WTIA Benefits Program

FOR OFFICE USE ONLY
Med RB: _____
Den RB: _____
Effective Date: _____
Group #: _____

MASTER APPLICATION AND AGREEMENT FOR INSURANCE COVERAGE

Company Information

Legal Name of Business:	Requested Effective Date:	☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other
dba (if applicable):	Employer Tax ID Number (EIN):	
Type of Business:	NAICS Code: SIC:	
Physical Address: (**Required**: street, city, zip)		
Mailing Address:		

Billing Contact *(☐ Contact for SIMON invitation?)*:	Phone:	Email:
Eligibility Contact *(☐ Contact for SIMON invitation?)*:	Phone:	Email:

Prior UnitedHealthcare Medical Coverage

Will this coverage replace existing group coverage with UnitedHealthcare? ☐ Yes ☐ No

Medical Coverage – UnitedHealthcare

Medical Plans(s)*:

- ☐ Tech Premier
- ☐ Tech 90 | $200
- ☐ Tech 90 | $500
- ☐ Tech 90 | $750
- ☐ Tech 80 | $250
- ☐ Tech 80 | $350
- ☐ Tech 80 | $500
- ☐ Tech 80 | $750
- ☐ Tech 80 | $1,000
- ☐ Tech 80 | $1,500
- ☐ Tech 80 | $2,000
- ☐ Tech 80 | $2,500
- ☐ Tech 80 | $3,000
- ☐ Tech 80 | $4,000
- ☐ Premier HSA $4,250
- ☐ HSA $1,700
- ☐ HSA $2,500
- ☐ HSA $3,400
- ☐ HSA $4,500
- ☐ Tech E | $1,000
- ☐ Tech E | $2,000
- ☐ Tech E | $2,500
- ☐ Tech E | $3,000
- ☐ Tech E HSA $1,700
- ☐ Tech E HSA $3,400

**Groups of 10 or more enrolled employees may select up to 3 plan offerings in any combination with no minimum enrollment.*

FSA/HSA – Navia Benefit Solutions

FSA and HSA services are available at no additional cost to you or your employees when enrolled in a UnitedHealthcare medical plan.

☐ Yes (a Navia representative will contact you to enroll) ☐ No

Dental – Delta Dental

Optional Dental:	☐ Dental 750 ☐ Dental 1000	☐ Dental 1500 ☐ Dental 2000	☐ Dental 2500 ☐ Decline	☐ Voluntary (Employee paid. Must have minimum 2 employees enrolled)

Orthodontia: ☐ Yes ☐ No (Available to groups of 10+. Voluntary Plan not eligible.)

When selecting a UnitedHealthcare plan, coverage for Temporomandibular Joint Disorder (TMJ) will be offered under the medical plan.

Vision – VSP Vision Care, Inc.

Vision: ■ Exam Plus ☐ Basic ☐ Preferred ☐ Enhanced ☐ EasyOptions ☐ Decline

Life and Disability Coverage – Metropolitan Life Insurance Company

Basic Life/AD&D *(Life plan required with all medical plans)*: 100% employee participation

☐ Plan A ($25,000) ☐ Plan B ($50,000) ☐ Plan C ($100,000) ☐ Plan D ($250,000)

Supplemental Life and AD&D: ☐ Yes ☐ No *(No minimum employee participation requirement)*

Short Term Disability: ☐ Yes *(salary information required)* ☐ 26-wk duration ☐ 13-wk duration ☐ No

100% employee participation: 60% of weekly salary. All plans Non-Contributory.

☐ **Plan1**: $2500 wkly benefit; 0/7 Day Elimination Period ☐ **Plan2**: $2000 wkly benefit; 7/7 Day Elimination Period
☐ **Plan3**: $1750 wkly benefit; 7/7 Day Elimination Period ☐ **Plan4**: $1250 wkly benefit; 14/14 Day Elimination Period

Long Term Disability: ☐ Yes *(salary information required)* ☐ 180-day EP ☐ 90-day EP ☐ No

100% employee participation: 60% of weekly salary; 180-day EP, 90-day EP Option if Stand-alone. All plans Non-Contributory.

☐ **Plan 1**: $10,000 max; Benefit to SSNRA ☐ **Plan 2**: $8,000 max; Benefit to SSNRA
☐ **Plan 3**: $6,000 max; Benefit to SSNRA ☐ **Plan 4**: $5,000 max; 5-Year Benefit Duration

EAP Plan

3 visits included in your UnitedHealthcare medical plan

Cleo – Services for Current and Prospective Caregivers

Cleo offers services to support families on their parenting journey at no cost to employers or employees. This includes support for employees caring for adult loved ones. Would you like to opt in? If yes, the group administrator agrees to furnish work emails for all employees enrolled in medical.

☐ Yes ☐ No

WTIA Membership

A membership fee, in an amount determined by the WTIA, is required to obtain coverage through WTIA Employee Benefit Trust. Your membership fee will appear as a line item on your first bill. Membership must be maintained to continue coverage under the plan. Membership fees are not used to provide plan benefits and are not considered plan assets. Any membership fees received by the WTIA Employee Benefit Trust will be forwarded to the WTIA.

Current Member: ☐ Yes ☐ No

Late Fee Policy – Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of 5% of the amount owed. 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: ☐ Electronic Funds Transfer (EFT) (You must fill out the EFT form) ☐ Online

***NEW GROUPS** – A binder check is not required for groups that elect EFT for payment. Binder checks are required for online payment option.*

COBRA and FMLA

	COBRA Administration: Regardless of size, all groups insured by Washington Technology Industry Association Employee Benefit Trust are eligible for COBRA. Vimly Benefit Solutions, Inc. will administer COBRA for all WTIA lines of coverage at no additional cost.
☐ Yes ☐ No	**FMLA:** Did your company employ 50 or more full and/or part-time employees during each of the 20 calendar weeks in the current or preceding calendar year, and is it subject to federal TEFRA laws?
_____	**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, 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 and Enrollment

Participation and Contribution Requirements	• Minimum 75% Employee Participation of all Eligible Employees • Minimum 50% Employer Contribution of Employee Coverage
Employer Contribution	Class 1: Employee: _____% Dependent: _____% Class 2: 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.)

Employee Classifications: *(10+ employees required for addition of Class 2)*
Class 1: _____Eligibility Requirements (other than hours): _____
Class 2: _____Eligibility Requirements (other than hours): _____

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

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 month following DOH, with the exception of when the DOH is the 1st of the month

Eligibility and Enrollment (continued)

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 applied due to a good faith uncertainty about whether the employee meets the eligibility criteria referenced above:
☐ Yes

(NEW GROUPS ONLY): Is probationary period waived on group's initial enrollment?
☐ No (Probationary period applies to all current and future full-time employees)
☐ Yes (Probationary period applies only to 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

Group Participation (Do not leave any blanks, if the answer is "zero" please put "0")	
Total # 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, or seasonal, or substitute** employees	- _____
• Equals total number of employees eligible to enroll	= _____
• Less employees waiving coverage because covered by **Medicare as primary**, at the request of the Medicare enrollee. **(Proof of coverage required if participation falls below 75%.)**	- _____
• 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%.)**	- _____
• Number of employee applications being submitted (75% participation required)	= _____
• Number of former employees currently covered by your group under the provisions of COBRA	_____

Adoption of Trust, Appointment of Trustee & Understanding of the Terms of the Selection & Participation

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 Trust Agreement, health service contracts, insurance policies, service contracts, benefit booklets and certificates of insurance issued by the WTIA Employee Benefit Trust ("Trust") or the WTIA Employee Benefit Trust's respective carriers.

Changes – The undersigned Employer acknowledges that this Agreement may only be changed at contract renewal or as mutually agreed between the Employer and Trust, and subject to the insurance carrier's approval. The undersigned Employer agrees to notify the Trust when there is a change to the Employer's name, address, phone number, contact person, or ownership status.

Sponsor – The undersigned Employer acknowledges and agrees that Washington Technology Industry Association (WTIA) is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. WTIA may also charge a service, license or other sponsorship fee for participating in the Trust. Additionally, WTIA may charge a membership fee for participating in the Trust. Membership fees are not used to provide health plan benefits and are not considered Trust or Plan assets.

Producers – The undersigned Employer acknowledges that it may hire a producer to represent the Employer when joining the Trust. The undersigned Employer authorizes the Trust to recognize any fee/commission arrangement between the Employer and its producer to receive and pay such fees/commissions to the producer. Employer producer fees/commissions received by the Trust shall not be used to providing Plan benefits and are not considered Trust or Plan assets.

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.

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 WTIA.

Contributions – The undersigned Employer agrees to pay the contributions established by the Trust. 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) shall fail or refuse 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 agree 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 Washington Technology Industry Employee Benefit Trust may appoint its own Insurance Producer to represent them as noted below:

Name of Insurance Producer: _____

Name of Producer's Agency: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: Fax Number: _____

E-Mail Address: _____

❑ We request the above-named producer be given access to our records in the online enrollment system, SIMON. *(Employer must complete separate SIMON authorization form. Our third-party administrator will send the form to your SIMON portal contact.)*

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:	UnitedHealthcare of Washington Inc. 17930 International Blvd #1000, SeaTac WA 98188
Dental Insurance:	Delta Dental of Washington, 400 Fairview Ave N #800, Seattle, WA 98109
Vision Insurance:	VSP Vision Care, Inc., 3333 Quality Drive, Rancho Cordova, CA 95670
Life Insurance:	Metropolitan Life Insurance Co., 200 Park Avenue, New York, NY 10166
Navia Benefit Solutions:	600 Naches Ave SW, Renton, WA 98057
Employee Assistance:	UnitedHealthcare of Washington Inc. 17930 International Blvd #1000, SeaTac WA 98188
Cleo Labs:	548 Market Street, PMB 46800, San Francisco, CA 94104