



FOR OFFICE USE ONLY	
Rate Level:	_____
Eff. Date:	_____
Group #:	_____

MASTER APPLICATION FOR INSURANCE COVERAGE

Company Information:

Legal Name of Business:		<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other
dba (if applicable):		
Employer Tax ID Number (EIN):	Requested Effective Date:	
Type of Business:		SIC Code:
Billing Address: (street, city, state, zip)		
Shipping Address: (if different)		

Billing/Eligibility Contact:	Phone: Fax:	Email:
COBRA Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No ▶▶▶ If yes, by checking the box to the right we authorize BSI to administer COBRA on terminating employees <input type="checkbox"/>	FMLA Employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	# of employees not covered by State Industrial Insurance <input type="text"/>
<input type="checkbox"/> An employer is subject to COBRA during the current calendar year if the group employed 20 or more employees on more than 50% of its typical business days in the preceding calendar year.	<input type="checkbox"/> An employer is subject to FMLA during the calendar year if the group employed 50 or more full and/or part time employees during each of the 20 calendar weeks in the preceding calendar year, and is subject to federal TEFRA laws.	

Coverage Type:

Medical / Vision (Required) <i>Underwritten by</i> Regence BlueShield 1800 Ninth Ave. PO BOX 21267 Seattle, WA 98111-3267	<input type="checkbox"/> PPO 250 <input type="checkbox"/> PPO 250a <input type="checkbox"/> PPO 350 <input type="checkbox"/> PPO 350a <input type="checkbox"/> PPO 500 <input type="checkbox"/> PPO 750 <input type="checkbox"/> PPO 1000 <input type="checkbox"/> PPO 50/50/50 <input type="checkbox"/> PPO 50/50/50ded <input type="checkbox"/> PPO 50/50/50ded (Waived on Rx) <input type="checkbox"/> HSA Healthplan <input type="checkbox"/> Selections				
Life/AD&D (Required) Includes \$2,000 Life Coverage per spouse and \$1,000 per child <i>Underwritten by</i> Regence Life & Health PO Box 1271, MS E3A Portland, OR 97207-1271	<table style="width: 100%;"> <tr> <td style="text-align: center;">Basic Life/AD&D</td> <td style="text-align: center;">Optional Basic Life/AD&D</td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/> \$10,000</td> <td style="text-align: center;"><input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000</td> </tr> </table> <div style="border: 1px solid black; padding: 5px; text-align: center; margin-top: 5px;"> All eligible employees MUST enroll for Life Coverage even if other benefits are waived. </div>	Basic Life/AD&D	Optional Basic Life/AD&D	<input checked="" type="checkbox"/> \$10,000	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000
Basic Life/AD&D	Optional Basic Life/AD&D				
<input checked="" type="checkbox"/> \$10,000	<input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000				
Dental: (Optional) <i>Underwritten by</i> Washington Dental Service 9706 Fourth Ave NE Seattle, WA 98115	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 Orthodontia (Available to groups of 10+) <input type="checkbox"/> Yes <input type="checkbox"/> No				

Participation / Contribution Requirements	<input checked="" type="checkbox"/> Minimum 75% Employee Participation of all eligible employees (regardless of coverage elsewhere) <input checked="" type="checkbox"/> Minimum 75% Employer Contribution for Employee Medical / Dental / Vision Coverage
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Employer Contribution (Must be expressed as a Percentage)	Employee: _____ %	Dependent: _____ %
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Eligibility: <input type="checkbox"/> All employees working a minimum of _____ hours per week (not less than 20 hours per week) <input type="checkbox"/> All those employees in a specific class or classes working a minimum of _____ hours per week ▶▶▶ <input type="checkbox"/> Domestic Partners of Employees (Domestic Partners are not eligible unless this box is checked.)	If this box is checked, please specify class, such as hourly, salaried, covered or not covered by collective, etc.: _____
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Are any employees excluded from coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify: _____
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The probationary period for newly hired employees is the first of the month following or coinciding with: <input type="checkbox"/> Date of Employment <input type="checkbox"/> 3 Months' Employment <input type="checkbox"/> 1 Month Employment <input type="checkbox"/> 6 Months' Employment <input type="checkbox"/> 2 Months' Employment <input type="checkbox"/> Other _____	For employees transferring from part-time to full-time status, the probationary period specified should apply: <input type="checkbox"/> Retroactive to the original date of hire or <input type="checkbox"/> Beginning on the date transferred to full-time status
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New Groups Only The probationary period specified in the category to the left applies to (Check one box): <input type="checkbox"/> Current and Future Eligible Employees <input type="checkbox"/> Future Eligible Employees Only	New Groups Only Has your group had prior group medical coverage in the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following information. Name of prior carrier: _____ Date coverage cancelled: _____
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Signature Section:

SIGNATURE & TITLE OF EMPLOYER REPRESENTATIVE: _____	DATE: _____
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Evergreen Security Trust Subscription Agreement Language

We, the Employer subscribed below, have read and approved the Evergreen Security Trust Restated Agreement and Declaration of Trust effective August 1, 2002. In conjunction with our request for Trust participation, in consideration of granting this request, we hereby agree to be bound by the terms, conditions and provisions of said Restated Agreement and Declaration of Trust and to assume the obligations of an Employer specified therein. We accept the designated Trustee and agree to be bound by all decisions and actions of the Trustee. Specifically we agree to do the following:

1. We agree to pay the contribution amounts established by the Trustee on or before the due date each month.
2. We understand and agree that the Trustee shall have the authority to adjust the rate of contributions from time to time.
3. We further understand and agree that benefits for our employees shall not be provided by the Trust during any month for which contributions are not paid.
4. We acknowledge that in the event of contribution delinquencies the Restated Agreement and Declaration of Trust provides for payment of liquidated damages, interest, costs and attorneys fees.
5. We agree that in the event we withdraw from the Trust or terminate this Agreement, the Trust will not continue COBRA coverage for our employees or former employees on COBRA coverage from the Trust and that we, the Employer, will be responsible for such coverage as may be applicable.

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 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 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.

Broker/Agent Application

A business applying for insurance coverage through the Evergreen Security Trust may appoint their own broker or agent to represent them as noted below.

Name of Broker/Agent: _____

Name of Brokerage/Agency: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: Fax Number: _____

We hereby appoint the above named broker/agent as our firm's broker/agent of record.

This agreement will serve as notice of cancellation of any previous broker/agent 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

Title of Employer Representative