Regence

Regence BlueShield serves select counties in the state of Washington and 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, including any applicable information on the last page, to our office **no later than 15 days prior to the requested effective date** to avoid delays to the processing and activation of your group. If additional space is needed, please attach a separate sheet of paper.

Requested Effective Date _____ Group Number |_|_|_|_|_|_|_|_|_|

SECTION A - GROUP INFORMATION

Group's Legal Name _____ City and State of Business Headquarters _____

Doing Business As (DBA) _____ Name to be used by Regence: ☐ Legal ☐ DBA

Physical Address (**Required**-No PO Box) _____ City _____ County _____ State ____ ZIP _____

Mailing Address _____ City _____ State ____ ZIP _____

Billing Address (if different) _____ City _____ State ____ ZIP _____

Federal Tax ID Number (EIN) _____ State Tax ID Number (UBI **required**) _____

SIC Code |_|_|_|_| Industry Description _____

Type of Business: ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Other (specify) _____

Is the group affiliated with any other business(es)? ☐ No ☐ Yes If yes, which one(s)? _____

SECTION B - CONTACT INFORMATION

Executive Contact Name (President, Owner, CEO, etc.) _____ Title _____

Email Address _____ Phone Number _____ Fax Number _____

Group Administrator Name _____ Title _____

Email Address _____ Phone Number _____ Fax Number _____

SECTION C - WORKERS' COMPENSATION AND OTHER CARRIER INFORMATION

Does your group have Workers' Compensation coverage? ☐ No ☐ Yes, name of carrier _____

Will you be offering other medical insurance coverage to eligible employees? ☐ No ☐ Yes

If Yes, you are not eligible for group coverage with Regence BlueShield.

Will you be offering other dental insurance coverage to eligible employees? ☐ No ☐ Yes

If Yes, you may not be eligible for group dental coverage with Regence BlueShield.

SECTION D - PRODUCER (AGENT) INFORMATION

Producer Name _____ Producer's Agency _____ Producer's Number _____

If there is a secondary Producer, add any secondary Producer information on the final ADDITIONAL INFORMATION page.

SECTION E - ENROLLMENT

Enrollment Method

Please check your enrollment method.

	Initial/Open Enrollment	Ongoing Enrollment
Spreadsheet (only available for Initial Enrollment)	☐	
Regence Online Enrollment (If yes, please complete Employer Center section below) When selecting Regence Online Enrollment, would you like to allow your employees to enroll themselves? ☐ No ☐ Yes	☐	☐
Paper Enrollment Forms	☐	☐

Employer Center Primary Group Administrator:

Name_____ Phone Number_____ Email Address _____

SECTION F - FEDERAL MANDATES

COBRA - Group subject to COBRA? ☐ No ☐ Yes COBRA Administrator? ☐ No ☐ Yes

☐ Regence billing sent directly to the Third Party Administrator (TPA) for COBRA participants (be sure to provide the COBRA Administrator billing information on the ADDITIONAL INFORMATION page TPA Billing Contact section).

☐ TPA submits COBRA enrollment and disenrollment directly to Regence.

OBRA - Group subject to OBRA? ☐ No ☐ Yes

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 _____

ERISA - Group subject to ERISA? ☐ No ☐ Yes

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

Affordable Care Act Information

In the previous calendar year (January - December) the average number of employees was _____

This employee count represents the calendar year of 20____

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 G - EMPLOYER REQUIREMENTS

Eligibility

1. The minimum number of hours worked for eligibility is 20 hours in a normal work week.
   This plan covers employees working the minimum number of hours required for coverage.
   The minimum number of hours for eligibility are _____ hours per week.

2. This plan covers the following options: (check those that apply)

	Medical/ Pharmacy/ Vision	Dental
Employee and Dependents (children and either legal spouse or domestic partner).	☐	☐
Employee Only (No dependent coverage)	☐	☐
Employee and Children Only (No spouse or domestic partner)	☐	

3. **Qualification for Group Plan**

   To qualify for a group health plan under clarified common-law rules, at least one employee must be enrolled. Employees, for this purpose, do not include:

   a. A self-employed individual;

   b. A sole proprietor of the sponsoring business or the sole proprietor's spouse;

   c. An individual that wholly owns a corporation that is the sponsoring business, or wholly owns the corporation with his/her spouse (except a corporate officer who is an employee as defined in 26 CFR 31-3121(d)-1(b)); and

   d. A partner in a partnership sponsoring the plan or the partner's spouse (except a "bona fide partner" as defined by law in 45 CFR section 146.145(c)(2)).

   Will you have at least one employee enrolling as of the effective date of coverage? ☐ No ☐ Yes

4. Do you have eligible employees outside the state of Washington (employees who reside in the state of Hawaii are not eligible for coverage)? ☐ No ☐ Yes

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

SECTION G - EMPLOYER REQUIREMENTS (continued)

Probationary Period

- If one class, enter all information in Class 1.
- All employees must be accounted for.

	Please place an X in the appropriate box below.				
	Coverage is effective on the first of the month following			**Coverage is effective on the actual***	
	Date of Hire (see 1 below)**	30 Days	60 Days	Date of Hire	90th Day
Class 1					
Class 2					
Class 3					

*Premium will be prorated for coverage effective dates other than the first of the month.

1. **If 1st of the month following date of hire: ☐ If hired on the 1st of the month, effective on the date of hire. ☐ Effective 1st of next month even if hired on the 1st.
2. Is probationary period waived on group's initial enrollment? ☐ No ☐ Yes
3. Probationary period begins ☐ date employee transfers to full-time coverage ☐ retroactive to the original date of hire

Note: A probationary period may not be waived or altered for a particular employee. Before adopting different probationary periods by employee class, consider seeking tax and/or legal advice. Federal health reform prohibits discrimination in favor of highly compensated individuals, though enforcement of the prohibition has been delayed until regulations or other guidance is issued (and it is unclear when that may occur).

Contribution

There is a minimum employer contribution percentage of 50% of employee premium of the lowest cost plan offered.

☐ **By Product** **Option 1**, specify product: _____ **Option 2**, specify product: _____

☐ **By Class**

Class 1		
Coverage Type	Medical/ Vision	Dental
Employee	%	%
Dependent	%	%

Class 2		
Coverage Type	Medical/ Vision	Dental
Employee	%	%
Dependent	%	%

Class 3		
Coverage Type	Medical/ Vision	Dental
Employee	%	%
Dependent	%	%

SECTION H - GROUP PARTICIPATION*

Participation: Minimum Participation Requirements

Groups with **1 to 3 eligible employees**: 100% of eligible employees after consideration of valid waivers

Groups with **4 or more eligible employees**: 75% of eligible employees after consideration of valid waivers

At the time of application, the Group represents that:

1. Total number of employees on payroll not including COBRA or non-COBRA continuation. + _____ (1)
2. Less individuals not eligible for coverage:
   - a) Number of employees working fewer than the minimum hours. – _____ (2a)
   - b) Number of employees fulfilling the New Hire Probationary Period. – _____ (2b)
   - c) Number of employees who are seasonal, substitute or temporary. – _____ (2c)
   - d) Number of individuals paid solely via IRS Form 1099. – _____ (2d)
   - e) Number of employees whose class is ineligible for coverage under this plan (**applies to groups of 10 or more enrolled employees, unless union)**. – _____ (2e)

     Please enter the description of your group's ineligible class _____.

     If union, please provide a copy of the union roster.
3. Equals subtotal number of employees eligible to enroll. = _____ (3)

Using the subtotal from line 3 above, continue for each type of coverage.	**Medical**	**Dental**
4. Less number of employees waiving with other qualifying coverage.	– _____ (4)	– _____ (4)
5. Equals total number of employees eligible to enroll.	= _____ (5)	= _____ (5)
6. Less number of employees declining (no other qualifying coverage).	– _____ (6)	– _____ (6)
7. Equals number of employees enrolling.	= _____ (7)	= _____ (7)
8. Participation percentage (line 7 divided by line 5).	= _____ %(8)	= _____ %(8)
9. Number enrolling on COBRA or non-COBRA Continuation of Coverage.	_____ (9)	_____ (9)
10. Number of former and current employees and/or dependents eligible for COBRA or non-COBRA Continuation of Coverage but have not yet applied.	_____ (10)	_____ (10)

***Special Annual Enrollment for Groups 1-50**

If and only as required by law, a special annual enrollment period will be offered during a period defined by regulators for a January 1st effective date to small 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 AND RATES

MEDICAL - Please make your selections here.

☐ If offered by class, specify Employee Classification _____ .

Signed rate sheets will be required once final rates are approved by underwriting.

Medical Plan Choices		Medical Rate Structure
You may select two provider network products, in addition to the Preferred provider network 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	☐ 2-tier composite ☐ Age banded
☒ Preferred-PPO ☐ The Everett Clinic ☐ EvergreenHealth Partners-Virginia Mason ☐ MultiCare Connected Care ☐ UW Medicine	Regence EmployeeChoice ☐ Platinum 250 ☐ Platinum 500 ☐ Gold 500 ☐ Gold 1000 ☐ Gold 2000 ☐ Silver 3000 ☐ Silver Essential 4000 ☐ Bronze Essential 7150	
	Regence EmployeeChoice-HSA ☐ Gold HSA 1500 ☐ Silver HSA 2000 ☐ Silver HSA 3500 ☐ Silver HSA 4000 ☐ Bronze HSA 5000 ☐ Bronze HSA 6000	

VISION - Please make your selection here.

☐ Regence Vision Plan - $150 vision hardware per calendar year and one routine exam per calendar year.
Note: Vision plan only available with purchase of Regence Medical plan.

DENTAL - Please make your selections here.

Plan Name and Member Coinsurance (select one)	Deductible and Annual Maximum (select one)
☐ Expressions 0/20/50	☐ $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
☐ Expressions Rewards 0/20/50	☐ $25 Deductible Classes II - III; $750 Annual Maximum ☐ $50 Deductible Classes II - III; $750 Annual Maximum ☐ $25 Deductible Classes II - III; $1,000 Annual Maximum ☐ $50 Deductible Classes II - III; $1,000 Annual Maximum

Optional Benefits	
TMJ	**Orthodontia** (Available with 26 or more enrolled employees)
☐ TMJ $1,000 Annual Maximum	☐ $1,000 Lifetime Maximum ☐ $1,500 Lifetime Maximum

SECTION J - HEALTH SAVINGS ACCOUNT (HSA) INFORMATION

Note: This section applies when offering an HSA benefit option.

Regence offers integration with HealthEquity, a HSA Administrator. This integration allows HealthEquity to automatically set up health savings accounts for each of your employees enrolled on a Regence HSA Healthplan and offers your employees the ability to pay providers directly from their HSA.

Do you want HealthEquity to administer your HSAs?

☐ Yes - Integrate with HealthEquity. Please submit a signed *Data Extract and Confidential Agreement* (form found on Regence.com).

If Yes - Who will be paying the monthly fee? ☐ Employer ☐ Employee

Note: The employer can be billed monthly by HealthEquity or the fee can be paid directly from the employee's HSA each month.

☐ No - We will be using another bank, name of bank (optional) _____

☐ No - We do not offer a banking arrangement

SECTION K - ACKNOWLEDGEMENTS 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.

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.

SECTION K - ACKNOWLEDGEMENTS AND CERTIFICATIONS (continued)

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 D - 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.

SECTION L - SIGNATURES

We certify that the information provided is accurate to the best of our knowledge.

If you type your name below, you understand that you are electronically signing this document and agree your electronic signature is the legal equivalent of your manual signature on this application.

Group Authorized Representative Signature ▶ _____ Signature Date _____

Group Authorized Representative (Print name) _____ Official Title _____

SECTION M - ADDITIONAL REQUIRED INFORMATION

Billing

Billing Name to be used by Regence ☐ Legal ☐ DBA

Payment Type: ☐ Pay by Check ☐ Surepay (EFT) (For Surepay, please provide the completed Surepay form with a voided check.)

Do you require separate billing invoices? ☐ No ☐ Yes, please complete Additional Billing section below.

Primary Billing Contact (if applicable)

Name _____ Title _____

Billing Address _____ City _____ State ____ ZIP _____

Email Address _____ Phone Number _____ Fax Number _____

Additional Billing Contact (if applicable)

Name _____ Title _____

Billing Address _____ City _____ State ____ ZIP _____

Email Address _____ Phone Number _____ Fax Number _____

TPA Billing Contact (if applicable)

Name _____ Title _____

Billing Address _____ City _____ State ____ ZIP _____

Email Address _____ Phone Number _____ Fax Number _____

Secondary Producer (if applicable)

Producer Name _____ Producer's Agency _____ Producer's Number _____

Commission Split %

Medical Commission Split: Producer 1 _____ % Producer 2 _____ % Dental Commission Split: Producer 1 _____ % Producer 2 _____ %

Current Carrier (if applicable)

Medical _____ Dental _____

Deductible and Out of Pocket Accumulators

Did deductible and out of pocket amounts accumulate on a calendar year or plan year? _____

If plan year, what were the dates for the plan year accumulators with prior carrier? _____

Calendar Year: Accumulates January through December, regardless of your contract renewal month.

Plan Year: Accumulation matches your contract renewal period (i.e. renewal month is April, deductible and out of pocket accumulation starts April 1 and ends March 31).

Group's Primary Language (if other than English) _____