MBA Health Insurance Trust Employer Participation Agreement

Return this completed form to the MBA Trust Administrator:
EPK & Associates, Inc., 15375 SE 30th Place, Suite 380 Bellevue, WA 98007
Phone: (425) 641-7762 Fax: (425) 641-8114 Email: sales@epkbenefits.com

1. GENERAL GROUP INFORMATION - Please print clearly.

Coverage Effective Date: ___________________________

Group's Legal Name	Association Membership Name	Group Number(s)
Doing Business As Name	UBI Number	TIN Number
Name to be used by Carrier ❑ Legal ❑ DBA		
Mailing Address	Physical Address, if different from Mailing Address	
City, State and Zip Code	City, State and Zip Code	
Name and Title of President, Owner or CEO	❑ Sole Proprietorship ❑ Corporation ❑ Partnership ❑ Other	
Primary Contact / Secondary Contact	Title	Date Business Started
E-mail Address	Phone Number	Fax Number
Location of Business Headquarters	Nature of Business	NAICS/SIC Code

2. EMPLOYEE ELIGIBILITY INFORMATION

A. An eligible employee, as defined in the group contract, is required to work a minimum of ____________ hours each week (this must be at least 20 hours but no more than 40 hours). Prior approval is required if you define different minimum hours for separate employee classifications.
Independent contractors, temporary and seasonal employees are not eligible. Persons whose earnings are based solely on income reported on IRS Form 1099 are not eligible. Group members who reside in the State of Hawaii are not eligible for coverage.

B. Groups may list employees in different classifications (e.g., hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. All employees must be accounted for.
Class 1: ______________________ Class 2: ______________________
Ineligible Employee Class: ___________________________ This class of employees is not eligible for coverage on this group plan.

C. Employees will be eligible for coverage on the first day of the month following the probationary period. The probationary period begins on the first working day of the month, unless otherwise specified and approved.

Class 1:	❑ 1st of month	❑ 30 days	❑ 60 days	❑ 90 days	❑ 120 days	❑ 180 days
Class 2:	❑ 1st of month	❑ 30 days	❑ 60 days	❑ 90 days	❑ 120 days	❑ 180 days

D. Do you wish to include non-state registered domestic partners for coverage? ❑ Yes ❑ No
If yes, the company must adopt an internal policy defining Domestic Partnership and a copy of the policy must be filed with EPK & Associates.

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

F. For new groups, the probationary period specified above applies to:
❑ All full-time employees (current and future) or ❑ Future full-time employees only

G. 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 rehire. The application must be received within 15 days of this effective date. Employees rehired after the designated rehire period will be subject to the company's probationary period established above. Companies may elect to include or waive the Rehire Policy.

❑ Waive Rehire Policy for all employees classes				
❑ Rehire policy is for employees in the following classes	❑ Class 1 & 2	❑ Class 1 Only	❑ Class 2 Only	❑ Other
IMPORTANT: Rehire policy requires that employees must be rehired within _______ months from the date coverage ended (maximum 6 months)				

Note: Effective September 23, 2010, the Patient Protection and Affordable Care Act (PPACA) prohibits employers from discriminating in favor of highly compensated individuals as set forth in Internal Revenue Code section 105(h) and implementing regulations. The carriers are unable to determine whether a plan discriminates in a way that violates PPACA because it does not have access to such information such as corporate structure, employee salaries, stock ownership, length of service, percentage of premiums paid by the employer, etc. Because PPACA imposes fines on employers with discriminatory plans, the carriers recommend that employers obtain tax and/or legal advice to ensure they are PPACA compliant.

3. EMPLOYEE PARTICIPATION REQUIREMENTS

A. Total number of full-time and part-time employees, not just those enrolling. (Do not include COBRA participants.) ____________

B. Less: Employees not eligible for coverage on this plan:

1. Employees working fewer than the minimum hours as indicated above - ____________
2. Employees who are not eligible by class as indicated above - ____________
3. Employees who have not completed the probationary period indicated above - ____________
   (For new groups only, enter zero (0) if you selected "future" employees in Section 2.E.)
4. Employees paid via IRS Form 1099, or are temporary, seasonal, or a substitute employee - ____________
5. Covered by Medicare as primary, at the request of the Medicare enrollee - ____________
6. Covered by Military, at the request of the Military enrollee - ____________
7. Number of employees covered on another plan. - ____________

C. Equals: Subtotal number of ineligible employees. (B1 through B7) = ____________

D. Total number of eligible employees. (A minus C) Total eligible = ____________

E. Total number of enrolled employees. Total enrolled = ____________

F. Number of employees covered by your group under the Federal provisions of COBRA. ____________

G. Employee participation percentage (E divided by D above). % Participation = ____________

4. FEDERAL MANDATES: FMLA/TEFRA/DEFRA/COBRA/OBRA (Family and Medical Leave Act/Tax Equity and Fiscal Responsibility Act of 1982/Consolidated Omnibus Budget Reconciliation Act of 1985/Omnibus Budget Reconciliation Act of 1989 & 1993)

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 it subject to FMLA? (If Yes, you are required by federal law to comply with FMLA provisions.)	☐ Yes	☐ No
Did your company employ 20 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 it subject to federal TEFRA/DEFRA laws?	All Trust Companies are subject to TEFRA/DEFRA laws.	
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 it 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 it subject to federal OBRA 1989/OBRA 1993 laws?	All Trust Companies are subject to OBRA laws.	
TEFRA/DEFRA and COBRA provisions may apply to your group even if you have fewer than 20 employees enrolled through this coverage. If you have questions regarding TEFRA/DEFRA, COBRA, or other employer laws, contact your legal counsel. ERISA Plan Year begin date 10/01/2012.		

5. PRIOR COVERAGE INFORMATION FOR NEW GROUPS

☐ If your group is renewing coverage, please check here and skip to section Section 6. (For renewing groups, the carrier has your group's prior coverage information on file.

☐ If your group is enrolling in the MBA Trust for the first time, please check here and complete this section in its entirety.

Has your group had prior group medical coverage in the last 90 days? ☐ Yes ☐ No
If Yes, complete the following information:
Name of prior medical carrier: ____________________ Date coverage began: ____________________
Date coverage canceled: ____________________

Has your group had prior group dental coverage in the last 90 days? ☐ Yes ☐ No
If Yes, complete the following information:
Name of prior dental carrier: ____________________ Date coverage began: ____________________
Date coverage canceled: ____________________

The probationary period for your prior carrier was: ____________________

To receive credit for waiting periods, please attach a copy of the last billing statement from your prior carrier. Indicate the number of months (next to his or her name) that each employee has been continuously covered (if over 3 months, show as 3+).

Please attach a copy of your most recent contract with your prior carrier and proof of any deductibles satisfied.

6. EMPLOYER CONTRIBUTION

The employer will pay the following percentages of the monthly rate. The employer must pay a minimum 75% of total employee cost.

Employer Contribution	Medical Plan %	Dental Plan %
Employer pays for Employee:	%	%
Employer pays for Dependents:	%	%

7. EMPLOYER PLAN SELECTION

- Plan changes are allowed only during the annual MBA Open Enrollment period.
- Companies with 2-9 enrolled employees may select one MBA Medical Plan.
- Companies with 10 or more enrolled employees may select two MBA Medical Plans (some restrictions apply).

A. Regence BlueShield Preferred Medical Plans — Underwritten by Regence BlueShield, 1800 Ninth Avenue, Seattle, WA 98101

HSA Plans	❑ HSA H10	❑ HSA H20	❑ HSA H30	❑ HSA H50	
Foundation Plans	❑ Foundation F40	❑ Foundation F50	❑ Foundation F60	❑ Foundation F70	❑ Foundation F80
Foundation "Plus" Plans	❑ Foundation F45	❑ Foundation F55	❑ Foundation F65	❑ Foundation F75	❑ Foundation F85
Market Plans	❑ Market M10	❑ Market M20	❑ Market M30	❑ Market M40	❑ Market M50
	❑ Market M60	❑ Market M70	❑ Market M80		
Market "Plus" Plans	❑ Market M15	❑ Market M25	❑ Market M35	❑ Market M45	❑ Market M55
	❑ Market M65	❑ Market M75	❑ Market M85		
Enhanced Plans	❑ Enhanced E10	❑ Enhanced E20	❑ Enhanced E30	❑ Enhanced E40	❑ Enhanced E50
	❑ Enhanced E60	❑ Enhanced E70	❑ Enhanced E80		
Pinnacle Plans	❑ Pinnacle P5	❑ Pinnacle P12			

B. Group Health Alliant Plus Medical Plans — Underwritten by Group Health Options, Inc, 320 Westlake Ave, N # 100, Seattle, WA 98109

❑ Plan G12	❑ Plan G22	❑ Plan G32	❑ Plan G42

C. Basic Life - AD&D Amount (employee only) — Underwritten by LifeMap Assurance Company, 100 SW Market Street, Portland, OR 97207

❑ $15,000 (Cost Included)	❑ $30,000 ($2.85/EE/Mo)	❑ $50,000 ($6.65/EE/Mo - 2+ EE's)	❑ $75,000 ($11.40/EE/Mo - 10+ EE's)
❑ $100,000 ($16.15/EE/Mo - 10+ EE's)	❑ Other $________________________		
❑ Yes Do you want to allow employees to individually purchase Additional "Term" Life coverage through payroll deduction?			

D. Employee Assistance Program — Underwritten by Magellan Health Services, 14100 Magellan Plaza, Maryland Heights, MO 63043

❑Yes

E. Regence BlueShield Dental & Vision Plans — Underwritten by Regence BlueShield, 1800 Ninth Avenue, Seattle, WA 98101

❑ Dental D10	❑ Dental D20	❑ Dental D30	❑ Dental D40
❑ Vision V10	❑ Vision V20	❑ Vision V30	

Notes:
- Dental Plan D10 requires 20+ employees; Dental Plans D20 requires 4+ employees; and Dental Plans D30 & D40 require 2+ employees
- If cancelled, dental and/or vision cannot be added until the Open Enrollment Period following 12-months after the date of cancellation.

8. MBA Health Insurance Trust Monthly Payment Requirements

Detailed monthly billing statements for the next month's premium are sent out to all companies before the end of each month. The Trust's "Contractual" PAYMENT DUE DATE is the first day of the billed month.

In order to maintain CURRENT ELIGIBILITY for employees, full payment must be received by the Trust on or before the 1st day of the billed month. A company's eligibility for the month will be DELINQUENT if full payment is not received by the 1st. DELINQUENT ELIGIBILITY STATUS results in claim payment delays and other difficulties involving employees, their medical providers and carriers.

If full payment for the month is not received within 30 days of the PAYMENT DUE DATE, company will be RETROACTIVELY CANCELLED back to the last day of the month in which full monthly payment was received. Partial payments will be refunded.

Payments returned to EPK & Associates (for non-sufficient funds, stop payment etc.) must be replaced with guaranteed funds (i.e. Cashier's check, money order, cash) before the expiration of the 30-day grace period. A $20 fee will be assessed on all returned drafts.

9. MBA Health Insurance Trust Eligibility and Participation Requirements

A. Company must be actively engaged in an income generating business licensed in the state of Washington.

B. Company must be a current, active member of an endorsing association or organization authorized by the MBA to participate in the Trust. Membership Dues and Access Fees (if applicable) must be maintained each year to continue participation in the Trust.

C. Company MUST satisfy the Trust's minimum "employee/subscriber participation" requirements:

- Companies of 2–5 eligible full-time employees: 100% participation is required (excluding Approved Waivers).
- Companies of 6 or more eligible full-time employees: 80% participation (excluding Approved Waivers).

Definition: Eligible employees are active employees or owners who satisfy the company's "full-time" employment definition and have met your company's insurance probationary period established in Section 2 of this form. For purposes of the program, MBA insurance carriers define an employee as meeting the following criteria:

1. They must be remunerated on a regular, periodic basis through the company's payroll; **AND**
2. They must appear on the company's quarterly report of wages filed with the State Employment Security Department.

D. Employees not enrolled when initially eligible may be denied coverage until the next MBA Open Enrollment period.

E. Dependent participation is optional. Companies may require employees to pay for the cost of dependent coverage through payroll deductions. Dependents not enrolled when initially eligible, may be required to wait until the next MBA Open Enrollment period to enroll (see benefit booklet for details).

F. Examples of INELIGIBLE participants include the following: Retirees, subcontractors, independent contractors, inactive owners, former employees, former owners, part-time employees. Eligible employees must have a direct, employee-employer relationship with the participating company.

G. Eligibility requirements must be administered to all employees on a uniform and consistent basis. Participating companies are subject to periodic eligibility verification audits by the insurance carriers to ensure eligibility compliance.

H. Cancelled companies or companies leaving the Trust will not be eligible to reapply for participation in the Trust Program for 24-months.

I. I understand that Regence BlueShield and Group Health Options, Inc will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Member Firm after untrue, incorrect or incomplete information is found to have been provided, and if as a result of correcting false information the Member Firm no longer qualifies for the Rate quoted, I understand that Regence BlueShield and Group Health Options, Inc will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Member Firm will be required to pay the Rate adjustment within 30 days of the notice by the issuer.

Booklet Distribution: To be more environmentally conscious, we will provide one paper copy of the Regence booklet(s) describing your plan(s) benefits. Please inform your employees that they can access the booklet electronically at myRegence.com. Or, if preferred, you can contact EPK & Associates, Inc, to order additional paper copies for distribution. Employees may also request a paper copy by contacting customer service. Group Health participants will receive booklets directly from the carrier.

10. ACCOUNTABLE OFFICER'S CERTIFICATION

If the MBA Trust carriers provide applications and/or change forms, or any benefit summaries, comparison sheets, and/or group contracts or member brochures in an electronic medium for inclusion on the Member Firm's internal intranet or by similar means, the group agrees that: 1) electronic access shall be limited to the Member Firm's applying employees and covered employees and be restricted to a 'read-only' or similar basis; 2) the Member Firm will make timely modifications to the electronically available forms corresponding to any substantive modifications that the MBA Trust carriers make to the hard-copies of our forms; 3) the hard-copy documents on file with the MBA Trust carriers shall control in the event of any discrepancy; and 4) the Member Firm remains solely responsible for the content of the documents and all other legal requirements pertaining to them (e.g. distribution).

I have provided these answers as part of the application procedure required by Regence BlueShield and Group Health Options, Inc to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield and Group Health Options, Inc will rely on each answer in making coverage and rating determinations. If Regence BlueShield and Group Health Options, Inc 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 Regence BlueShield and Group Health Options, Inc 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 Regence BlueShield and Group Health Options, Inc. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the insurer. Penalties include imprisonment, fines, and denial of insurance benefits. In addition, Regence BlueShield and Group Health Options, Inc will have the right to collect any claims payment or other damages.

X______________________________ ______________________________ __________

Accountable Officer's Signature Title Date