WASHINGTON FARM BUREAU
Healthcare

Group Master Application for Coverage Effective: ________________________/01/2010

Group Name: ____

GROUP SUBMISSION CHECKLIST – 2 TO 99 EMPLOYEES		
☐	Proposal Rate Sheet | Rate Band: _____	Group Number: ____________________
☐	Enrollment Applications and Waiver Forms ***New Groups***: *One for each eligible employee* ***Renewals***: *Changes only*	
☐	For Employees Waiving with Current Coverage: Include Copies of Current Health Plan ID Cards	
☐	Copy of Current Carrier's Medical Billing Required ***(New Groups Only)***	
☐	Washington Farm Bureau Membership Application and Annual Dues *(Or copy of most recent valid Membership Card issued)*	
☐	Check for First Month's Premium payable to: **Washington Farm Bureau Healthcare** ***(New Groups Only)***	
☐	Micro-Group Employer Documentation (If required; see Section E)	
☐	Other:	

Coverage Underwritten By:

Medical Insurance Benefits are underwritten by:
Regence BlueShield; 1800 Ninth Avenue; PO BOX 21267; Seattle, WA 98111-3267
Life Insurance Benefits are underwritten by:
Regence Life and Health Insurance; PO Box 1271, MS E3A; Portland, OR 97207-1271
Vision Insurance Benefits are underwritten by:
Vision Service Plan; 600 University Street, Suite 2004; Seattle, WA 98101
Dental Insurance Benefits are underwritten by:
Washington Dental Service; 9706 Fourth Avenue NE; Seattle, WA 98115

MAIL COMPLETED APPLICATIONS TO:
FB Healthcare
1301 Fifth Avenue, Suite 3701
Seattle, WA 98101-2636
206-957-5157 | 800-681-7177
E-mail: rfp@fbhealthcare.com | Fax: 206-264-1240

SECTION A – BUSINESS INFORMATION

Legal Name of Business			"dba," If Applicable		
Billing/Eligibility Contact			Owner or President		
Mailing Address			City	State	Zip
Street Address			City	State	ZIP
Business Phone	Business Fax	E-mail Address		Web Site Address	
Type of Business		SIC Code		Employer Tax ID Number	
Type of Organization	☐ C-Corporation ☐ S-Corporation ☐ L.L.C. ☐ Partnership ☐ Proprietorship ☐ Other				

SECTION B – WASHINGTON FARM BUREAU MEMBERSHIP

A Farming or Business Membership to the Washington Farm Bureau is required to obtain this coverage. During the term of this agreement membership must be maintained to continue coverage under the plan.

Current Member	☐ Farming	☐ Business	Membership #
New Member	☐ Farming	☐ Business	Membership #
Membership Upgrade	☐ Farming	☐ Business	Membership #

Current Member of Farm Bureau Retro/Safety? ☐ Yes ☐ No

SECTION C – BENEFIT PLAN SELECTION

1. Employer Premium Contribution

- Applies to all coverage purchased — For Employees: % ________ (75% required)
- Medical and Dental enrollment must be identical — For Dependents: % ________ (0% required)

2. Regence BlueShield Medical Plan Choice (Requires 2+ employees)

☐ PPO 250 ☐ PPO 500 ☐ PPO 750 ☐ PPO 1000 ☐ PPO 1500 ☐ PPO 2500

☐ PPO 3000 ☐ PPO 5000 ☐ PPO 7500 ☐ PPO 10000

☐ PPO 50/50 ☐ Legacy 1000 ☐ HSA 1500 ☐ HSA 2500

3. Additional Regence Life & Health Life/AD&D Plan Choice – ($10,000 Basic Life/AD&D Included with Medical)

☐ $20,000 Enhanced Life/AD&D (Requires 5+ employees) ☐ $2,500 Dependent Life (Requires 5+ employees)

4. Additional Vision Service Plan Benefit Choice – (Exam Plus Included with Medical)

☐ Hardware I (Requires 5+ employees) ☐ Hardware II (Requires 5+ employees)

5. Washington Dental Service Plan Choice (Requires 5+ employees)

☐ Core	Delta PPO: 100 | 80 | 0 | $1,000	Delta Premier: 80 | 70 | 0 | $1,000
☐ Core Plus	Delta PPO:: 100 | 80 | 50 | $1,000	Delta Premier: 80 | 70 | 40 | $1,000
☐ Traditional Plus	Delta PPO: 100 | 90 | 50 | $2,000	Delta Premier: 100 | 80 | 50 | $2,000
☐ Choice Plus	Delta PPO: 100 | 80 | 50 | $2,000	Delta Premier: 80 | 70 | 40 | $2,000

SECTION D – ELIGIBILITY & ENROLLMENT

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:	Ineligible Employee Classifications:
Class 1: ________________________	________________________
Class 2: ________________________	________________________
Dependents: ________________________	________________________

Probationary Period – Coverage should be effective on the first of the month following:

Class 1: ☐ Date of Hire ☐ 1 month ☐ 2 months ☐ 3 months ☐ 6 months ☐ 12 months

Class 2: ☐ Date of Hire ☐ 1 month ☐ 2 months ☐ 3 months ☐ 6 months ☐ 12 months

Applies to: ☐ Current and future employees ☐ Future employees only

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

☐ Yes ☐ No	**COBRA**: Did your company employ 20 or more full and/or part-time employees for at least 50% of the workdays of the preceding calendar year, and is it subject to federal COBRA laws?
☐ Yes ☐ No	**OBRA**: Did your company employ 100 or more full and/or part-time employees for at least 50% of the workdays of the preceding calendar year, and is it subject to federal OBRA 1989/OBRA 1993 laws?
☐ 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?

SECTION E – 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 **Waiver Forms** because they are covered by **TRICARE (CHAMPUS)**
- Less employees completing **Waiver Forms** because they are covered by a spouse's or parent's **similar group medical plan** - ___________
- Less employees completing **Waiver Forms** because they are covered by **Medicare as primary**, at the request of the Medicare enrollee - ___________
- Equals total number of employees eligible to enroll =___________
- Number of employee applications being submitted (75% participation required) If **2 or 3, Micro Group documentation** is required ___________
- Number of employees covered by your group under provisions of COBRA _ ___________

SECTION F – FRAUD AND HIPAA STATEMENTS

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. 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. For the protection of all of our members, fraud or misrepresentation of material fact by the Group for the purposes of defrauding the issuer may result in the issuer taking any action allowed by the law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, the issuer will have the right to collect any claims payments or other damages.

SECTION G – EMPLOYER AGREEMENT & SIGNATURES

Employers Statement: I have read and agree to the terms of the Participation Agreement. I understand that medical, life; accidental death and dismemberment (AD&D), vision and dental coverages are underwritten by the selected carriers of Washington Farm Bureau Healthcare. I understand that life and AD&D benefits reduce after age 65 according to the life coverage schedule in the master contract. I certify that the information on this application is complete and accurate. I understand that if false information has been submitted, the selected carriers will have the right to cancel retroactively to the date that such misrepresentation occurred and to collect any claims payments or damages. I understand that if coverage is continued by the selected carriers, they will have the right to adjust premium rates to reflect complete and accurate information, retroactively to the date the misrepresentation occurred.

Employer Representative Name: ______________________________ Date: ____________________

Signature : ____ Title: _____________________

SECTION H – PRODUCER APPLICATION

A business applying for insurance coverage through the Washington Farm Bureau Healthcare plan may appoint a WFB Healthcare credentialed producer to represent them.

We hereby appoint the below named producer as our company's producer of record. This agreement will serve as notice of cancellation of any previous producer agreement, and will remain in effect until written notice of a change is given by either party. No changes may be made retroactively. All appointments and changes are subject to approval by Washington Farm Bureau Healthcare.

Name of Producer: ____

Name of Brokerage/Agency: ____

Producer's Statement: I certify the information provided in this application is complete and accurate to the best of my belief.

Producer Signature:_____________________________________

Date: ____________________

Print Name: ____

Mailing Address		City	State	Zip
Street Address		City	State	Zip
Business Phone	Business Fax	E-mail Address	Web Site Address	