

BIAW Health Insurance Trust Employer Participation Agreement

Return this completed form to:
 EPK & Associates, Inc., 15375 SE 30th Place, Suite 380 Bellevue, WA 98007 (425) 641-7762
 Fax: (425) 641-8114 Email: sales@epkbenefits.com

New or Renewal Coverage Effective Date: _____

1. GENERAL GROUP INFORMATION - Please print clearly.

Group's Legal Name	Association Membership Name	Group Number(s)
Doing Business As Name	UBI Number	TIN Number
Business Address	Billing Address, if different from Business Address	
City, State and Zip Code	City, State and Zip Code	
Name and Title of President, Owner, or CEO	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other	
Primary Contact / Secondary Contact	Title	Date Business Started
E-mail Address	Phone Number	Fax Number
Location of Business Headquarters	Nature of Business	NAISC/SIC Code

Our company would prefer to have Benefit Booklets sent to our company:

Booklets emailed in PDF format
 Hard copy Booklets only
 Booklets emailed in PDF format and a few hard copy Booklets

2. EMPLOYEE ELIGIBILITY INFORMATION

A. An eligible employee, as defined in the group contract, is required to work a minimum of _____ hours each week (this must be at least 20 hours but no more than 40 hours). Prior approval is required if you define different minimum hours for separate employee classifications.

Independent contractors, temporary, and seasonal employees are not eligible. Persons whose earnings are based solely on income reported on IRS Form 1099 are not eligible. Group members who reside in the State of Hawaii are not eligible for coverage.

B. 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.

Class 1: _____ Class 2: _____

Ineligible Employee Class: _____ This class of employees is not eligible for coverage on this group plan.

C. Employees will be eligible for coverage on the first day of the month following the probationary period. The probationary period begins on the first working day of the month, unless otherwise specified and approved.

Class 1:	<input type="checkbox"/> 1 st of month	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 120 days	<input type="checkbox"/> 180 days
Class 2:	<input type="checkbox"/> 1 st of month	<input type="checkbox"/> 30 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 120 days	<input type="checkbox"/> 180 days

D. For employees transferring from part-time to full-time status, the probationary period specified above should apply:
 Retroactive to the original date of hire OR Beginning on the date transferred to full-time status

E. For new groups, the probationary period specified above applies to:
 All full-time employees (current and future) OR Future full-time employees only

F. The Rehire Policy applies only to employees that were covered under the plan at the time their employment was terminated. Employees subject to the rehire policy must be added the first of the month following the date of rehire. The application must be received within 15 days of this effective date. Employees rehired after the designated rehire period will be subject to the company's probationary period established above. Companies may elect to include or waive this option.

<input type="checkbox"/> Waive Rehire Policy for all employees classes				
<input type="checkbox"/> Rehire policy is for employees in the following classes	<input type="checkbox"/> Class 1 & 2	<input type="checkbox"/> Class 1 Only	<input type="checkbox"/> Class 2 Only	<input type="checkbox"/> Other

IMPORTANT: Rehire policy requires that employees must be rehired within _____ months from the date coverage ended (maximum 6 months)

3. EMPLOYEE PARTICIPATION REQUIREMENTS

A.	Total number of full-time and part-time employees, not just those enrolling. (Do not include COBRA participants.)		_____
B.	Less: Employees not eligible for coverage on this plan:		
	1. Employees working fewer than the minimum hours as indicated above	-	_____
	2. Employees who are not eligible by class as indicated above	-	_____
	3. Employees who have not completed the probationary period indicated above (For new groups only, enter zero (0) if you selected "future" employees in Section 2.E.)	-	_____
	4. Employees paid via IRS Form 1099, or are temporary, seasonal, or a substitute employee	-	_____
	5. Covered by Medicare as primary, at the request of the Medicare enrollee	-	_____
	6. Covered by Military, at the request of the Military enrollee.	-	_____
C.	Equals: Subtotal number of ineligible employees		= _____
D.	Total number of eligible employees.	Total eligible	= _____
E.	Total number of enrolled employees.	Total enrolled	= _____
F.	Number of employees covered by your group under the Federal provisions of COBRA.		_____
G.	Employee participation percentage (E divided by D above).	% Participation	= _____

4. FMLA/TEFRA/COBRA/OBRA (Family and Medical Leave Act/Tax Equity and Fiscal Responsibility Act of 1982/Consolidated Omnibus Budget Reconciliation Act of 1985/Omnibus Budget Reconciliation Act of 1989 & 1993)

Did your company employ 50 or more full-time and/or part-time employees during each of 20 calendar weeks in the current or preceding calendar year (January - December), and is it subject to FMLA? (If Yes, you are required by federal law to comply with FMLA provisions.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did your company employ 20 or more full-time and/or part-time employees during each of 20 calendar weeks in the current or preceding calendar year (January - December), and is it subject to federal TEFRA laws?	All Trust Companies are subject to TEFRA laws.	
Did your company employ 20 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December), and is it subject to federal COBRA laws?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did your company employ 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December), and is it subject to federal OBRA 1989/OBRA 1993 laws?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
TEFRA and COBRA provisions may apply to your group even if you have fewer than 20 employees enrolled through this coverage. If you have questions regarding TEFRA, COBRA, or other employer laws, contact your legal counsel.		

5. PRIOR COVERAGE INFORMATION FOR NEW GROUPS

If your group is renewing coverage, please check here and skip to section Section 6. (For renewing groups, the carrier has your group's prior coverage information on file)

If your group is enrolling in the BIAW Trust for the first time, please check here and complete this section in its entirety.

Has your group had prior group medical coverage in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of prior medical carrier: _____	If Yes, complete the following information. Date coverage began _____ Date coverage canceled _____
Has your group had prior group dental coverage in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of prior dental carrier: _____	If Yes, complete the following information. Date coverage began _____ Date coverage canceled _____

The probationary period for your prior carrier was: _____

To receive credit for waiting periods, please attach a copy of the last billing statement from your prior carrier. Indicate the number of months (next to his or her name) that each employee has been continuously covered (if over 3 months, show as 3+).

Please attach a copy of your most recent contract with your prior carrier and proof of any deductibles satisfied.

6. EMPLOYER CONTRIBUTION

The employer will pay the following percentages of the monthly rate. The employer must pay a minimum 75% of total employee cost.			
Employer Contribution	Medical Plan %	Dental Plan %	Vision Plan %
Employer pays for Employee:			
Employer pays for Dependents:			

7. EMPLOYER PLAN SELECTION

- Plan changes are allowed only during the annual BIAW Open Enrollment period (April 1st).
- Companies with 2-9 enrolled employees may select one BIAW Medical Plan.
- Companies with 10 or more enrolled employees may select two BIAW Medical Plans (some restrictions apply).

A. Regence BlueShield Preferred Medical Plans

Underwritten by Regence BlueShield
P.O. Box 21267, Seattle, WA 98111

<input type="checkbox"/> Enhanced E30	<input type="checkbox"/> Enhanced E100	<input type="checkbox"/> Enhanced E200	<input type="checkbox"/> Enhanced E300
<input type="checkbox"/> Enhanced E400	<input type="checkbox"/> Enhanced E500		
<input type="checkbox"/> Market M100	<input type="checkbox"/> Market M200	<input type="checkbox"/> Market M300	<input type="checkbox"/> Market M400
<input type="checkbox"/> Market M500	<input type="checkbox"/> Foundation F200	<input type="checkbox"/> Foundation F400	<input type="checkbox"/> Foundation F500
<input type="checkbox"/> HSA H100	<input type="checkbox"/> HSA H200		

B. Regence BlueShield Point-of-Service Medical Plans

Underwritten by Regence BlueShield
P.O. Box 21267, Seattle, WA 98111

<input type="checkbox"/> Selections S100	<input type="checkbox"/> Selections S200	<input type="checkbox"/> Selections S300	<input type="checkbox"/> Selections S400
<input type="checkbox"/> Selections S15			

C. Basic Life - AD&D Amount (employee only)

Underwritten by Regence Life & Health Insurance Company
P.O. Box 1271, Portland, OR 97207

<input type="checkbox"/> \$25,000 (Cost Included)	<input type="checkbox"/> \$30,000 (\$.95/EE/Mo)	<input type="checkbox"/> \$50,000 (\$4.75/EE/Mo - 10+ EE's)	<input type="checkbox"/> \$75,000 (\$9.50/EE/Mo - 10+ EE's)
<input type="checkbox"/> \$100,000 (\$14.25/EE/Mo - 10+ EE's)	<input type="checkbox"/> Other \$ _____		
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you want to allow employees to individually purchase Additional "Term" Life coverage through payroll deduction?			

D. Employee Assistance Program

Underwritten by Reliant Behavioral Health
1221 SW Yamhill Suite 200, Portland, OR 97201

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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E. Regence BlueShield Dental & Vision Plans

Underwritten by Regence BlueShield
P.O. Box 21267, Seattle, WA 98111

<input type="checkbox"/> Dental D100	<input type="checkbox"/> Dental D200	<input type="checkbox"/> Dental D300	<input type="checkbox"/> Dental 400
<input type="checkbox"/> Columbia Dental			
<input type="checkbox"/> Vision V100	<input type="checkbox"/> Vision V200	<input type="checkbox"/> Vision V300	

- Notes:
- Dental Plan D100 requires 20+ employees; Dental Plans D200 & D300 require 4+ employees; and Dental Plans D400 & Columbia Dental require 2+ employees
 - If cancelled, dental and/or vision cannot be added until the Open Enrollment Period following 12-months after the date of cancellation.

BIAW Group Insurance Trust Eligibility and Participation Requirements

- A. Company must be actively engaged in an income generating business licensed in the state of Washington.
- B. Company must be a current, active member of an endorsing association or organization authorized by the BIAW to participate in the Trust. Membership Dues and Access Fees (if applicable) must be maintained each year to continue participation in the Trust.
- C. Company MUST satisfy the Trust's minimum "employee/subscriber participation" requirements:
- Companies of 2–5 eligible full-time employees: 100% participation is required (all employees must enroll).
 - Companies of 6–10 eligible full-time employees: 100% participation, less one, is required (one employee may waive coverage).
 - Companies of 11 or more eligible full-time employees: 80% participation (example: for a company of 14 eligible employees, 3 employees may waive coverage).
- Eligible employees are active employees or owners who satisfy the company's "full-time" employment definition and have met your company's insurance probationary period established in Section 5 of this form. For purposes of the program, BIAW insurance carriers define an employee as meeting the following criteria:
1. They must be remunerated on a regular, periodic basis through the company's payroll
 2. They must appear on the company's quarterly report of wages filed with the State Employment Security Department
- D. Employees not enrolled when initially eligible may be denied coverage until the next BIAW Open Enrollment period (April 1st of each year).
- E. Dependent participation is optional. Companies may require employees to pay for the cost of dependent coverage through payroll deductions. Dependents not enrolled when initially eligible, may be required to wait until the next BIAW Open Enrollment period to enroll (see benefit booklet for details).
- F. Examples of INELIGIBLE participants include the following: Retirees, subcontractors, independent contractors, inactive owners, former employees, former owners, part-time employees. Eligible employees must have a direct, employee-employer relationship with the participating company.
- G. Eligibility requirements must be administered to all employees on a uniform and consistent basis. Participating companies are subject to periodic eligibility verification audits by the insurance carriers to ensure eligibility compliance.
- H. Cancelled companies or companies leaving the Trust will not be eligible to reapply for participation in the Trust Program for 24-months.
- I. Washington State Law requires at least two (2) employees/subscribers to be considered for group coverage. If your company enrolled in the BIAW Trust after June 10, 2004, and on the renewal date of April 1st your enrollment has dropped to just one enrolled employee/subscriber, we will be unable to renew your coverage.
- J. I understand that the issuer will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Member Firm after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Member Firm 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 Member Firm will be required to pay the Rate adjustment within 30 days of the notice by the issuer.

BIAW Group Insurance Trust Monthly Payment Requirements

Detailed monthly billing statements for the next month's premium are sent out to all companies before the end of each month. The Trust's "Contractual" PAYMENT DUE DATE is the first day of the billed month.

In order to maintain CURRENT ELIGIBILITY for employees, full payment must be received by the Trust on or before the 15th day of the billed month. A company's eligibility for the month will be DELINQUENT if full payment is not received by the 15th. DELINQUENT ELIGIBILITY STATUS results in claim payment delays, and other difficulties involving employees, their medical providers and carriers.

If full payment for the month is not received within 45 days of the PAYMENT DUE DATE, company will be RETROACTIVELY CANCELLED back to the last day of the month in which full monthly payment was received. Partial payments will be refunded.

Payments returned to the Administrator (for any reason) must be replaced with guaranteed funds (i.e. Cashier's check, money order, cash) within 5 working days of being notified by the Administrator. A \$20 fee will be assessed on all returned drafts.

8. ACCOUNTABLE OFFICER'S CERTIFICATION

If the BIAW Trust carriers provide applications and/or change forms, or any benefit summaries, comparison sheets, and/or group contracts or member brochures in an electronic medium for inclusion on the Member Firm's internal intranet or by similar means, the group agrees that: 1) electronic access shall be limited to the Member Firm's applying employees and covered employees and be restricted to a 'read-only' or similar basis; 2) the Member Firm will make timely modifications to the electronically available forms corresponding to any substantive modifications that the BIAW Trust carriers make to the hard-copies of our forms; 3) the hard-copy documents on file with the BIAW Trust carriers shall control in the event of any discrepancy; and 4) the Member Firm remains solely responsible for the content of the documents and all other legal requirements pertaining to them (e.g. distribution).

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 purposes of defrauding the insurer. Penalties include imprisonment, fines, and denial of insurance benefits. In addition, the issuer will have the right to collect any claims payment or other damages.

X

Accountable Officer's Signature

Title

Date