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

Group Master Application – for Group Size 1-50

Please submit a complete and accurate application to our office **by the 15th of the month prior to the requested effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate page.

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

SECTION A – GROUP NAME & ADDRESS

Group's Legal Name:				
Doing Business As (DBA):				
Name to be used by Regence: ☐ Legal ☐ DBA				
City of Business Headquarters:		Federal Tax ID Number (EIN):		
State of Business Headquarters:		State Tax ID Number (UBI required):		
Address (include attention line if applicable)				
Physical Address (required – no PO Box)	City	County	State	ZIP
Mailing Address (if different from physical)	City	County	State	ZIP

SECTION B – CONTACT INFORMATION

1. Executive Contact (President, Owner, etc.)

Name	Phone (area code required) Ext.	Fax (area code required)
Title	Email	

2. Group Administrator

Name	Phone (area code required) Ext.	Fax (area code required)
Title	Email	

SECTION C – BILLING INFORMATION

1. Primary Billing Information

Billing Address (if different from mailing)			Contact Name (if different from group administrator)
			Title:
			Phone (area code required): Ext.
City:	State:	ZIP:	Email:

Select a premium payment method:
☐ Pay via ACH pull (attach a completed Automatic Bank Deduction form) ☐ ~~Pay via ACH push~~ ☐ Pay by check

SECTION C – BILLING INFORMATION (continued)

2. Secondary Billing Information – Complete only if there is more than one billing address. If you have more than two billing locations, submit that billing information on another page.

Secondary Billing/Business Name:

Billing Address			Contact Name:
			Title:
			Phone (area code required): Ext.
City:	State:	ZIP:	Email:

Select a premium payment method:

☐ Pay via ACH pull (attach a completed Automatic Bank Deduction form) ☐ Pay via ACH push ☐ Pay by check

3. Third Party Administrator – Complete only if an outside Third Party Administrator (TPA) is used.

TPA Name:

Address			Contact Name:
			Title:
			Phone (area code required): Ext.
City:	State:	ZIP:	Email:

Does the group use this TPA for COBRA administration? ☐ No ☐ Yes

If yes: Will the TPA submit COBRA enrollment/disenrollment directly to Regence? ☐ No ☐ Yes

Will invoices for COBRA participants go to the TPA address listed? ☐ No ☐ Yes

SECTION D – PRODUCER INFORMATION

1. Primary Producer

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

2. Secondary Producer (if no secondary producer, skip to next section)

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

Commission Split – Medical: Primary Producer: _____% Secondary Producer: _____%

Commission Split – Dental: Primary Producer: _____% Secondary Producer: _____%

SECTION E – GROUP INFORMATION

1. General Information

SIC Code	Industry Description	Date Business Started

Type of Business (if LLC, please choose the option that matches how the business files with the IRS):

☐ Sole Proprietorship ☐ Partnership ☐ S-Corp ☐ C-Corp ☐ Other: _____

Does the group have any affiliated businesses? ☐ No ☐ Yes – Enter name(s) of affiliated businesses:

Name of Workers' Compensation Carrier (if none, please explain)

Current Medical Carrier	Current Dental Carrier

Will the group offer other coverage to its eligible employees?

Medical: ☐ No ☐ Yes – If yes, then the group is not eligible for group medical coverage with Regence.

Dental: ☐ No ☐ Yes – If yes, then the group is not eligible for group dental coverage with Regence.

SECTION E – GROUP INFORMATION (continued)

2. Deductible and Out of Pocket Accumulators – To comply with properly crediting amounts accumulated from the prior carrier, the group must confirm if amounts accumulated on the basis of a calendar year or a plan year (matching your contract renewal period e.g., renewal month is April, accumulation starts April 1 and ends March 31).

Under the prior carrier, deductible and out of pocket amounts accumulated on the basis of a:

☐ calendar year (January through December).

☐ plan year. Enter dates for the plan year accumulators with prior carrier: _____

3. COBRA – Applies if group employed 20 or more employees for 50% or more of the typical business days in the preceding calendar year (excluding church and federal government groups). You may count a part-time employee as a fraction of a full-time employee.

Is the group subject to COBRA? ☐ No ☐ Yes

4. ERISA – Applies to most groups other than church and government entities.

Is the group subject to ERISA? ☐ No ☐ Yes

If yes, does ERISA plan year differ from your renewal date? ☐ No ☐ Yes, when does the plan year begin (MM/DD):_____

5. OBRA – Applies if group employed 100 or more employees (full-time and/or part-time) for at least 50% of the workdays of the preceding calendar year.

Is the group subject to OBRA? ☐ No ☐ Yes

6. TEFRA/DEFRA – Applies if group employed 20 or more employees (full-time and/or part-time) for each working day in each of 20 or more calendar weeks in the current or preceding calendar year.

Is the group subject to TEFRA/DEFRA? ☐ No ☐ Yes

If status has changed in the last year, date of change: _____

7. Employee Counts – Affordable Care Act (ACA) Requirements – ACA requires us to record the group's (and all affiliates') average number of employees for the preceding **completed** calendar year. This count includes the following local & worldwide employees: full-time, part-time, seasonal, union workers, as well as business owners, corporate officers, and partners if they are also employees. The count does **not** include contracted 1099 individuals or non-employees.

Average number of employees (for ACA) was_____ in the preceding **completed** calendar year 20 _____.

8. Employee Counts – Non-residents – Count of eligible employees outside the state. Employees residing in the state of Hawaii are not eligible.

State					
Number of Employees					

SECTION F – ADMINISTRATION

1. Eligibility – Changes may only be made at renewal.

Provide the minimum number of hours (must be at least 20) employees are required to work to be eligible for coverage under this plan:_____ If this varies by employee class, please submit on a separate page.

Who will be covered by this plan?

	Employee and dependents (children and spouse/domestic partner)	Employee and children only (no spouse/domestic partner)	Employee only (no dependents)
Medical/Pharmacy/Vision	☐	☐	☐
Dental	☐	N/A	☐*

***Employee Only Dental coverage** is available only if the group is electing **Employee Only Medical coverage**, or if the group is not electing any Regence Medical coverage (~~i.e., a Dental-only policy~~).

2. Qualification for Group Plan – To qualify for a group health plan, 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 the group have at least 1 employee **enrolled** as of the effective date of coverage? ☐ No ☐ Yes

SECTION F – ADMINISTRATION (continued)

3. Probationary Period – A probationary period may not be waived or altered for a particular employee. Before adopting different probationary periods by employee class (hourly, salaried, etc.), consider seeking tax and/or legal advice. Premiums will be prorated for coverage effective dates other than the 1st of the month.

List classes below (if one class, make selection on line 1), then select an option indicating when coverage is effective.

Class (account for all employees)	1st of the month following: Date of hire*	30 days	60 days	On the actual: Date of hire	90th day
1	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐

*If choosing "**1st of the month following the date of hire**," employees hired on the 1st of the month are effective on the:

☐ date of hire.

☐ 1st of next month.

Part-time employees transferring to full-time will start their probationary periods on the:

☐ original hire date (retroactive).

☐ date the employee transfers to full-time hours.

Will the group waive the probationary period on initial enrollment (new groups only)? ☐ No ☐ Yes

4. Premium Contribution – There is a minimum employer contribution percentage of 50% of the employee premium for the lowest cost plan offered.

Specify contribution either by class (as defined above in Probationary Period) or by product (specify products in space below). Attach another page if needed. If contribution is the same for all employees, enter contribution amounts on the first row.

☐ By Class ☐ By Product		Medical/Vision Employee	Medical/Vision Dependent	Dental Employee	Dental Dependent
Class 1	Product 1:	%	%	%	%
Class 2	Product 2:	%	%	%	%
Class 3	Product 3:	%	%	%	%

5. Minimum Participation Requirements – To be eligible for coverage at least 75% of the group's eligible employees must participate in the plan after consideration of valid waivers (or 100% if the group has 1 to 3 employees).

At the time of the application, the group represents that:

		Medical	Dental
A.	Number of employees on payroll plus working owners (excluding COBRA participants†)	(A)	
B.	Minus individuals not eligible: working fewer than the minimum hours	- (B)	
C.	Minus individuals not eligible: still serving new-hire probationary period	- (C)	
D.	Minus individuals not eligible: seasonal, substitute or temporary	- (D)	
E.	Minus individuals not eligible: contracted 1099 individuals	- (E)	
F.	Minus individuals not eligible: employee segment is ineligible for coverage under this plan (applies to groups of 10 or more enrolled employees, unless union) Description of group's ineligible employee segment: _____ If union, provide a copy of the union roster.	- (F)	
G.	Equals the subtotal number of eligible employees	= (G)	
	Use subtotal (G) to continue calculations for Medical and Dental.	**Medical**	**Dental**
H.	Minus employees waiving with other qualifying coverage	- (H)	- (H)
I.	Equals number of employees eligible to enroll	= (I)	= (I)
J.	Minus employees declining (no other qualifying coverage)	- (J)	- (J)
K.	Equals number of employees enrolling	= (K)	= (K)
L.	Participation percentage (K divided by I)	%(L)	%(L)
M.	Number enrolling on COBRA†	(M)	(M)
N.	Number of former and current employees and/or dependents eligible for COBRA† for whom election and payment is not yet received	(N)	(N)

†Refers to both COBRA and non-COBRA continuation of coverage participants.

SECTION F – ADMINISTRATION (continued)

6. Special Annual Enrollment Period – If required by law (and subject to the law's required terms), small groups that do not meet minimum contribution and/or participation rules will be offered a special annual enrollment period for a January 1st effective date. Minimum contribution and participation rules must be met for renewing groups.

7. Enrollment Method

	Spreadsheet	Regence Online Enrollment*	Paper Enrollment Forms
Initial/Open Enrollment	☐	N/A	☐
Ongoing Enrollment	N/A	☐	☐

*If choosing "**Regence Online Enrollment**," will the group allow employees to enroll themselves? ☐ No ☐ Yes

8. Employer Center – Our online portal allows registered users access to group information at any time. To request an Employer Center account, provide contact information for the primary user below (**required if selecting Regence Online Enrollment method**). An email will be sent to this user with registration instructions once the group is set up.

Primary User Name	Phone (area code required) Ext.	Email

SECTION G – BENEFIT OPTIONS

1. Medical Plan Choices – Select up to 5 different metallic plans. Please attach a signed rate sheet for each medical product selected. Pharmacy benefits are embedded in the medical plans.

If offered by class, specify employee class (otherwise leave blank): _____

Attach another page for each class specification if offering different plans per employee class.

The Preferred PPO provider network product must be offered to all employees, and has been automatically selected. Up to 2 additional provider network products may be selected:

☒ Preferred PPO (required) ☐ UW Medicine ☐ MultiCare Connected Care ☐ Eastside Health Network

Regence EmployeeChoice:

☐ Platinum 250	☐ Gold 500	☐ Silver 3250	☐ Bronze 7900
☐ Platinum 500	☐ Gold 1000	☐ Silver 5500	☐ Bronze HSA 5000
	☐ Gold 2000	☐ Silver HSA 2000	☐ Bronze Essential 5000
	☐ Gold 2500	☐ Silver HSA Embedded 3000	
	☐ Gold HSA 1500	☐ Silver HSA 3500	
		☐ Silver HSA 4000	
		☐ Silver Essential 4000	

Select medical rate structure: ☐ Composite ☐ Age Banded

2. Health Savings Account (HSA) – Complete only if an HSA Healthplan will be offered.

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

Will the group elect HealthEquity to administer its health savings accounts?

☐ No ☐ Yes – Who will pay the monthly fee? ☐ Employer ☐ Employee

3. Vision Plan Choice – Vision plan is only available with the purchase of a medical plan.

☐ Regence Choice Vision

4. Dental Plan Choices – Available options are shown below. Deductibles apply to class II & class III dental services. Please attach a signed rate sheet for the dental product selected.

	Deductible	Annual Maximum
☐ Expressions	☐ $25 ☐ $50	☐ $1,000 ☐ $1,500 ☐ $2,000
☐ Expressions Rewards	☐ $25 ☐ $50	☐ $750 ☐ $1,000

Additional Coverage Options:

☐ Orthodontia $1,000 lifetime maximum (available with 26 or more enrolled employees)

☐ Orthodontia $1,500 lifetime maximum (available with 26 or more enrolled employees)

☐ TMJ $1,000 annual maximum

SECTION H – 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 Name & Address 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 G – Benefit Options 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 that, where permitted by law, 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 conditions of the entire group contract(s).

f) Acknowledges that eligibility standards (e.g., minimum hours, eligible dependents, 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 higher 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 producers 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 and 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) and 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 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.

u) Acknowledges that Regence's statements in this application, including the descriptions of laws in E.3 through 7, are not legal advice and that the Company should look solely to its legal advisor with legal questions or concerns.

For assistance in administering your group's benefit plan, see the Group Administrator Guide on regence.com. The guide provides information about benefits, eligibility, enrollment, monthly billing statements and claims submission to help you answer your employees' questions.

SECTION I – SIGNATURE

I certify that the information provided is accurate to the best of my 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 _____

1. Attach rate sheets for product selections.
2. If ACH pull was chosen for the group's premium payment method, attach a completed Automatic Bank Deduction form.
3. Submit a complete, accurate application **no later than the 15th of the month prior to the requested effective date**.

Regence BlueShield: 1800 Ninth Avenue, Seattle, Washington 98101