

# Employer Application

For groups of 2 to 50 employees

Coverage provided by Group Health Cooperative or Group Health Options, Inc.

## COMPANY INFORMATION

Company name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Doing business as \_\_\_\_\_

Type of business \_\_\_\_\_

In business since \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_ Tax ID # \_\_\_\_\_ SIC # \_\_\_\_\_

Is business a branch office?  yes  no Or subsidiary?  yes  no

In which city and state is your company headquartered? City \_\_\_\_\_ State \_\_\_\_\_

Has your firm ever been covered in the past by a plan offered by Group Health Cooperative or Group Health Options, Inc.?  
 yes  no If so, under what name? \_\_\_\_\_ Date last covered \_\_\_\_\_

Are you replacing existing group coverage?  yes  no If yes, attach a copy of your last premium bill to show proof of prior coverage. How long has your group been covered by this carrier? \_\_\_\_\_

## CONTACT INFORMATION

Main contact name \_\_\_\_\_ Title \_\_\_\_\_

Company name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

E-mail \_\_\_\_\_

Who should receive billing statements (if different from above)? Name \_\_\_\_\_

Title \_\_\_\_\_ Company \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**We look forward to serving you for years to come.**

Internal use only

Plan \_\_\_\_\_ Group number \_\_\_\_\_

Effective date \_\_\_\_\_ Sales executive \_\_\_\_\_

## REQUIRED ENROLLMENT INFORMATION

1. A small group is defined as a business with 2-50 employees, as defined under RCW 48.43.005(10) and (24). How many employees in total do you have, including out-of-state employees? \_\_\_\_\_
2. Of these employees, how many are enrolling? \_\_\_\_\_ Or waiving coverage? \_\_\_\_\_
3. Hours per week employees must work to be eligible for benefits? \_\_\_\_\_
4. Do you have any terminated employees on COBRA benefits now?  yes  no  
Employers with 20 or more full-time equivalent employees at least 50 percent of the year in the past calendar year are required by federal regulations to offer COBRA benefits to terminated employees.  
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:  30 days  60 days  90 days  6 months  
 Other: \_\_\_\_\_
5. Do you include domestic partners of employees as eligible dependents?  yes  no
6. How many active employees are eligible for Medicare coverage? \_\_\_\_\_ Please call us if you have Medicare eligible employees. We must send you additional forms for them to fill out.
7. Employers must pay a minimum 70 percent of the employee coverage to qualify for group insurance.  
The Employer agrees to make the following contribution toward the employee and dependent coverage:  
Employees \_\_\_\_\_ % Dependents \_\_\_\_\_ %

### Follow these 4 easy steps to apply:

## 1. SELECT ONE HEALTH PLAN

### Group Health

Offered by Group Health Cooperative.  
Features the Group Health provider network.

- Welcome 200 – '09
- Welcome 500 – '09
- Welcome 1000 – '09
- Welcome 2000 – '09
- Balance 200 – '09
- Balance 500 – '09
- Balance 1000 – '09
- Compass 500/80% – '09
- Compass 1000/80% – '09
- Compass 0/50% – '09

### Options

Offered by Group Health Options, Inc.  
Features the Group Health provider network plus the option to see any other provider at a higher cost share.

- Welcome 200 – '09
- Welcome 500 – '09
- Welcome 1000 – '09
- Welcome 2000 – '09
- Balance 200 – '09
- Balance 500 – '09
- Balance 1000 – '09
- Compass 500/80% – '09
- Compass 1000/80% – '09
- Compass 0/50% – '09

### Alliant Plus

Offered by Group Health Options, Inc.  
Features the Group Health, Virginia Mason, and the Everett Clinic provider networks, plus the option to see any other provider at a higher cost share.

- Welcome 200 – '09
- Welcome 500 – '09
- Welcome 1000 – '09
- Welcome 2000 – '09
- Balance 200 – '09
- Balance 500 – '09
- Balance 1000 – '09
- Compass 500/80% – '09
- Compass 1000/80% – '09
- Compass 0/50% – '09

### HealthPays® Health Savings Account (HSA) qualified plans:

- 1250 Individual/2500 Family – '09
- 1500 Individual/3000 Family – '09
- 2500 Individual/5000 Family – '09
- 1250 Individual/2500 Family – '09
- 1500 Individual/3000 Family – '09
- 2500 Individual/5000 Family – '09
- 1250 Individual/2500 Family – '09
- 1500 Individual/3000 Family – '09
- 2500 Individual/5000 Family – '09

## 2. SELECT ONE VISION HARDWARE BENEFIT

If you chose the Compass 0/50% plan or an HSA plan, you cannot select a vision benefit.

- None
- \$150 24-month hardware benefit
- \$250 24-month hardware benefit

### 3. SELECT ONE DENTAL BENEFIT

The dental benefit is provided by Delta Dental/Washington Dental Service. If a dental plan is selected, all members (including dependents) enrolling in a medical plan will also be enrolled in the dental plan.

- None
- Commercial Group Dental Plan
- Commercial Group Dental Plan With Temporomandibular Joint (TMJ) Rider

### 4. SELECT COVERAGE EFFECTIVE DATE

Month \_\_\_\_\_  1st or  15th

### PRINCIPAL OWNERS OR CORPORATE OFFICERS

---

**Full legal name**

**Title**

---

**Full legal name**

**Title**

#### Principal/corporate officer certification

I certify that the information on this application is complete and accurate. I understand that if false information has been submitted, Group Health Cooperative or Group Health Options, Inc. will have the right to cancel the contract to the extent allowable under applicable federal and state law. Group Health Cooperative and Group Health Options, Inc. reserve the right to pursue all civil remedies allowable under federal and state law for the collection of claims, losses, or other damages. It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

---

**Principal/corporate officer's signature**

**Title**

**Date**

---

**Principal/corporate officer's signature**

**Title**

**Date**

### APPOINTMENT OF PRODUCER (BROKER/AGENT)

Please complete this section if you have an insurance Producer representing your company.

Mail group contract to:  Producer  Group  Both

#### Appointment of Producer of Record

I hereby appoint \_\_\_\_\_ (Producer) with \_\_\_\_\_ (Agency), as a Producer of Record, effective \_\_\_\_\_, for purposes of arranging and servicing health care coverage with Group Health Cooperative or Group Health Options, Inc. for the firm's employees and dependents.

This appointment rescinds all previous appointments and continues in effect until termination by either party in writing. Producer may make requests concerning rates, benefits, eligibility requirements, and other matters relating to our companies' coverage. The firm understands that commissions due to the Producer for services provided pursuant to the appointment are governed by an agreement between the Producer and the health plan.

If you are a Producer who completed this application on behalf of a client, please indicate by signing here.

---

**Producer signature**

**Phone number**

---

**Name of Producer (please print)**

**Fax number**

---

**Address**

**E-mail**

---

**SS or Tax ID number**

**License number**

## APPLICATION CHECKLIST

- Signed employer application
- A copy of employer's license to do business in Washington state
- Signed enrollment form for each employee wanting coverage
- Waiver form for each eligible employee declining coverage
- First month's premium to be paid by business check
- A copy of the last premium bill from the prior medical plan carrier, if applicable
- If you have employees eligible for Medicare, please call us; there are additional forms these employees must complete to meet regulatory requirements.
- For groups of 2–3 subscribers, the group must show proof of being a business by submitting the appropriate tax documentation forms as listed here:

|                                 |   |
|---------------------------------|---|
| <b>Sole Proprietor</b>          | 1040 and Schedule C (first and second page of 1040 including signature by the taxpayer) |
| <b>Farmer</b>                   | 1040 and Schedule F (first and second page of 1040 including signature by the taxpayer) |
| <b>Corporation</b>              | 1120 (first four pages with preparer's or owner's signature)                            |
| <b>Subchapter S Corporation</b> | 1120S (first four pages with preparer's or owner's signature)                           |
| <b>Partnership</b>              | 1065 (first four pages with preparer's or owner's signature)                            |
| <b>Nonprofit</b>                | 990   |
| <b>Religious Organizations</b>  | Tax forms not required  |

## SEND THE MATERIALS TO THE MARKETING OFFICE NEAREST TO YOU

### Western Washington

**Group Health Cooperative  
Small Business Group  
320 Westlake Ave. N Suite 100  
Seattle, WA 98109-5233  
206-448-4140 or 1-800-542-6312**

### Eastern Washington

**Group Health Cooperative  
Small Business Group  
5615 W. Sunset Highway  
Spokane, WA 99224  
509-459-9100 or 1-800-497-2210**

1. Materials must be received by the **20th of the month** for coverage to be effective on the **first of the following month**. Materials must be received by the **5th of the month** for coverage to be effective on the **15th of the month**. Incomplete or inaccurate information will delay the effective date of coverage.
2. If you have questions about this application process, please call your agent or call us at one of the numbers above and we will be happy to help you.

NOTE: You must meet the underwriting guidelines for small groups in order to qualify for coverage. Continuation of coverage is available upon request in accordance with Washington state law for employees and their dependents who choose to exercise this option when they become ineligible for group coverage.