Northwest Employers MARKETPLACE

Offered By Evergreen Security Trust

Managing General Agent: DiMartino Associates
1325 Fourth Avenue, Suite 1705, Seattle, WA 98101

FOR OFFICE USE ONLY	
Dent Key :	
Eff. Date :	
Group # :	
Area :	

MASTER APPLICATION FOR INSURANCE COVERAGE

Return application to NWEM@dimarinc.com

COMPANY INFORMATION

Legal Name of Business:	Requested Effective Date:	☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other: _____
Doing Business As (DBA):	Employer Tax ID Number (EIN):	
Type of Business:	NAICS Code:	SIC Code:

Physical Business Address (No PO Box or PMB):

Mailing Address (if different from Physical Business Address):

Billing/Eligibility Contact:	Phone: Fax:	Email:

MEDICAL – Medical coverage is required in order to apply for other lines of coverage through Northwest Employers Marketplace. An additional application must be completed in order to enroll in medical coverage. All lines of coverage require common enrollment.

Medical Coverage (Required):

☐ An application for medical coverage has also been completed

☐ Medical Coverage through Northwest Employers Marketplace is already in force

Chosen rate structure: ☐ age rates ☐ composite rates

LIFE/AD&D COVERAGE – USAble Life - $10,000 Life/AD&D coverage is required. The below amounts represent total coverage elected.

Life/AD&D Plans: ☐ $15,000 ☐ $25,000 ☐ $50,000 (only available for groups of 5 or more enrolled employees) ☐ Dependent Life $5,000/SP | $2,500/CH

VISION – VSP

Vision Coverage: ☐ Exam Plus ☐ Basic ☐ Preferred ☐ Enhanced

DENTAL **(Uncommon Enrollment Allowed)** – Delta Dental of Washington

Group Dental: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4

(requires 2+ employees and 51% employee participation)

☐ Orthodontia - only available to groups of 10 or more enrolled employees

☐ Voluntary Plan 5 ☐ Voluntary Plan 6

(Voluntary Plans require 5 or more enrolled employees and 35% minimum enrollment of eligible employees)

CDHP Administration - Vimly Benefit Solutions, Inc. - You may select more than one option; separate application is required.

CDHP Administration: ☐ HSA ☐ HRA ☐ FSA ☐ DCAP

PAYMENT METHOD - Effective 11/1/2017 Electronic Funds Transfer (EFT) is the required payment option. Please complete an EFT form. Surepay is not an available payment option through Northwest Employers Marketplace. If Medical coverage is already using Surepay, it will be automatically cancelled.

COBRA ADMINISTRATION – Vimly Benefit Solutions Inc.	
☐ Yes ☐ No	COBRA: Is your company subject to federal COBRA laws in the current CALENDAR year based on employing 20 or more full-time equivalent employees for at least 50% of the workdays in the preceding CALENDAR year? NOTE TO RENEWING GROUPS: Although you need to confirm your COBRA status on the application, since COBRA eligibility runs calendar year, Vimly cannot change your status effective as of your renewal.
☐ Yes ☐ No	COBRA Administration: If you answered YES to the above, would you like to authorize Vimly to administer COBRA on terminating employees? If so, please complete a **Vimly** COBRA Administration Agreement.
_____	Affordable Care Act Required Information: Please enter the average number of employees that were employed by your company during the prior CALENDAR year. This count should include: full-time, part-time, seasonal, and union employees that work inside or outside the state of Washington and employees in any state from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.

ELIGIBILITY & ENROLLMENT – Must Match Medical		
Participation and Contribution Requirements	■ Minimum 75% Employee Participation of all eligible employees ■ Minimum 50% Employer Contribution for Employee Coverage	
Employer Contribution	Employee: %	Dependent: %

Eligible Employees are required to work _____ hours per week

(Minimum Requirement: 20 hours per week, administered on a non-discriminatory basis, based on conditions of employment)

Eligible Employee Classifications:

Class 1: _____ Class 2: _____

Class 3: _____ Class 4: _____

Eligibility should be effective on the 1st of the month following or coinciding with:

Class 1: ☐ Date of Hire* ☐ 30 Days ☐ 60 Days Class 2: ☐ Date of Hire* ☐ 30 Days ☐ 60 Days

Class 3: ☐ Date of Hire* ☐ 30 Days ☐ 60 Days Class 4: ☐ Date of Hire* ☐ 30 Days ☐ 60 Days

*If 'Date of Hire' (DOH) is selected above, choose how DOH will be administered:

☐ If hired on the 1st of the month, effective on the date of hire.

☐ Effective 1st of the next month even if hired on the 1st.

Is probationary period waived on group's initial enrollment? (NEW GROUPS ONLY):

☐ Yes ☐ No

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

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

GROUP PARTICIPATION

Total number of employees on payroll regardless of hours worked (do not include COBRA participants)…….. _____

- Less employees working fewer than the minimum hours required. …… _____
- Less employees who have not completed the probationary period……...……..…….- _____
- Less employees paid via IRS Form 1099, or temporary, seasonal or substitute employees…….- _____
- Less employees waiving coverage because they are covered by TRICARE (CHAMPUS)……- _____
- Less employees waiving coverage because they are covered by a spouse's or parent's similar group medical plan (proof of coverage required if participation falls below 75%)..…….……..- _____
- Less employees waiving coverage because they are covered by Medicare as primary, at the request of the Medicare enrollee (proof of coverage required if participation falls below 75%)…….- _____
- Equals total number of employees eligible to enroll…….= _____
- Number of employee applications being submitted (75% participation required)…… _____
- Number of employees covered by your group under provisions of COBRA…….. _____

NORTHWEST EMPLOYERS MARKETPLACE - SUBSCRIPTION AGREEMENT LANGUAGE

Understanding of the Terms & Provisions of Participation

The undersigned Employer agrees to adhere to the terms, conditions and limitations of coverage as set forth in the health service contracts, insurance policies, service contracts, benefit booklets and certificates of insurance issued by each of the respective carriers that are contracted with the Northwest Employers Marketplace.

Sponsor – The undersigned Employer acknowledges and agrees that the Sponsor shall have all rights and powers described in the Trust Agreement. The Sponsor shall be entitled to reimbursement for any out-of-pocket expenses directly related to its marketing support and activities from Trust assets. The Sponsor may also charge a service fee to its Member Companies as a condition to participating in the benefits offered under the Trust. The service fee is not paid for by employee contributions. It is solely paid by the participating Member Company.

Authority of Trustees – The undersigned Employer acknowledges and agrees that all Trustees appointed under the Trust Agreement shall have all rights and powers described here under.

Third Party Administrator – The undersigned Employer agrees that the Trust may select one or more service providers to act as a third party administrator ("TPA") for the Trust and/or the Plans, and that such service providers may be a member of the NWEM.

Contributions – The undersigned Employer agrees to pay the contributions established by the Trust every month. The undersigned Employer further understands and agrees that benefits for employees shall not be provided by the Trust during any month for which contributions are not paid.

Termination – This Agreement may be terminated by the undersigned Employer, which may withdraw from participation in the Trust by giving thirty (30) days written notice of intent to terminate this Agreement. Such Employer shall have the rights and duties specified in the Trust Agreement. This Agreement may be terminated by the Trust, in the event that the undersigned Employer (a) fails or refuses to pay contributions due to the Trust, or (b) shall be in breach of any of its other obligations under the Trust Agreement.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trust, its Trustees and the Sponsor from any and all loss, damages or liability resulting from the undersigned Employer's negligence, misrepresentation, breach of contract or dishonesty. In the event that the Trust, its Trustees or the Sponsor are made a party to any legal proceeding arising from the undersigned Employer's negligence, misrepresentation, breach of contract or dishonesty, the undersigned Employer agrees to indemnify and hold them harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting therefrom.

Governing Law – This Agreement shall be construed and enforced in accordance with ERISA and, to the extent applicable, the laws of the State of Washington.

ANTI-FRAUD STATEMENT

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. 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. I understand that the issuer will rely on each answer in making coverage and rating determinations. If the issuer 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 the issuer will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the Rate adjustment within 30 days of the date of notice by the issuer. In addition, the issuer will have the right to collect any claims payments or other damages.

GROUP SIGNATURE SECTION

Signature & Title of Employer Form Date

INSURANCE PRODUCER APPLICATION

A business applying for insurance coverage through the Northwest Employers Marketplace may appoint their own Insurance Producer to represent them as noted below.

Name of Insurance Producer: _____

Name of Producers Brokerage/Agency: _____

Street Address: _____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

We hereby appoint the above named Insurance Producer as our firm's Producer of Record.
This agreement will serve as notice of cancellation of any previous Insurance Producer agreement. This new appointment will remain effective until written notice is given by either party of a change. No changes may be made retroactively.

Name of Employer	Signature of Employer Representative
Date	Name & Title (PRINTED) of Employer Representative

COVERAGE UNDERWRITTEN BY

Life/AD&D: USAble Life; P.O. Box 1650 Little Rock, AR 72223
Dental: Delta Dental of Washington; 400 Fairview Avenue North, Suite 800, Seattle, WA 98109-5371
Vision: VSP Vision Care, Inc. (HCSC); 600 University Street, Suite 2004, Seattle, WA 98101

DELTA DENTAL®

Delta Dental of Washington

USAble Life

vsp VISION™