

Northwest Employers Trust

Return to: Thompson, Spears & Associates, 1950 112th Avenue NE, Suite 201 Bellevue, WA 98004 (425) 451-9141
Make checks payable to: Northwest Employers Trust

Employer Information

Effective Date: _____ TIN # _____ Group Number: _____
Group's Legal Name: _____
Doing Business As Name (DBA) _____
Group's Address: _____
Street City State Zip
Billing Address (if different from Business Address): _____
Contact Name: _____ Phone: (____) _____
Email Address: _____ Fax: (____) _____
Nature of Business: _____ SIC: _____ Prior Coverage: _____
Type of Business: Sole Proprietorship Corporation Partnership

Producer Agreement

Producer's Name: _____
Agency: _____
Company Address: _____
Phone #: _____ Fax # _____
Producer Email: _____ ANH Producer Number: _____
Producer Signature: _____

Asuris Northwest Health
(PO Box 91130, Seattle, WA 98111) Underwritten by Asuris Northwest Health

Select One Medical Plan:

- \$500 Deductible PPO \$750 Deductible PPO \$1000 Deductible PPO
 \$1500 Deductible PPO \$2000 Deductible PPO \$2500 Deductible PPO
 HSA 1500

Select One Vision Plan if applicable:

- Vision Exam ONLY Vision Exam & Hardware Option 80% to \$200 hardware maximum every 2 years

Select Cobra Services Option if applicable:

- COBRA SERVICES (\$1.00 per employee per month)

Employer Contribution and Rates

The employer will pay the following percentages of the monthly rate. (minimum 75% of EE cost is required)

Employer Contribution

Class 1: _____ Class 1 Employee: _____ % Dependents: _____ %
Class 2: _____ Class 2 Employee: _____ % Dependents: _____ %
Class 3: _____ Class 3 Employee: _____ % Dependents: _____ %

<u>RATES:</u>	Subscriber	Spouse	Child
Medical Plan:	\$ _____	\$ _____	\$ _____
Vision Option:	\$ _____	\$ _____	\$ _____

Has your group had prior group medical coverage in the past 90 days? Yes No

Name of carrier: _____ Date coverage began and ended: _____/_____/_____

Regence Life and Health Employee Life & AD&D Coverage
(PO Box 1271, Portland, OR 97207) Underwritten by Regence Life and Health

New and Renewing groups: (Choose one option)

Basic \$10,000 Life and AD&D - Premium included in medical plan chosen above

Buy Up Options (Select Benefit amount below):

\$15,000 Employee Life and AD&D (\$1.25 per employee per month)

\$25,000 Employee Life and AD&D (\$3.75 per employee per month)

\$50,000 Employee Life and AD&D (\$10.00 per employee per month)

United Concordia Dental Plan Selection
(2200 6th Ave #804 Seattle WA 98121) May be written freestanding Underwritten by United Concordia Dental

Advantage Plus Network Benefits:

Flex 800 Flex 1000 Flex 1500 Flex 2000

OPTIONS: Groups of 10 or more- increase out of network reimbursement to 90th percentile
Groups of 25 or more- add Child Orthodontia

Rates
Employee \$ _____ Employee & Spouse \$ _____ Employee & Child(ren) \$ _____ Employee & Family \$ _____

Employer Contribution: Employee: _____% Dependents: _____%

Prior Dental Coverage: Yes No

Name of Carrier: _____ Policy Number: _____

Effective Date: _____ Termination Date: _____

FMLA/TEFRA/COBRA/OBRA

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 subject to FMLA? Yes No

TEFRA eligibility will be assumed for all participating member companies of the Northwest Employers Trust regardless of group size; however, it will be the responsibility of the member to inform Medicare of their status so that claims will be properly adjudicated. I Agree

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 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 subject to Federal OBRA 1989/OBRA 1993 laws? Yes No

Rehire Policy

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 hire. Employees rehired after the designated rehire period will be subject to the company's current probationary period. Companies may elect to include or waive this option.

_____ Waive Rehire policy

_____ Choose Rehire Policy (if chosen, complete requirement below): Check one:

Rehire policy requires that employees must be rehired within (3 months 6 months) from the date coverage ended.

Employee Eligibility Information

An eligible employee, as defined by the group contract, is required to work a minimum of _____ hours each week. (This must be at least 20 hours for medical and 30 hours for Dental only).

Independent contractors, temporary and seasonal employees and 1099 employee are not eligible.

Employees will be eligible for coverage on the first day of the month following the probationary period:

Medical, Dental & Vision (as applicable)

Class 1:	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 60 Days	<input type="checkbox"/> 90 Days	Other _____
Class 2:	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 60 Days	<input type="checkbox"/> 90 Days	Other _____
Class 3:	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> 30 Days	<input type="checkbox"/> 60 Days	<input type="checkbox"/> 90 Days	Other _____

The probationary period applies to: All Full-Time Employees Future Full-Time Employees Only

For employees transferring from part-time to full-time status, the probationary period above should apply:

Retroactive to the original date of hire or Beginning on the date transferred to full-time status

Employee Participation Requirements

	Medical & Vision	Dental
A. Total number of full-time and part-time employees		
B. Number of EE's working fewer than the minimum hours		
C. Number of EE's who have not completed probationary period		
D. Subtotal of A. minus B. minus C.		
E. Number of employees who have waived coverage (*)		
F. Total number of eligible employees (D. minus E.)		
G. Total number of enrolled employees		
H. Total number of employees covered under the provisions of COBRA or on 6 month extension		

(*) For employees waiving coverage, please include the waiver form and proof of other coverage if applicable.

Identification Cards and Plan Booklets

ID cards will be delivered to the Employees home address. Booklets to be delivered via the following method:

Emailed in PDF Format Hard copy booklets only Emailed in PDF format with a few hard copy booklets

Accountable Officer's Certification:

I have provided these answers as part of the application procedure required by the issuers to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the issuers will rely on each answer in making coverage and rating determinations. If the issuers continue 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 issuers 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 issuers. 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. In addition, the issuers will have the right to collect any claims payments or other damages.

Accountable Officer's Signature : _____

Date: _____

Managing General Producer: Thompson Spears & Associates #T39187