VIGILANT
Group Benefits Trust

FOR OFFICE USE ONLY
Rate Band: _____
Eff. Date: _____
Dental Key:_____
Group #: _____

MASTER APPLICATION FOR INSURANCE COVERAGE

Company Information:

Legal Name of Business:	Employer Tax ID Number (EIN):	❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other
dba (if applicable)	Requested Effective Date:	
Type of Business:	Next Renewal Date:	NAICS Code:
Billing Address: (street, city, state, zip)		SIC Code:
Shipping Address: (if different)		
Billing/Eligibility Contact:	Phone: Fax:	Email:

Medical Coverage – Regence BlueCross BlueShield of Oregon

PPO A Plans: ❑ PPO | 500 ❑ PPO | 1000 ❑ PPO | 1500 ❑ PPO | 2000 ❑ PPO | 2500 ❑ PPO | 3500 ❑ PPO | 5000

PPO B Plans: ❑ PPO | 500 ❑ PPO | 1000 ❑ PPO | 1500 ❑ PPO | 2000 ❑ PPO | 2500 ❑ PPO | 3500 ❑ PPO | 5000 ❑ PPO | 7000

PPO C Plans: ❑ PPO | 2500 ❑ PPO | 3000 ❑ PPO | 4000 ❑ PPO | 5500 ❑ PPO | 7000

PPO D Plans (HSA): ❑ HSA | 1600 ❑ HSA | 2500 ❑ HSA | 3500 ❑ HSA | 5000

If an HSA plan is selected, will the group be utilizing Health Equity Bank? ❑ Yes ❑ No
If using Health Equity Bank, responsible party for monthly account fee shall be: ❑ Employer ❑ Employee

Prior Coverage (NEW GROUPS ONLY): Will this coverage replace existing group coverage with another carrier? ❑ Yes ❑ No
If yes, name of carrier: _____

EAP – Uprise Health

Optional EAP: ❑ 3-Visit Model ❑ 6-Visit Model

Life & AD&D – LifeMap Assurance Company

Optional Life/AD&D: ❑ Plan A ($10,000) ❑ Plan B ($15,000) ❑ Plan C ($25,000)

Vision – VSP

Optional Vision: ❑ Plan 1 ❑ Plan 2 ❑ Plan 3

Dental – Delta Dental of Washington (Uncommon Enrollment Allowed)

Group Dental (requires 2+ employees and 51% employee participation)**:**
❑ Plan I ❑ Plan II ❑ Plan III ❑ Plan IV **Orthodontia** (Available to groups of 10+): ❑ Yes ❑ No

Regence Required Domestic Partner Eligibility – Please Check One

❑ This plan will allow coverage for Certified Domestic Partners *only*
❑ This plan will allow coverage for *both* Certified and Non-Certified Domestic Partners

Late Fee Policy – *Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of $20 or 1.5% of the amount owed, whichever is greater. The fee will be added to the next month's billing statement. Unpaid balances may be referred to collections. The employer will be responsible for any fees, attorney fees or other fees, associated with the collections process.*

Payment Options – *if you choose EFT as your payment option you must also complete the EFT form*

Pay Via: ❑ Electronic Funds Transfer (EFT) ❑ Other

Vigilant Membership – *A membership with Vigilant is required to obtain coverage through Vigilant Group Benefits Trust. Please complete the attached Vigilant Membership Application. Membership must be maintained to continue coverage under the plan.*

Current Member: ❑ Yes ❑ No

COBRA, Worker's Compensation, & ACA Information

COBRA Administration: Regardless of size, all groups insured by Vigilant Group Benefits Trust are eligible for COBRA. Vimly Benefit Solutions will administer COBRA for all VGBT lines of coverage at no additional cost.

❑ **Yes** ❑ **No**	**Worker's Compensation:** Does your group have Worker's Compensation coverage? If yes, name of carrier: _____
_____	**Affordable Care Act Required Information:** Please enter the average number of employees that were employed by your company during the prior calendar year (January – December). This count should include: full-time, part-time, seasonal, union employees, out of state employees, and employees from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.

Eligibility and Enrollment

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: 17.5 hours per week, administered on a non-discriminatory basis, based on conditions of employment)

Eligible Employee Classifications:

Class 1:_____ Eligibility Requirements (other than hours):_____

Class 2:_____ Eligibility Requirements (other than hours):_____

Class 3:_____ Eligibility Requirements (other than hours):_____

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

Class 1: ❑ Date of Hire* ❑ 30 Days ❑ 60 Days – not to exceed 90 Days

Class 2: ❑ Date of Hire* ❑ 30 Days ❑ 60 Days – not to exceed 90 Days

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

❑ Effective date will always be 1st of month following DOH, even if DOH is the 1st of the month.

❑ Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

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

❑ Yes (Probationary period applies only to future full-time employees) ❑ No (Probationary period applies to current and future full-time employees)

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

Eligibility Look Back Measurement/Stability Period: Has your company adopted a look back measurement/stability period under the ACA for the employee classification referenced above? ❑ Yes ❑ No

If Yes, the Measurement Period is ___ months and the Stability Period is ___ months. Please confirm that this measurement period is being applied due to a good faith uncertainty about whether the employee meets the eligibility criteria referenced above: ❑ Yes

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 not in an **eligible class** - _____
- Less employees who have not completed the **probationary period** - _____

- Less employees paid via IRS Form **1099, or temporary, seasonal or substitute** employees - _____
- Less employees completing 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 _____

Vigilant Group Benefits Trust - 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 Vigilant Group Benefits Trust or Vigilant Group Benefits Trust's respective carriers.

Sponsor – The undersigned Employer acknowledges and agrees that Vigilant is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. Vigilant shall be entitled to reimbursement for any out-of-pocket expenses directly related to its marketing support and activities from Trust assets. Vigilant may also charge a service fee for services performed on behalf of the Trust.

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 and as set forth in the Trust Agreement, which is available upon request.

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 VGBT.

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 Oregon.

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 application 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 REPRESENTATIVE **DATE**

Insurance Producer Application

A business applying for insurance coverage through the Vigilant Group Benefits Trust may appoint their own Insurance Producer to represent them as noted below.

Name of Insurance Producer: _____

Name of Producers Brokerage/Agency: _____

Regence Producer Number: _____

Street Address: _____

City, State, Zip Code: _____

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

Medical Insurance Benefits are underwritten by:
Regence BlueCross BlueShield of Oregon; 200 SW Market Street; Portland, OR 97201
Dental Insurance Benefits are underwritten by:
Delta Dental of Washington; 400 Fairview Ave North, Suite 800; Seattle, WA 98109-5371
Life and AD&D Insurance Benefits are underwritten by:
LifeMap Assurance Company; PO Box 1271, MS E3A; Portland, OR 97207
Employee Assistance Program underwritten by:
UpriseHealth; 1220 SW Morrison Street #600; Portland, OR 97205
Vision Insurance Benefits are underwritten by:
VSP Vision Care Inc; 3333 Quality Drive; Rancho Cordova, CA 95670

Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

DELTA DENTAL

Delta Dental of Washington

LifeMap

upriseHealth

VSP VISION