

Renewal 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 of any changes to your group. If additional space is needed, please attach a separate page.

Requested Effective Date _____

Group Number

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SECTION A – GROUP NAME

Group Name:

Have there been any changes to the Group's Legal Name, Doing Business As (DBA), or the Name to be used by Asuris in the last year? ☐ No – Skip to Section B. ☐ Yes – Make changes below.

Group's Legal Name:

DBA:

Name to be used by Asuris: ☐ Legal ☐ DBA

SECTION B – BENEFIT OPTIONS

Medical Plan Options – Select up to 5 different metallic plans. Pharmacy benefits are embedded in the medical plans. Please attach a signed rate sheet for each medical plan selected. For groups using paper enrollment applications, attach a copy of the EmployeeSelect Request form if offering multiple 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.

Network: ☒ Preferred PPO

Asuris EmployeeSelect (must select at least one):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Platinum 250 | <input type="checkbox"/> Gold 500 | <input type="checkbox"/> Silver 3000 | <input type="checkbox"/> Bronze 8850 |
| <input type="checkbox"/> Platinum 500 | <input type="checkbox"/> Gold 1000 | <input type="checkbox"/> Silver 5500 | <input type="checkbox"/> Bronze HSA 6000 |
| <input type="checkbox"/> Platinum 1200 | <input type="checkbox"/> Gold 1500 | <input type="checkbox"/> Silver HSA 3000 | <input type="checkbox"/> Bronze Essential 7500 |
| | <input type="checkbox"/> Gold 2000 | <input type="checkbox"/> Silver HSA Embedded 3600 | |
| | <input type="checkbox"/> Gold 2500 | <input type="checkbox"/> Silver HSA 3500 | |
| | <input type="checkbox"/> Gold Abound 3500 | <input type="checkbox"/> Silver HSA 5450 | |
| | <input type="checkbox"/> Gold HSA 1800 | <input type="checkbox"/> Silver Essential 3000 | |
| | | <input type="checkbox"/> Silver Essential 4000 | |

Network – Available in limited areas; refer to your Sales Representative:

☐ Asuris RealValue Network

Asuris RealValue:

- | | | |
|--|--|--|
| <input type="checkbox"/> Gold 2500 | <input type="checkbox"/> Silver 3000 | <input type="checkbox"/> Bronze Essential 7500 |
| <input type="checkbox"/> Gold HSA 1800 | <input type="checkbox"/> Silver HSA 3000 | <input type="checkbox"/> Bronze HSA 6000 |

Select medical rate structure: ☐ Composite ☐ Age Banded

Health Savings Account (HSA) – Complete only if an Asuris HSA-eligible healthplan will be offered.

Asuris offers integration with HealthEquity, an HSA Administrator. This integration allows HealthEquity to automatically set up health savings accounts for each employee enrolled on an Asuris HSA-eligible 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

Vision Plan Option – The vision plan is only available with the purchase of a medical plan.

☐ Asuris Choice Vision



SECTION B – BENEFIT OPTIONS

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

Non-Network Provider Allowed Amount

- ☐ MAC* inside the four-state area we serve (Washington, Idaho, Oregon and Utah) and 85% UCR** outside the four states.
☐ 90% UCR** in and outside the four-state area we serve. Not available for Asuris Enhance ValueCare.

*Maximum Allowable Charge (MAC) is the predetermined fee set by Asuris for specific dental procedures.

**Usual and Customary Rate (UCR) fee schedule in the geographic area in which the expense is incurred for non-network reimbursement.

	Deductible	Annual Maximum
<input type="checkbox"/> Asuris Enhance <input type="checkbox"/> Asuris Enhance ValueCare	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$1,500 Preventative Care benefits do not accumulate toward the Annual Maximum (only when \$50 deductible is selected) <input type="checkbox"/> \$2,000
<input type="checkbox"/> Asuris Enhance Rewards	<input type="checkbox"/> \$25 <input type="checkbox"/> \$50	<input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000
Optional Orthodontia (available with 10 or more enrolled employees)	<input type="checkbox"/> \$1,000 Lifetime Maximum (not available when \$50 ded/\$1,500 max or \$50 ded/\$2,000 max is selected) <input type="checkbox"/> \$1,500 Lifetime Maximum (only available when \$50 ded/\$1,500 max or \$50 ded/\$2,000 max is selected)	

SECTION C – GROUP INFORMATION CHANGES

Complete this section if there have been changes to the items below. Refer to your original GMA and any subsequent addendums or amendments.

Select all items to change, then provide details in the space below.

- | | |
|---|--|
| <input type="checkbox"/> Add/Remove Employee Class | <input type="checkbox"/> Probationary Period: |
| <input type="checkbox"/> Add/Remove Subgroup for Billing Purposes | If changing to 1st of the month following date of hire , employees hired on the 1 st of the month will be effective on: |
| <input type="checkbox"/> Domestic Partner Eligibility | <input type="checkbox"/> their date of hire. <input type="checkbox"/> the 1 st of the next month. |
| <input type="checkbox"/> Employer Contribution | Part-time employees transferring to full-time will start their probationary periods on the: |
| <input type="checkbox"/> Group Address (specify physical, mailing, billing) | <input type="checkbox"/> Original hire date (retroactive) |
| <input type="checkbox"/> Group Contact Names | <input type="checkbox"/> Date the employee transfers to full-time hours |
| <input type="checkbox"/> Number of Working Hours for Eligibility | |
| <input type="checkbox"/> Add/Remove Online Enrollment Access | |

Changes to the items below require a **Group Change Notification** form to be submitted in addition to this form.

- Name of Business • Tax ID Number and/or UBI • Headquarters Location • Ownership

Describe Changes:

Address Change(s)**Identify Which Address(es) are Changing**

- ☐ Physical ☐ Mailing ☐ Billing ☐ All

SECTION D – ACKNOWLEDGMENTS

I request the above-described changes on behalf of the group. Requested changes will not become effective unless approved in writing by Asuris Northwest Health (Asuris). Approval may be for an effective date other than the requested effective date entered above, but any change of effective date will be specified in writing. If approved in writing by Asuris, the approved request shall operate to amend the group's Group Master Application as of the effective date assigned by Asuris, but shall amend that Group Master Application only as necessary to effectuate the requested and approved change. All other terms of the Group Master Application shall remain in force. If any requested change is approved, the group should retain a copy of this Asuris Renewal Group Master Application for the group's record.



SECTION D – ACKNOWLEDGMENTS (continued)

Certifies that all forms and processes, electronic or otherwise, used by the group for enrollment purposes, other than those provided directly by Asuris, are in compliance with all applicable state guidelines and regulations and/or have been provided to the state insurance regulator for approval prior to use.

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.

SECTION E – 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 (No producer signatures)	Signature Date
_____	_____
Group Authorized Representative (print name)	Official Title

Asuris Northwest Health: 528 East Spokane Falls Boulevard, Suite 301, Spokane, Washington 99202