GroupHealth

Group master application

Marketing Locations:

Seattle Sales
320 Westlake Ave. N., #100
Seattle, WA 98109
206-448-4140
1-800-542-6312
Fax: 206-877-0655

Tacoma Sales
950 Pacific Ave., #900
Tacoma, WA 98402
253-383-6226
1-800-854-5322
Fax: 253-383-7825

Central Washington Sales
1009 Center Parkway
Kennewick, WA 99336
509-783-3484
1-800-458-5450
Fax: 509-736-1910

Eastern Washington/ North Idaho Sales
5615 W Sunset Highway
Spokane, WA 99224
509-459-9100
1-800-497-2210
Fax: 509-459-1080

This is an application for (check one):

- ☐ New coverage ..... Submit this application and enrollment forms.
- ☑ Coverage renewal ..... Complete sections 1, 3, 5, and 6.
- ☐ Information change ..... If renewing coverage with changes, complete all other applicable sections. If renewing coverage with no changes, type N/C in other sections.

Select health plans:

Group Health Cooperative health plan

☑ Group Health
- ☐ with HSA
- ☐ with HRA

OR

Group Health Options, Inc. health plans

☐ Options	☐ Options Select	☐ Options PPO	☐ Alliant Plus	☐ Alliant Select
☐ with HSA	☐ with HSA	☐ with HSA	☐ with HSA	☐ with HSA
☐ with HRA	☐ with HRA	☐ with HRA	☐ with HRA	☐ with HRA

SECTION 1. GENERAL INFORMATION

Renewal date 1/1/2010 Effective date _____ Group number(s) 0026100

Firm's legal name Everett School Employee Benefit Trust

Firm's DBA (if applicable) _____

Firm's tax ID number 91-1297853

Firm's address 3715 Oakes Avenue, Everett, WA 98201

Billing address (if different than business address) P. O. Box 2098, Everett, WA 98203

Telephone number _____ Fax number 425 385 4102

How long in business? _____ S.I.C. 8211

Nature of business public school district

Name and title of CEO, president, or owner Molly Ringo, Chair

Name and title of contact person (decision maker) Randi Seaberg

Telephone number 425 385 4104 E-mail address rseaberg@everettsd.org

Name and title of billing person Vickie Loyola

Telephone number 425 385 4115 E-mail address vloyola@everettsd.org

Parent company n/a

Affiliates/subsidiaries/other office locations to be covered n/a

SECTION 2. PRODUCER CERTIFICATION

Do you have an insurance producer? Yes ☐ No ☐

I have appointed _____ as my insurance producer with respect to the coverage described in this application, effective ____ / ____ / ____

Accountable officer's signature and title _____

Producer's name _____

Producer's company name _____

Company address _____

☐ Consultant ☐ Producer ☐ Commission to be paid to _____

Telephone _____ License number _____

E-mail address rseaberg@everettsd.org

Producer/representative's social security or tax ID number _____

Certification: I certify that to the best of my knowledge the information on this application is accurate.

Producer signature _____ Date _____

SECTION 3. ELIGIBILITY

This group defines a bona fide employee as one who works a minimum of _____ hours .33 FTE or higher

☐ per month ☐ per week (check one)

Open enrollment month November Effective month January

Total number of persons employed full-time 1500

Total number of persons employed part-time 425

Total number of eligible employees in Washington state 1925

Employees will be eligible for benefits upon (select one):

☐ Date of hire ☐ First of the month following date of hire ☐ First of the month following or coincident with date of hire

☐ First of the month following: ☐ 30 days ☐ 60 days ☐ 90 days

☑ Other (please specify) see attached

Rehire policy ☐ None ☐ 3 months ☐ 6 months ☑ Other same as new employee

Other types of eligibility _____

Coverage terminates: Date of termination _____ End of month following termination _____ Other see attached

Dependents are eligible until age 25

Full-time students are eligible until age 25 (Must be a minimum of age 25)

For self-insured clients, please indicate independent age limit _____

Domestic partner coverage? ☑ Yes ☐ No

Any Medicare employees? ☑ Yes ☐ No

Are 50 percent or more family-related? ☐ Yes ☑ No

The employer agrees to make the following contribution toward the employee and dependent coverage:

Employee $ or % See below Dependents $ or % _____

Note: Continuation of coverage is available upon request in accordance with Washington State Law to employers who choose to exercise this option for their employees who become ineligible for group coverage.

Notes Contributions based on formula and lowest priced HMO and PPO3

SECTION 4. TEFRA/DEFRA/COBRA (TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1962/ CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985)

Is your company subject to COBRA? ☑ Yes ☐ No

Is your company subject to TEFRA/DEFRA? ☐ Yes ☐ No

Please note: If you have any questions regarding TEFRA or COBRA, please contact your legal counsel.

SECTION 5. ERISA-5500

Do you require a 5500 Schedule A? ☐ Yes ☑ No

What is your reporting period? _____

SECTION 6. OTHER CARRIER INFORMATION

Do you offer another medical plan to your employees? ☑ Yes ☐ No

If yes, please list the carrier name PacifiCare; self-funded plans administered by HMA

Workers' Compensation: ☑ Self-insured ☐ Department of Labor and Industries

Retrospective ☐ Yes ☐ No

SECTION 7. BENEFITS SELECTION

Please attach premium schedule(s) of rates.

SECTION 8. SIGNATURE

Applicant agrees that if the requested insurance is acceptable to the applicable Health Carrier (either Group Health Cooperative or Group Health Options, Inc.) under its current rules and practices and is legally permissible, a policy will be issued in the policy language customarily used by the Health Carrier and will be effective on the date determined by the Health Carrier. No insurance producer has the authority to guarantee that the Health Carrier will accept the application for the requested insurance and no insurance producer has the authority to contract on behalf of the Health Carrier.

Group Health Cooperative and Group Health Options, Inc. reserve the right to review 5208A Employers' Quarterly Report to confirm eligibility and participation requirements.

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.

Authorized signature Molly Lyons

Title Chair Everett School Employees Benefit Trust

Requested effective/renewal date 01 / 01 / 2010
(month / day / year)

Remarks _____

Section 3. ELIGIBILITY

Employees will be eligible for benefits upon:

Other: 1st day of the 1st calendar month following the issuance of the employee's first pay warrant as determined by the school district

Coverage terminates:

Other: End of the month for which subscriber last made contributions, if required; in accordance with procedures established by school district