and the Company agree to cooperate in the defense of such claim, action, or proceeding and to resolve any controversy or claim between Regence and the Company through arbitration under this paragraph only after the resolution of the enrollee's (or alleged enrollee's) claim.

r) Appoints the producer of record (if any) indicated in Section B - Producer (Agent) Information as the Company's representative in matters of group coverage benefits provided by Regence. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.

s) Acknowledges that if the Company has a producer, that producer may receive bonuses, commissions, administrative services fees, or other compensation, including non-cash compensation from Regence. Incentives may be based on any of several factors, including the size of the Company's business, the products the Company purchases, the producer's volume of business with Regence, and other services the producer provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information please contact the producer or Regence.

t) Acknowledges that the option has been presented to include or exclude TMJ as a covered benefit.

WE'VE GONE GREEN! To be more environmentally conscious and in response to employer requests, we will attach one paper copy of the booklet (unless another quantity has been previously arranged) describing your plans benefits to your contract. Inform your plan participants that they can access the booklet electronically at myRegence.com. Or, if preferred, you can contact your sales representative to order additional paper copies for distribution or can have any requesting plan participant request a paper copy by contacting customer service.

SIGNATURE

Group Authorized Signature ▶ _____

Group Authorized Name ▶ _____

Official Title ▶ _____

Signature Date ▶ _____