

**GROUP MASTER APPLICATION**  
**For Groups of 51 or More Employees**



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association.  
 1800 Ninth Avenue | PO Box 21267  
 Seattle, Washington 98111-3267

This is an application for (check one):

**NEW COVERAGE FOR GROUPS OF 100 OR MORE ENROLLED EMPLOYEES**

Requested Effective Date: \_\_\_\_\_

Complete this entire application along with the Benefit Selection Insert and submit with Employee Enrollment & Change Forms, Waiver Forms (if any) and payment of the first month's rates. If we are unable to offer the coverage you select, or decline the application, your deposit will be returned.

**RENEWAL OF EXISTING COVERAGE FOR GROUPS OF LESS THAN 100 ENROLLED EMPLOYEES (\*)**

Requested Effective Date: \_\_\_\_\_

**(\*) Note: Groups of less than 100 enrolled employees can only renew on existing coverage thus, if any changes to existing benefits are introduced please complete the application materials for our new products, rather than this application.**

**RENEWAL/CHANGE OF EXISTING COVERAGE FOR GROUPS OF 100 OR MORE ENROLLED EMPLOYEES**

Requested Effective Date: \_\_\_\_\_

Complete this entire application along with the Benefit Selection Insert and submit with applicable Employee Enrollment & Change Forms and Waiver Forms (if any)

**INSTRUCTIONS (Please print legibly): THIS APPLICATION MUST BE COMPLETED AND SUBMITTED TO OUR OFFICE NO LATER THAN 15 DAYS PRIOR TO THE EFFECTIVE DATE**, or delays in processing your application will occur. We cannot issue a contract or produce a billing statement until this application is processed by our office. For additional information please, contact your Sales Representative. Regence BlueShield office locations are listed on our Web site at [www.wa.regence.com](http://www.wa.regence.com).

**1. GENERAL GROUP INFORMATION**

Group's Legal Name	Plan/Branch	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"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> Other
Primary Contact	Title	Telephone Number
E-mail Address	Fax Number	Date Business Started
Location of Business Headquarters	Nature of Business	SIC Code

Contracts and Brochures should be sent to:  Agent/Broker's office **or**  Employer's office

Proof of common ownership is required to rate and insure multiple businesses together under the same contract. Companies are required to provide proof that they are eligible to file a combined tax return for purposes of taxation by the State of Washington or are affiliated or in a parent/subsidiary relationship. A copy of the Master Business Application filed with the Department of Licensing is usually acceptable proof. However, we reserve the right to request additional information as deemed necessary.

**AGENT/BROKER INFORMATION**

Do you have an Agent/Broker?  Yes  No **If Yes, please complete the following:**  
 Is this an Agent/Broker change?  Yes  No

Agents who do not have a current appointment with our Company are not authorized to enroll groups.

Name of Agent/Broker Appointed by Group	Effective Date of Appointment by Group
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**The Agent/Broker must complete the following information.**

Agent/Broker's Name	Agency/Brokerage Name
Agency/Brokerage Address (Street or PO Box, City, State, and ZIP Code)	

**1. GENERAL GROUP INFORMATION - CONTINUED**

Regence Broker Number	Broker E-mail Address	Telephone Number
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**Certification:** I certify that to the best of my knowledge the information on this application is accurate and that I know of no other information that could affect the underwriting of this group.

**Agent/Broker Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_

If you have an agent, that agent may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueShield. Incentives may be based on any of several factors, including the size of group business, the products you buy, your agent's volume of business with Regence, and the other services your agent provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your agent.

**2. GROUP ELIGIBILITY**

Group Eligibility is based on Group Size (Employee Counts). Group size is determined by the average count of the total number of employees who were on your group's payroll or that were affiliated with your company during the previous calendar year (January – December). Groups that were not in business during the previous calendar year would base their employee counts on the current calendar year. The term "employee" means any individual employed by an employer. (Contracted 1099 individuals are not included).  
Based on the above:

- A. Did your group **average more** than 50 employees during the previous calendar year?  Yes  No
  - B. Is the company's headquarters located outside the State of Washington?  Yes  No
  - C. Is the group a subsidiary of or affiliated with another company?  Yes  No
- If yes, please explain: \_\_\_\_\_

**3. FAMILY AND MEDICAL LEAVE ACT (FMLA)**

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.)  Yes  No

**4. TEFRA/COBRA/OBRA** (Tax Equity and Fiscal Responsibility Act of 1982/Consolidated Omnibus Budget Reconciliation Act of 1985/Omnibus Budget Reconciliation Act of 1989 and 1993)

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?  Yes  No

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?  Yes  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?  Yes  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. EMPLOYEE ELIGIBILITY INFORMATION**

A. An eligible employee, as defined in the Group's contract, is required to work a minimum of \_\_\_\_\_ hours each week (this must be at least 20 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: \_\_\_\_\_ Class 3: \_\_\_\_\_

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

C. Employees will be eligible for coverage on the first day of the month following completion of the probationary period. Group coverage begins on the first day of the month, following:

- |          |                                       |                                  |                                  |                                  |                                   |                                   |
|----------|---------------------------------------|----------------------------------|----------------------------------|----------------------------------|-----------------------------------|-----------------------------------|
| Class 1: | <input type="checkbox"/> Date of Hire | <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"/> Date of Hire | <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 3: | <input type="checkbox"/> Date of Hire | <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 of 100 or more enrolled employees, the probationary period specified above applies to:  
 All full-time employees (current and future) **or**  Future full-time employees only

F. Please specify the number of eligible employees who work outside of Washington State. (If more than 50% of all eligible employees work outside of the Company's service area, Underwriting approval is required.) If more than three states, please provide information in section 11.

State	# of Eligible Employees	State	# of Eligible Employees	State	# of Eligible Employees
_____	_____	_____	_____	_____	_____

## 6. GROUP PARTICIPATION REQUIREMENTS

A.	1. Total number of employees currently on your group's payroll regardless of hours worked. (Do not include COBRA participants or contracted (1099) individuals.)	+ _____	
	2. Total number of employees that are not currently on your group's payroll but are affiliated with your company. (Do not include contracted (1099) individuals.)	+ _____	
	3. Equals subtotal of employees.	= _____	
B.	Less employees not eligible for coverage on this plan:		
	1. Employees working fewer than the minimum hours described in Section 5.A.	- _____	
	2. Employees who are not eligible by class described in Section 5.B.	- _____	
	3. Employees who have not completed the probationary period described in Section 5.C. (For new groups of 100 or more enrolled, enter zero (0) if you selected "future" employees in Section 5.E.)	- _____	
	4. Temporary, seasonal, substitute or affiliated employees that are not offered your group's coverage.	- _____	
C.	Equals subtotal number of employees eligible to enroll.		= _____
D.	Less number of employees completing Waiver Forms (evidence is required) because they are:	<u>MEDICAL</u>	<u>DENTAL</u>
	1. Covered by TRICARE (CHAMPUS).	- _____	- _____
	2. Covered by a similar group plan through group coverage through a spouse or parent.	- _____	- _____
	3. Covered by Medicare as primary, at the request of the Medicare enrollee.	- _____	- _____
E.	Equals total number of employees eligible to enroll.	= _____	= _____
F.	Number of employees enrolled as of the effective date.	_____	
G.	Number of employees covered by your group under the provisions of COBRA.	_____	

## 7. PRIOR COVERAGE INFORMATION FOR NEW GROUPS OF 100 OR MORE ENROLLED EMPLOYEES

Has your group had prior **group medical** coverage in the last 90 days?  Yes  No      If Yes, complete the following information.

Name of prior medical carrier: \_\_\_\_\_      Date coverage canceled \_\_\_\_\_

Has your group had prior **group dental** coverage in the last 90 days?  Yes  No      If Yes, complete the following information.

Name of prior dental carrier: \_\_\_\_\_      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+). NO credit will be given toward transplant waiting periods, unless transferring from another medical plan affiliated with the Company without a lapse in coverage.

To receive credit for deductibles, please attach a copy of any deductibles satisfied with your prior carrier.

## 8. MEDICAL AND DENTAL PARTICIPATION REQUIREMENTS

**Medical Participation Requirements**

- If the employer contributes 100% of the employee rate, 100% of the eligible employees in Section 6, Line E must participate and at least 50% of the eligible employees in Section 6, Line C must participate.
- If the employer contributes less than 100% (but no less than the minimum of 75%) of the employee rate, at least 75% of the eligible employees in Section 6, Line E must participate and at least 50% of the total eligible employees in Section 6, Line C must participate.
- If another medical plan option is offered through another carrier (**prior approval is required**), minimum enrollment in the Company's plans is 75%.
- Under Dual Option, a minimum of 5 employees must enroll on each plan.

**Dental Participation Requirements**

- If the employer contributes 100% of the employee rate, 100% of the eligible employees in Section 6, Line E must participate and at least 50% of the eligible employees in Section 6, Line C must participate.
- If the employer contributes less than 100% (but not less than the minimum of 75%) of the employee rate, at least 75% of the eligible employees in Section 6, Line E must participate and at least 50% of the total eligible employees in Section 6, Line C must participate.
- Under dual option (Traditional Dental and Columbia Dental Plans), a minimum of 2 employees must be enrolled on the Columbia Dental Plan and a minimum of 5 employees must be enrolled on the Traditional Dental Plan.
- Children up to three years old are not required to enroll in dental coverage.

**9. RATES, DUAL OPTION REQUIREMENTS AND CONTRACTUAL PROVISIONS**

Specify below the rates quoted for the plan(s). If more than one medical plan, provide a short description of each (such as Preferred or Selections) next to the group number. Include the rates for prescription drug, vision care and medical options (preventive care etc.) in the rates for the medical plan(s). The plans must have identical riders and prescription drug benefits. A minimum of five employees must enroll on each plan. Prior approval is required for multiple plan offerings.

	Description	Group Number	Subscriber Rate	Spouse Rate	Child(ren) Rate or 1 <sup>st</sup> Child Rate	2 <sup>nd</sup> Child Rate
Medical Plan 1:	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____
Medical Plan 2:	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____
Dental Plan:	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____

**Multiple Carrier Offerings**

Regence BlueShield is the sole medical and/or dental carrier offered by the group:  Yes  No If No, complete the following information. Prior approval is required for multiple carrier offerings.

Name of other carrier \_\_\_\_\_ Number of employees enrolled on other carrier \_\_\_\_\_

**Employer Contribution**

The group will contribute the following amounts of the monthly rate. If different employee classes are chosen, please indicate the contribution for each class. The minimum employer contribution amount for employee medical and/or dental coverage is 75%.

	% or \$ of Employee Rate	% or \$ of Dependent Rate	
Medical Plan 1:	_____	_____	For renewing groups, is this a change in the employer contribution percentages? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Plan 2:	_____	_____	If Yes, was prior Underwriting approval obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental Plan:	_____	_____	


**Brokerage/Commission**

Rates include the following brokerage/commission level: \_\_\_\_\_ % of medical rate \_\_\_\_\_ % of the dental rate

**10. ACCOUNTABLE OFFICER'S CERTIFICATION**

I have provided these answers as part of the application procedure required by Regence BlueShield to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. If Regence BlueShield 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 Regence BlueShield 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 Regence BlueShield. For the protection of all of our members, fraud or misrepresentation of material fact by you and/or the Group for the purposes of defrauding Regence BlueShield may result in Regence BlueShield taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, Regence BlueShield will have the right to collect any claims payments or other damages.

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

 **Regence** x \_\_\_\_\_  
 Accountable Officer's Signature Title Date  
Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association.

**11. ADDITIONAL**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Thank you for choosing Regence BlueShield.