



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

MASTER APPLICATION FOR INSURANCE COVERAGE

Company Information:

Legal Name of Business:	dba (if applicable)	<input type="checkbox"/> Corporation
Employer Tax ID Number (EIN):	Requested Effective Date:	<input type="checkbox"/> Partnership
Type of Business:	SIC Code:	<input type="checkbox"/> Proprietorship
Billing Address: (street, city, state, zip)	Shipping Address: (if different)	<input type="checkbox"/> Other
Billing/Eligibility Contact:	Phone: Fax:	Email:
COBRA <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 <input type="checkbox"/> Yes <input type="checkbox"/> No Employer?	# of employees not covered by State Industrial Insurance: _____
<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.

Coverage Type:

Medical (Required) <i>Underwritten by</i> Asuris Northwest Health 1800 Ninth Ave. PO BOX 21267 Seattle, WA 98111-3267	PPO Plans: <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 Traditional 50% Plans: <input type="checkbox"/> T50/\$3,500 <input type="checkbox"/> T50/\$5,000 <input type="checkbox"/> T50/\$10,000 Traditional 50% Plans With Deductibles: <input type="checkbox"/> T50/\$2,500 <input type="checkbox"/> T50/\$2,500 (Deductible Waived on Rx) HSA Plans: <input type="checkbox"/> HSA 1500 <input type="checkbox"/> HSA 2500 <input type="checkbox"/> HSA 3500
Life/AD&D (Required) <i>Underwritten by</i> Regence Life & Health 100 SW Market Street PO Box 1271, MS E3A Portland, OR 97207-1271	Basic Life/AD&D <input type="checkbox"/> \$10,000 Includes dependent life coverage: \$2,000 for spouse and \$1,000 per child All eligible employees MUST enroll for Life Coverage even if other benefits are waived <i>Underwritten by Asuris Northwest Health</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
Vision (Optional)	Optional Life/AD&D <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000
Dental (Optional)	<i>Underwritten by Washington Dental Service 9706 Fourth Ave NE Seattle, WA 98115</i> <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

- ▶ Minimum 75% Employee Participation of all eligible employees
- ▶ Minimum 75% Employer Contribution for Employee Medical / Dental / Vision Coverage

Employer Contribution (Must be expressed as a Percentage)	Employee: _____ %	Dependent: _____ %
--	-------------------	--------------------

Eligibility:

All employees working a minimum of _____ hours per week (not less than 20 hours per week)

All those employees in a specific class or classes working a minimum of _____ hours per week **▶▶▶**

If this box is checked, please specify class, such as hourly, salaried, covered or not covered by collective, etc:

Are any employees excluded from coverage? Yes No If yes, please specify: _____

The probationary period for newly hired employees is the 1st of the month following or coinciding with:

- Date of Employment 1 Month Employment Other _____
- 2 Months Employment 3 Months Employment

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

New Groups Only:

The probationary period specified in the category to the above applies to (Check one box): <input type="checkbox"/> Current and Future Eligible Employees <input type="checkbox"/> Future Eligible Employees 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: _____
---	--

Signature Section:

SIGNATURE & TITLE OF EMPLOYER REPRESENTATIVE

DATE

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.

Insurance Producer Application

A business applying for insurance coverage through the Evergreen Security Trust may appoint their Insurance Producer to represent them as noted below.

Name of Insurance Producer: _____

Name of Agency: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: Fax Number: _____

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 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