



## Broker Administrative Guide

**Willis**

**General Agent**

Willis of Oregon, Inc.  
222 SW Columbia Street, Suite 600  
Portland OR, 97201  
Phone: (866) 873-6175 Fax: (503) 459-4555



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# Letter from the General Agent

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Dear Appointed Pacific Health Trust Broker,

We would like to thank you for your continued support and partnership with Pacific Health Trust. The Trust values your contributions and efforts in creating a strong, healthy association plan that serves PHT members in their group benefits needs.

As the Trust's General Agent, we are working very closely with the Trust's Board of Trustees, third party administrators, and carrier partners to create efficiencies, improve communication, and control premium costs. Changes and improvements have already begun to be implemented and will continue for the future.

One of the projects we have undertaken recently has been to analyze each quote we release, comparative to that specific groups current (or renewal) rates and plan structures. We pass this information along to the carriers who use the information to make sure their plans and rates are in-line with the marketplace. Any competitive data we receive from you is a vital flow of information that provides the Trust with opportunities to enrich and enhance the Pacific Health Trust's value to all the enrolled members.

In addition, we will be working closely with appointed agencies over the next year to do broker reviews, training, and continued RFP analysis. If you have any questions about the process or suggestions about how we can make the association better, please call us. We have an open door policy and believe new ideas help create opportunity.

This packet is designed to assist you in the submission process for RFPs, new group sales and the renewal process. All of the documents included in this packet are available on the website at <http://www.pacifichealthtrust.com> and will be updated on the website as necessary. In addition, all of our current and prior year plan documents can be found here. Broker specific forms for renewals and RFP submissions can be found at <http://www.pacifichealthtrust.com/broker.htm>. Benefit summaries and carrier specific information can be found at: <http://www.pacifichealthtrust.com/Admin.htm>.

We are here to serve your needs. Please call us at any time with any questions or concerns. We look forward to working with you and a busy 2012!

Thank you,

**Willis**

**General Agent**

Willis of Oregon, Inc.

222 SW Columbia Street, Suite 600

Portland OR, 97201

Phone: (866) 873-6175 Fax: (503) 459-4555

## Contact Information for Brokers

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Do you have questions about **RFP, New or Renewal Group Submissions, Prospecting, Rate Negotiation or General Association Administration?** Contact the General Agent!

Willis of Oregon, Inc.  
222 SW Columbia Street, Suite 600  
Portland, OR 97201  
Phone: (866) 873-6175  
Fax: (503) 459-4555 or (866) 999-3485

Team Contact Information:

Cindy Barnes:	(503) 459-4583	<a href="mailto:cindy.barnes@willis.com">cindy.barnes@willis.com</a>
Susan Taylor:	(971) 255-5359	<a href="mailto:susan.taylor@willis.com">susan.taylor@willis.com</a>
Wendy Esther:	(503) 459-4562	<a href="mailto:wendy.esther@willis.com">wendy.esther@willis.com</a>

Do you have questions about **Billing, Eligibility, Enrollment, Cobra, Dollar Bank or CDHP administration?** Contact your dedicated AGC Service Center!

Benefit Solutions, Inc. (BSI)  
PO Box 6  
12121 Harbour Reach Drive, Suite 105  
Mukilteo, WA 98275  
Phone: (877) 694-8291  
Fax: (866) 867-2752  
E-mail: [pht@bsitpa.com](mailto:pht@bsitpa.com)

# Contact Information for Brokers

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Do you have questions about **Benefits or Claims?** Contact the carrier!

## Heath Net of Oregon

for *Members*: (888) 802-7001

for group administrators or Agents\*

Phone: (800) 547-2967

E-mail: [HN\\_Account\\_Services@healthnet.com](mailto:HN_Account_Services@healthnet.com)

\*This phone number and e-mail are exclusively for group administrators and agents. This unit can answer claims and benefits questions. If applicable, please have the member ID number, member name and dates of services handy when calling.

Website: [www.healthnet.com](http://www.healthnet.com)

## Guardian Life Insurance Company

Dental Claims

Phone: (800) 541-7846

Fax: (509) 465-3404

Website: [www.guardiananytime.com](http://www.guardiananytime.com)

## Vision Service Plan

Phone: (800) 877-7195

Website: [www.vsp.com](http://www.vsp.com)

## Lifewise Assurance

Phone: (800) 258-0394

E-mail: [customer.service@lifewiseac.com](mailto:customer.service@lifewiseac.com)

Website: [www.lifewiseac.com](http://www.lifewiseac.com)

## LifeBalance

Phone: (800) 754-5433 or (503) 234-1375

Website: [www.lifebalanceprogram.com](http://www.lifebalanceprogram.com)

## Resources for Living

Phone: (800) 223-3541

Website: [www.rfl.com](http://www.rfl.com)

# RFP Submission

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In order to process a Request for Proposal for Pacific Health Trust, the following items are required:

- Group Quote Request Form\* (*Appendix 3*)
- A group census\* in Excel format (*Appendix 4*)
- Group Health Questionnaire (*Appendix 5*)
- Individual Health Questionnaires\*\* (*Appendix 6*)

\*Included in this packet is the Pacific Health Trust *preferred* group quote request form and group census.

\*\*Individual Health Questionnaires are only required to receive FINAL rates. Pacific Health Trust will issue a proposal with PRELIMINARY rates if Individual Health Questionnaires are not received at the time of quoting.

Pacific Health Trust is an open-SIC MEWA servicing the entire state of Washington. Please see the underwriting guidelines (*Appendix 1*) for specific information on group eligibility for Pacific Health Trust. Also provided within this booklet, you will find a Preferred SIC Code list for your reference (*Appendix 2*). The list includes *generally* preferred industries by the underwriting medical carrier. These industries receive discounted rating during the underwriting process.

For questions regarding RFP Submission, please contact the Trust's General Agent:

Willis of Oregon, Inc.  
222 SW Columbia Street, Suite 600  
Portland, OR 97201  
Phone: (866) 873-6175  
Fax: (503) 459-4555 or (866) 999-3485  
E-mail: [quote@pacifichealthtrust.com](mailto:quote@pacifichealthtrust.com)

# New Group Submission

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In order to process a New Group submission for Pacific Health Trust, the following items are required at the time of submission:

- Master Application, completed and signed (*Appendix 8*)
- PHT Joinder Agreement, signed (*Appendix 7*)
- EFT form, completed and voided check attached (*Appendix 11*) – If the group is paying by EFT, PHT does not require a binder check at the time of submission.
  - If the group is electing to pay by check... PHT assesses a monthly admin fee of 2% of total premium to check payers. If a group is paying by check, **a binder check for the first month's premium is due with the group's submission.** Binder checks can be made payable and mailed to:  

Pacific Health Trust  
c/o Benefit Solutions Inc  
PO Box 6  
Mukilteo, WA 98275
- Form 5208A/B and/or ownership documents (for groups of 2-5 employees only)
- Copy of sold proposal
- Individual Health Risk Questionnaire, completed and signed by the employee(s) (*Appendix 6*)
- Employee Enrollment Forms, completed and signed by the employee(s) (*Appendix 10*)
- COBRA Administrative Agreement (if applicable) (*Appendix 13*)
- CDHP Group and Employee Enrollment Forms (if applicable) (*Appendix 14 and 15*)
- Late Submission Application/Letter (if submitting after the 20<sup>th</sup> of the month) (*Appendix 12*)
- Authorization for Disclosure of R Numbers (if you want R #'s released to you)

In addition, the following items are required; however they are not required at the time of submission.

- Deductible Credit forms (if applicable) – For groups that qualify for deductible credit, you will need to provide a deductible credit report from the prior carrier. If a deductible credit report is unavailable, members may submit EOB's directly to Health Net at the time of the claim.

New Group Submission Deadline is the **20<sup>th</sup> of the month** preceding the group's sold effective date. New group materials can be submitted electronically to the email address below.

For questions regarding New Group Submission, please contact the Trust's General Agent:

Willis of Oregon, Inc.  
222 SW Columbia Street, Suite 600  
Portland, OR 97201  
Phone: (866) 873-6175  
Fax: (503) 459-4555 or (866) 999-3485  
E-mail: [service@pacifichealthtrust.com](mailto:service@pacifichealthtrust.com)

# Renewal Group Submission

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In order to process a Renewal Group submission for Pacific Health Trust, the following items are required:

- Renewal Application, completed and signed (*Appendix 9*)
- COBRA Administrative Agreement (if applicable) (*Appendix 13*)
- CDHP Group Enrollment Form (if applicable) (*Appendix 14*)
- CDHP Employee Enrollment Forms (if applicable) (*Appendix 15*)

**~ ALL OF THE ABOVE ITEMS ARE REQUIRED AT THE TIME OF SUBMISSION ~**

**Pacific Health Trust will be unable to accept a renewal submission without all of the above items.**

The renewal submission deadline is the **20<sup>th</sup> of the month** preceding the group's renewal effective date.

For questions regarding Renewal Group Submission, please contact the Trust's General Agent:

Willis of Oregon, Inc.  
222 SW Columbia Street, Suite 600  
Portland, OR 97201  
Phone: (866) 873-6175  
Fax: (503) 459-4555 or (866) 999-3485  
E-mail: [service@pacifichealthtrust.com](mailto:service@pacifichealthtrust.com)



**Pacific Health Trust Underwriting Guidelines – Page 1**

Plans Underwritten by Health Net Health Plan of Oregon, Guardian, Vision Service Plan and LifeWise Assurance  
Contract Period: August 1, 2011 through July 31, 2012

<b>Group Eligibility:</b>	<ul style="list-style-type: none"> <li>Group must be a member of PHT and have a minimum of 2 enrolled employees (employees working at least 20 hours/week).</li> <li>Retirees are not eligible.</li> <li>Group must be headquartered in Washington and have been in business for 60 days.</li> </ul>
<b>Minimum Contribution and Participation:</b>	<ul style="list-style-type: none"> <li>Employer must contribute at least 50% toward the cost of employee coverage. At least 75% of eligible employees must enroll.</li> <li>Employees with other group coverage will not be counted against participation as long as that coverage is through a spouse, registered domestic partner, another employer, Medicare, Medicaid CHAMPUS, Indian Health Services or the Oregon Health Plan.</li> </ul>
<b>Multiple Plan Choice:</b>	<ul style="list-style-type: none"> <li>Groups with 6 or more enrolling employees may offer as many plans as the association offers, with no load impact for multiple plan offerings.</li> </ul>
<b>Probationary Period:</b>	<ul style="list-style-type: none"> <li>Newly Eligible Employees: First day of the month following 0, 30, 60, 90, or 180 days from date of hire.</li> <li>Newly Eligible Hour Bank Employees: First of the month following 130, 260 or 390 hours.</li> </ul>
<b>Out of Area Employees</b>	<ul style="list-style-type: none"> <li>A maximum of 49% of the total enrolling eligible population may be out of state/out of area.</li> </ul>
<b>RFP Restriction:</b>	<ul style="list-style-type: none"> <li>1099 employees are not eligible for coverage.</li> </ul>
<b>Product Enrollment:</b>	<ul style="list-style-type: none"> <li>RX, Vision and Domestic Partner require medical enrollment. COBRA requires medical and/or dental enrollment.</li> </ul>
<b>Remittance:</b>	<ul style="list-style-type: none"> <li>All quoted rates assume remittance via EFT. <b>Check payments require 2% administrative fee.</b></li> </ul>
<b>Renewal:</b>	<ul style="list-style-type: none"> <li>Association Anniversary date is August 1.</li> </ul>
<b>Rolling Renewal:</b>	<ul style="list-style-type: none"> <li>12-month contracts begin on each group's effective date.</li> </ul>
<b>Open Enrollment:</b>	<ul style="list-style-type: none"> <li>The month prior to each group's anniversary.</li> </ul>
<b>Dependents:</b>	<ul style="list-style-type: none"> <li>Dependents are covered to age 26.</li> </ul>
<b>Late Enrollees:</b>	<ul style="list-style-type: none"> <li>Late enrollees may enroll at open enrollment only, unless they have a qualifying event.</li> </ul>
<b>Current HN Groups</b>	<ul style="list-style-type: none"> <li>Groups currently enrolled directly with HN Oregon may only enroll under the Association at the August 1<sup>st</sup> annual group enrollment period. <b>Note: The current Agent of Record for a Health Net group may request an Association quote at the group's renewal if the Agent is also appointed with the Association.</b></li> </ul>
<b>COBRA:</b>	<ul style="list-style-type: none"> <li>COBRA provisions apply based on group size and location, according to federal law.</li> </ul>
<b>Carve Outs:</b>	<ul style="list-style-type: none"> <li>Not eligible</li> </ul>
<b>Domestic Partners:</b>	<ul style="list-style-type: none"> <li>Coverage available at no additional charge, however, coverage must be elected by group.</li> </ul>
<b>Medical Riders:</b>	<ul style="list-style-type: none"> <li>Groups may choose one Rx and / or Well Net rider to attach to the medical plan(s)</li> </ul>
<b>Pre-Existing Waiting:</b>	<ul style="list-style-type: none"> <li>Employer groups and newly eligible employees or dependents will be subject to Pre-Existing Condition Exclusion. Credit will be provided in accordance with State and Federal requirements.</li> </ul>
<b>Funding Deductibles:</b>	<ul style="list-style-type: none"> <li>Benefit plans may be combined with any form of self funding or insuring the deductible subject to Underwriting approval.</li> </ul>
<b>24 Hour Coverage:</b>	<ul style="list-style-type: none"> <li>For Owners/officers excluded from Workers Compensation is included in the medical plan. The owners first and last name must be listed on the Master Application for 24 hour coverage to be in effect.</li> </ul>
<b>Final Rates:</b>	<ul style="list-style-type: none"> <li>All rates are based on final enrollment and subject to underwriting approval.</li> </ul>



**Pacific Health Trust Underwriting Guidelines – Page 2**

Plans Underwritten by Health Net Health Plan of Oregon, Guardian, Vision Service Plan and LifeWise Assurance  
 Contract Period: August 1, 2011 through July 31, 2012

<b>Case Submission</b>	<ul style="list-style-type: none"> <li>All new groups requesting coverage must be submitted by the 20<sup>th</sup> of the month prior to the month coverage is to be effective. Any case submitted after the 20<sup>th</sup> must be accompanied by a late submission letter.</li> </ul>
<b>Health Statement</b>	<ul style="list-style-type: none"> <li>Individual Health Statements are required.</li> </ul>
<b>Underwriting:</b>	<ul style="list-style-type: none"> <li>If any of the Underwriting Guidelines are not met, coverage will be declined.</li> </ul>
<b>New Group Paperwork</b>	<ul style="list-style-type: none"> <li>Groups of 2-5 enrolled subscribers are required to submit a Form 5208A/B and/or Ownership documents to establish the employer-employee relationship. Note: A Form 5208 A/B is required for those groups who have been in business long enough to have a Form 5208A/B. Those groups who have not been in business long enough to have a Form 5208 A/B may submit 2 weeks of payroll. Ownership documents must be submitted for owners not appearing on the payroll/Form 5208 A/B.</li> </ul>

Pacific Health Trust

Health Net of Oregon - Preferred Industries					
SIC	Description	SIC	Description	SIC	Description
110	CASH GRAINS	2390	MISC FABRICATED TEXTILE PROD	5210	RETAIL LUMBER,BLDG MATL DEALER
130	AGRICULTURE-FIELD CROPS	2410	LOGGING	5230	RETAIL PAINT,GLASS,WALLPAPER
160	VEGETABLES & MELONS	2420	SAWMILLS & PLANING MILLS	5250	RETAIL HARDWARE STORES
170	FRUITS AND TREE NUTS	2710	NEWSPAPERS: PUBLISH &/OR PRINT	5260	RETAIL NURERY,LAWN,GARDEN SUP
180	HORTICULTURE SPECIALTIES	2720	PERIODICALS:PUBLISH &/OR PRINT	5310	RETAIL DEPARTMENT STORES
190	GENERAL FARMS, PRIMARILY CROPS	2730	BOOKS	5330	RETAIL VARIETY STORES
210	LIVESTOCK,EXCEPT DAIRY,POULTRY	2740	MISC PUBLISHING	5390	RETAIL MISC GEN MERCHANDISE
240	DAIRY FARMS	2750	COMMERCIAL PRINTING	5410	RETAIL GROCERY STORES
250	POULTRY AND EGGS	2760	MANIFOLD BUSINESS FORMS	5420	RETAIL MEAT & SEAFOOD MARKETS
270	ANIMAL SPECIALTIES	2770	GREETING CARDS	5430	RETAIL FRUIT & VEGETABLE MARKE
290	GENERAL FARMS,PRIM. LIVESTOCK	2780	BLANKBKS,LOOSELEAF,BOOKBINDING	5440	RETAIL CANDY,NUT,CONFECTIONARY
710	SOIL PREPARATION SERVICES	2790	SERV INDUS FOR PRINTING TRADE	5450	RETAIL DAIRY PRODUCTS STORE
720	CROP SERVICES	3210	FLAT GLASS	5460	RETAIL BAKERIES
740	VETERINARY SERVICES	3220	GLASS&GLASSWARE,PRESSED,BLOWN	5490	RETAIL MISC FOOD STORES
750	ANIMAL SERVICES,EXC VETERINARY	3230	GLASS PROD FROM PURCHASED GLAS	5610	RETAIL MEN/BOY CLOTHING, ACCES
760	FARM LABOR, MANAGEMENT SERV	3240	CEMENT, HYDRAULIC	5620	RETAIL WOMENS CLOTHING STORES
780	LANDSCAPE & HORTICULTURAL SERV	3250	STRUCTURAL CLAY PRODUCTS	5630	RETAIL WOMENS ACCES/SPECIALTY
810	TIMBER TRACTS	3260	POTTERY & RELATED PRODUCTS	5640	RETAIL CHILDREN & INFANT WEAR
830	FOREST NURSERY,GATHER PRODUCTS	3270	CONCRETE,GYPSUM & PLASTER PROD	5650	RETAIL FAMILY CLOTHING STORES
850	FORESTRY SERVICES	3280	CUT STONE & STONE PRODUCTS	5660	RETAIL SHOE STORES
910	COMMERCIAL FISHING	3290	ABRASIVE,ASBESTOS,MINERAL PROD	5690	RETAIL MISC APPAREL,ACCESSORY
920	FISH HATCHERIES AND PRESERVES	3550	SPECIAL INDUSTRY MACHINERY	6010	CENTRAL RES DEP INSTITUTIONS
970	HUNTING,TRAPPING,GAME PROPAGA.	3560	GEN INDUSTRIAL MACHINERY &EQPT	6020	COMMERCIAL BANKS
1310	CRUDE PETROLEUM & NATURAL GAS	3610	ELEC TRANSMISSION & DIST EQPT	6030	SAVINGS INSTITUTIONS
1320	NATURAL GAS LIQUIDS	3620	ELECTRIC INDUSTRIAL APPARATUS	6060	CREDIT UNIONS
1381	DRILLING OIL & GAS WELLS	3630	HOUSEHOLD APPLIANCES	6080	FOREIGN BANKING/BRANCHES
1382	OIL & GAS EXPLORATION SERVICES	3640	ELECTRIC LIGHTING &WIRING EQPT	6090	FUNCTIONS REL TO DEP BANKING
1389	OIL & GAS FIELD SERVICES,NEC	3650	HOUSEHOLD AUDIO/VISUAL EQPT	6110	FED&FED SPONSORED CRED AGENCY
2020	DAIRY PRODUCTS	3660	COMMUNICATIONS EQUIPMENT	6140	PERSONAL CREDIT INSTITUTIONS
2030	CANNED,FROZEN,PRESERVED FOODS	3670	ELECTRONIC COMPONENTS & ACCESS	6150	BUSINESS CREDIT INSTITUTIONS
2040	GRAIN MILL PRODUCTS	3690	MISC ELEC MACH,EQPT & SUPPLIES	6160	MORTGAGE BANKERS & BROKERS
2050	BAKERY PRODUCTS	3710	MOTOR VEHICLES & MOTOR VEH EQP	6210	SECURITY BROKERS, DEALERS
2060	SUGAR & CONFECTIONERY PRODUCTS	3720	AIRCRAFT & PARTS	6220	COMMODITY CONTRACTS BROKERS
2070	FATS & OILS	3730	SHIP & BOAT BLDG & REPAIRING	6230	SECURITY & COMMODITY EXCHANGES
2082	MALT BEVERAGES	3740	RAILROAD EQUIPMENT	6280	SVC ALLIED EXCHANGE/SECURITIES
2083	MALT	3750	MOTORCYCLES, BICYCLES & PARTS	6310	LIFE INSURANCE
2084	WINE, BRANDY & BRANDY SPIRITS	3760	GUIDED MISSILE,SPACE VEH&PARTS	6320	ACCIDENT/HEALTH MEDICAL PLANS
2085	DISTILLED & BLENDED LIQUORS	3790	MISC TRANSPORTATION EQUIPMENT	6330	FIRE, MARINE & CASUALTY INS.
2086	SOFT DRINKS & CARBONATED WATER	4510	SCHEDULED AIRPLANES & COURIERS	6350	SURETY INSURANCE
2087	FLAVOR EXTRACTS & SYRUPS NEC	4810	TELEPHONE COMMUNICATIONS	6360	TITLE INSURANCE
2090	MISC FOOD PREP & KINDRED PROD	4820	TELEGRAPH & MESSAGE COMMUNICAT	6370	PENSION, HEALTH/WELFARE FUNDS
2110	CIGARETTES	4830	RADIO & TV BROADCASTING	6390	INSURANCE CARRIERS, NEC
2120	CIGARS	4840	CABLE & OTHER PAY TV SERVICES	6710	HOLDING OFFICES
2310	MEN,BOYS SUITS,COATS,OVERCOATS	4890	COMMUNICATION SERVICES NEC	6720	INVESTMENT OFFICES
2320	MEN'S & BOYS FURNISHINGS	4910	ELECTRIC SERVICES	6730	TRUSTS
2330	WOMEN,MISSES & JR OUTERWEAR	4920	GAS PRODUCTION & DISTRIBUTION	6790	MISCELLANEOUS INVESTING
2340	WOMEN,CHILDREN,INFANT UNDERWR	4930	COMB.ELEC,GAS & OTHER UTILITY	8210	ELEM & SECONDARY SCHOOLS
2350	HATS,CAPS & MILLINERY	4940	WATER SUPPLY	8710	ENGINEERING,ARCHITECTUAL SVC
2360	GIRL,CHILDREN,INFANT OUTERWEAR	4950	SANITARY SERVICES	8720	ACCT/AUDITING/BOOKKEEPING SVC
2370	FUR GOODS	4960	STEAM AIR CONDITIONING SUPPLY	8730	RESEARCH,DEVEL & TESTING SRV
2380	MISC APPAREL & ACCESSORIES	4970	IRRIGATION SYSTEMS	8740	MANAGEMENT & PR SERVICE
				8990	SERVICES, NEC



# Group Quote Request Form

Fax or Email to Pacific Health Trust  
 (866) 999-3485 quote@pacifichealthtrust.com

Date Submitted: \_\_\_\_\_ Eff Date Requested: \_\_\_\_\_  
 Agent: \_\_\_\_\_ Contact Phone: \_\_\_\_\_  
 Agency: \_\_\_\_\_ Sent quote to (email): \_\_\_\_\_

Group Name: \_\_\_\_\_ Business Type: \_\_\_\_\_ SIC: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ County: \_\_\_\_\_

<b>Current Coverage</b>	<u>Plan 1</u>		<u>Plan 2</u>		<u>Dental</u>	
Carrier: _____	_____	_____	_____	_____	_____	_____
Renewal Date: _____	_____	_____	_____	_____	_____	_____
Office Visit Copay: _____	\$ _____	_____	\$ _____	_____	Deductible: \$ _____	_____
Hospital Copay: _____	\$ _____	_____	\$ _____	_____	Annual Max: \$ _____	_____
Deductible: _____	\$ _____	_____	\$ _____	_____	Ortho: <input type="checkbox"/> Yes	_____
Coinsurance %: _____	_____ %	_____	_____ %	_____	<u>Coverage</u>	_____
Stop Loss: _____	\$ _____	_____	\$ _____	_____	Preventive: _____ %	_____
Max Out of Pocket: _____	\$ _____	_____	\$ _____	_____	Basic: _____ %	_____
Pharmacy Benefit: _____	_____	_____	_____	_____	Major: _____ %	_____
<b>Rates</b>	<u>Current</u>	<u>Renewal</u>	<u>Current</u>	<u>Renewal</u>	<u>Current</u>	<u>Renewal</u>
Employee: \$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
E+ Spouse: \$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
E+ Children: \$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
E+Family: \$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**Total Employees:** \_\_\_\_\_  
 Waiving Employees: \_\_\_\_\_  
 Ineligible Employees: \_\_\_\_\_

**Employer Contribution**  
 Employee: \_\_\_\_\_ %  
 Dependents: \_\_\_\_\_ %

Individual Medical Questionnaires Are Required for Cases Under 21 Employees:  Attached

For Office Use Only:

Date Received in Underwriting: \_\_\_\_\_

Date Entered: \_\_\_\_\_



# Employee Census Form

Please email spreadsheet to: [quote@pacifichalthtrust.com](mailto:quote@pacifichalthtrust.com)

Date: \_\_\_\_\_

Broker / Agency: \_\_\_\_\_

Name of Group: \_\_\_\_\_

Please list all eligible Employees (those working 20 hours or more a week).

Please Note: Please note if an eligible employee is waiving coverage for other group coverage. If the census of enrolling employees changes more than 10% from the RFP census, the group may require re-rating.

	Employee	M/F	Date of Birth	Spouse Y/N	# of Children	Waiving? G=Has Other Group Coverage W=Simply Waiving	ZIP
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
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Pacific  
Health  
Trust

# Individual Health Risk Questionnaire (HRQ)

**Instructions:** The questions below apply to each employee and dependents that are applying for coverage listed on this application. They apply to both past and present conditions or symptoms. Answer each question truthfully and completely. Attach a piece of paper if you need more space. Complete every item, even if the answer is “No.” We consider the answer to each question to be material to the risk Health Net assumes in extending health care coverage. Applications will be returned if any question is not answered completely.

**Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement:** This Health Risk Questionnaire (HRQ) is not a request for genetic information. In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

## Part I. Applicant(s) information

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

	First name	Last name	Sex M/F	Date of birth	Height	Weight (lbs.)	Tobacco use within last 12 months?	Name of primary physician	Physician's phone number
Employee							<input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse/ State Reg DP <sup>1</sup>							<input type="checkbox"/> Yes <input type="checkbox"/> No		
Child(ren)							<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No		
							<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Part II. (a) Statement of Health

Please check any condition, treatment or care mentioned below that applies. All questions must be answered. For “Yes,” please provide detail in Part III.

Indicate if you or any listed dependents have ever suffered from, or received care, counseling or been advised for, any of the following:

		Primary applicant	Dependent 1	Dependent 2
1)	Alcohol/drug use or abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2)	AIDS/HIV or ARC	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3)	Back or spine disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4)	Cancer or tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5)	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6)	Digestive/bowel disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(continued)

<sup>1</sup>State Registered Domestic Partner

**Part II. (a) Statement of Health (cont.)**

		Primary applicant	Dependent 1	Dependent 2
7)	Heart condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8)	Immune system disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9)	Kidney/renal disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10)	Liver disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11)	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
12)	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13)	Mental disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
14)	Neurological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15)	Paralysis/stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
16)	Respiratory/lung disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
17)	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
18)	Last reading (systolic/diastolic):			

**Female applicant(s) only**

Is female applicant, spouse, State Registered Domestic Partner or any dependent now pregnant?  Yes  No

If "Yes," name and relationship: \_\_\_\_\_ Due date: \_\_\_\_\_

		Primary applicant	Dependent 1	Dependent 2
19)	Are complications anticipated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
20)	Multiple birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
21)	Prior history of miscarriage, therapeutic abortions, stillbirth, cesarean section or other complication of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
22)	Any congenital anomalies or health complications with previous newborns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
23)	Any congenital anomalies or health complications with current fetus?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
24)	Any problems, including vaginal bleeding, with pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**All applicant(s)**

		Primary applicant	Dependent 1	Dependent 2
25)	Have any applicant(s) been counseled or advised that they have or may have any disease, disorder, impairment, deformity, injury, or any chronic or untreatable condition whether active or in remission?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
26)	Have any applicant(s) had medical or surgical consultation, advice, or treatment (including medication) for any condition(s) during the past 36 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

(continued)

### Part III. (b) Statement of Health

If you have checked "Yes," for any item in Part II, please explain below (use additional sheet of paper if necessary).

Patient's name	Diagnosis/condition requiring treatment	Treatment	Physician	Physician's phone number	Date of illness (mm/yy)	Was recovery complete?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you or any listed dependents taken or used any medication or drug within the past 12 months?  Yes  No

If "Yes," please explain below. (Use extra sheet of paper if necessary.)

Patient's name	Medication name	Condition requiring medication	Still taking?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

		Primary applicant	Dependent 1	Dependent 2
1)	Has the applicant or any listed dependent ever been denied insurance coverage? If "Yes," please explain below:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2)	Do you and your dependents currently have comprehensive coverage under another health plan? If "Yes," please attach copies of current enrollment cards to this form.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby declare that the foregoing is true and correct to the best of my knowledge. This declaration is made under the penalty of perjury of the laws of the State of Washington. **I understand that fraud or intentional misrepresentation of material fact, in order to obtain coverage, may result in termination of coverage.**

**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.**

Employee name (please print)	Signature	Daytime phone #	Date
		( )	

## **PACIFIC HEALTH TRUST**

THIS TRUST, made and entered into as of this 1<sup>st</sup> day of May, 2004, by and between each of the Individual Employers that become a signatory to this Trust ("Individual Employer") and THINC USA LLC, an Oregon limited liability company, as Trustee (the "Trustee").

### **RECITALS:**

1. Each of the Individual Employers has been authorized to establish a health and security plan for the benefit of their respective employees.
2. Enrollment of their respective employees under this plan shall be voluntary on the part of the Employers, shall be subject to Trust rules and the contributions therefor, and shall be payable to and deposited in the Trust Fund created and established hereunder.
3. The purpose of this Trust is to provide for the establishment of such Trust Fund and for the maintenance of such health and security plan in the manner hereinafter set forth.

### **AGREEMENT:**

In consideration of the premises, and in order to create this Trust to be known as the PACIFIC HEALTH TRUST, it is understood and agreed by all parties hereto as follows:

### **ARTICLE 1**

#### **DEFINITIONS**

Unless the context or subject matter otherwise requires, the following definitions shall govern in this Trust.

#### **Section 1.**

The term "Employer" or "Individual Employer" means an employer which voluntarily subscribes to this Plan by executing a joinder agreement in the form attached hereto, and which makes contributions to the Trust Fund on behalf of its employees.

**Section 2.**

The term "Employee" means any employee of an Individual Employer for whom contributions have been made on his or her behalf by his or her Employer. The term "Employee" may also mean a retired person who was covered under the Plan prior to his or her retirement and who has elected to maintain coverage by making required contributions on his or her own behalf.

**Section 3.**

The term "Fund" as used herein means the trust estate of the Pacific Health Trust, which shall consist of all contracts and policies together with all dividends, refunds, or other sums payable to the Trustee on account of such policies, all investments made and held by the Trustee, all monies received by the Trustee as Employer contributions or as income from investments made and held by the Trustee for uses, purposes and trust set forth in this Trust.

**Section 4.**

The term "Trustee" as used herein means Pacific Health Trust together with its successors as appointed in this Trust.

**ARTICLE 2**

**PURPOSE OF THE TRUST AND APPLICATION OF THE FUND**

**Section 1.**

There is hereby created the Pacific Health Trust Plan as hereinbefore defined, which may hereinafter be referred to as the "Plan."

**Section 2.**

This Trust Fund is created for the purpose of providing and maintaining through policies issued by duly licensed insurance carriers or hospital-medical service organizations, group life

and group accident and health insurance including group hospitalization, medical and surgical benefits, or any of such insurance as may be determined by the Trustee for the benefit of the Employees of the Individual Employers, and is so determined by the Trustee, in whole or in part, group insurance for hospitalization, surgical and medical care for the families of such employees as defined by the Trustee.

The Trustee may agree with regard to any such policy or service contract with the carrier thereof, upon waiting periods, definition of employment, and such other provisions concerning eligibility of employees as the Trustee may deem appropriate.

**Section 3.**

The Fund shall have its principal office in the City of Vancouver, County of Clark, and State of Washington.

**Section 4.**

No Employee or beneficiary shall be entitled to receive any part of the contributions made or required to be made to the Fund in lieu of the benefits provided by the Plan.

**Section 5.**

No Individual Employer, employee, beneficiary of the Plan, or any other person shall have any right, title or interest in the Fund other than as specifically provided in this Trust, and no part of the Fund shall revert to any Individual Employer. Should excess monies accrue by the receipt of insurance dividends or other means, said excess monies may at the discretion of the Trustee be used to increase benefits. Neither the Fund nor any contributions to the Fund shall be in any manner liable for or subject to the debts, contracts or liabilities of any Individual Employer or any employee or beneficiary. No part of the Fund, or any benefits payable in accordance with the Plan shall be subject in any manner to anticipation, alienation, sale, transfer,

assignment, pledge, encumbrance or charge by any person. The Trustee shall establish a procedure whereby any beneficiary may direct that benefits due him or her be paid to an institution in which he or she is hospitalized in consideration for medical or hospital services rendered or to be rendered.

**Section 6.**

No officer, agent, employee or committee member of any Individual Employer shall be liable to make contributions to the Fund or be under any other liability to the Fund or with respect to the Plan, except to the extent that it may be an Individual Employer required to make contributions to the Fund with respect to its own individual or joint venture operations. The liability of any Individual Employer to the Fund, or with respect to the Plan, shall be limited to the payments required for the employees that the Employer desires to cover under the Plan with respect to its individual or joint venture operations, and in no event shall it be liable or responsible for any portion of the contributions due from other Individual Employers with respect to the operations of such Employers. The Individual Employers shall not be required to make any further payments or contributions to the cost of operation of the Fund or of the Plan.

**Section 7.**

No Individual Employer or any employee shall be liable or responsible for any debts, liabilities or obligations of the Fund or the Trustee.

**Section 8.**

Contributions to the Fund shall be due and payable in Vancouver, Washington, and shall be made in regular monthly installments. Each contribution shall be accompanied by a simple report in a form prescribed by the Trustee.

## **ARTICLE 3**

### **TRUSTEE**

#### **Section 1.**

The Fund shall be administered by the Trustee. The Trustee shall sign this Trust, and such signature shall constitute its acceptance of the office and agreement to act under and be subject to all the terms and conditions of this Trust.

#### **Section 2.**

The Trustee shall serve until its removal or resignation. The Trustee shall be subject to removal "for cause" by the affirmative vote of a majority of the Individual Employers then participating in the Plan. "For cause" shall mean (i) gross misconduct on the part of a Trustee; (ii) a Trustee's willful and continued failure to perform substantially the Trustee's duties under this Trust which failure continues for more than ten (10) business days after receipt by the Trustee of a demand for substantial performance from a majority of the Individual Employer's then participating in the Plan which specifically identifies the manner in which the Trustee has failed to perform its duties; and (iii) a Trustee's commission of a material act of personal dishonesty which involves personal profit in connection with the Trust.

#### **Section 3.**

The Trustee may resign at any time by serving written notice of such resignation upon the Individual Employers and the appointment of a Successor Trustee. Any Successor Trustee may resign upon 30 days advance written notice of its resignation and the appointment of a successor Trustee.

**Section 4.**

If the Trustee resigns, a successor Trustee shall be appointed by the affirmative vote of a majority of the Employers then participating in the Plan. If a majority of the Individual Employers then participating in the Plan are unable to agree on a Successor Trustee within 30 days following a Trustee's notice of resignation, the Successor Trustee shall be appointed by the then acting Presiding Judge of the Superior Court of Clark County, Washington, upon application of any interested party. Any successor Trustee so appointed shall sign this Trust, or letter of acceptance, and such signature shall constitute its acceptance of office and agreement to act under and be subject to all of the terms and conditions of this Trust.

**ARTICLE 4**

**DUTIES AND FUNCTIONS OF TRUSTEE**

**Section 1.**

The Trustee may exercise all rights or privileges granted to the policy or contract holder by provisions of each policy or service contract or those allowed by the insurance carrier of such policy or hospital-medical service organization. The Trustee may agree with such insurance carrier or service organization to any alteration, modification, or amendment of such policy or contract and may take any action respecting such policy or contract or the insurance provided thereunder which may be necessary or advisable, and such insurance carrier or service organization shall not be required to inquire into the authority of the Trustee with regard to any dealings in connection with such policy or contract.

**Section 2.**

The Trustee shall have the power to construe all ambiguous or doubtful provisions of this Trust and the terms used herein and any construction adopted by the Trustee in good faith shall be binding upon the Individual Employers.

**Section 3.**

The Trustee shall have the power to administer the Fund and to administer and maintain the Plan in effect.

**Section 4.**

The Trustee shall collect and receive all contributions due to the Fund, and shall promptly deposit such contributions in a special Trust Fund account or accounts established in a reputable bank or banks located in the city and county of the principal office of the Fund.

**Section 5.**

The Trustee shall promptly use the monies available in the Fund to provide the benefits specified in the Plan. The Trustee shall have power to enter into contracts and procure insurance policies necessary to place into effect and maintain the Plan, to terminate, modify or renew any such contracts or policies, and to exercise and claim all rights and benefits granted to the Trustee or the Fund by any such contracts or policies. Any such contract may be executed in the name of the Fund, and any such policy may be procured in such name.

**Section 6.**

The Trustee shall have power:

- (a) To pay out of the Fund the reasonable expenses incurred in the establishment of the Fund and the Plan.

(b) To establish and accumulate such reserve funds as may be adequate to provide for administration expenses and other obligations of the Fund, including the maintenance in effect of the Plan.

(c) To employ such executive, consultant, administrative, clerical, secretarial, and legal personnel and other employees and assistants, as may be necessary in connection with the administration of the Fund and the Plan, and to pay or cause to be paid, out of the Fund, the compensation and necessary expenses of such personnel and assistants and the cost of office space, furnishings and supplies and other essentials required in such administration.

(d) To incur and pay out of the Fund any other expenses reasonably incidental to the administration of the Fund or Plan.

(e) To compromise, settle, or release claims or demands in favor of or against the Fund on such terms and conditions as the Trustee may deem desirable.

(f) To invest and reinvest such portion of the Fund as is not required for current expenditures and charges in such securities as are legal for investment of Trust funds under the laws of the State of Washington.

(g) To establish the amounts of money to be contributed to the Fund monthly for each employee covered under the Plan.

#### **Section 7.**

The Trustee may adopt bylaws, working rules, regulations and underwriting guidelines that are not contrary to nor inconsistent with the provisions of this Trust and may make amendments thereto from time to time.

**Section 8.**

The Trustee shall procure fidelity and fiduciary bonds for the Trustee or other person authorized to receive, handle, deal with or draw upon the monies in the Fund for any purpose whatsoever, said bonds to be in such reasonable amount and to be obtained from such duly authorized surety company as the Trustee shall determine. The cost of the premiums on such bonds shall be paid out of the Fund.

**Section 9.**

All checks, drafts, vouchers or other withdrawals of money from the Fund shall be authorized in writing or countersigned by the Trustee.

**Section 10.**

The Trustee shall maintain suitable and adequate records of and for the administration of the Fund and the Plan. The Trustee may require any Individual Employer, any employee or any other beneficiary under the Plan to promptly furnish to the Trustee on demand any such payroll records, information, data, report or documents reasonably relevant to and suitable for the purposes of such administration of the Fund and the policies. The parties agree that they will use their best efforts to secure compliance with any reasonable request of the Trustee for any such information, data, report or documents.

**Section 11.**

The books of account and records of the Trustee, including the books of account and records pertaining to the Fund, shall be audited at least once each year by a qualified certified public accountant to be selected by the Trustee. The Trustee shall also make all other reports required by law. A statement of the results of the annual audit shall be available for the inspection by interested persons at the principal office of the Fund and at such other suitable

place as the Trustee may designate from time to time. A copy of such statement shall at all times be available for inspection by interested persons at the principal office of the Fund.

## **ARTICLE 5**

### **GENERAL PROVISIONS APPLICABLE TO TRUSTEE**

#### **Section 1.**

No party who has verified that he or it is dealing with the duly appointed Trustee, shall be obligated to see to the application of any monies or property of the Fund, or to see that the terms of this Trust have been complied with, or to inquire as to the necessity or expediency of any act of the Trustee. Every instrument executed by the Trustee or by its direction shall be conclusive in favor of every person who relies on it, that (a) at the time of the delivery of the instrument this Trust was in full force and effect, (b) the instrument was executed in accordance with the terms and conditions of this Trust, and (3) the Trustee was duly authorized to execute the instrument or direct its execution.

#### **Section 2.**

The duties, responsibilities, liabilities and disabilities of the Trustee under this Trust shall be determined solely by the express provisions of the Trust, and no further duties, responsibilities, liabilities or disabilities shall be implied or imposed.

#### **Section 3.**

The Trustee may delegate only ministerial powers or duties to regularly chosen agents or employees. The Trustee shall not incur any liability for simple negligence, oversight or carelessness in connection with the performance of the duties as Trustee. The Fund shall exonerate, reimburse and save harmless the Trustee, against any and all expenses and liabilities

arising out of Trusteeship, except for expenses and liabilities arising out of willful misconduct or gross negligence.

**Section 4.**

Neither the Individual Employers nor Trustee shall be responsible or liable for:

- (a) The validity of this Trust or the Plan.
- (b) The form, validity, sufficiency, or effect of any contract or policy for insurance or other benefits which may be entered into.
- (c) Any delay occasioned by any restriction or provision in this Trust, the Plan, any contract or policy procured in the course of the administration of the Fund, or by any other proper procedure in such administration.
- (d) The making or retention of any deposit or investment of the Fund, or any portion thereof, or the disposition of any such investment, or failure to make any investment of the Fund, or any portion thereof, or any loss or diminution of the Fund, except, as to the particular person involved, such loss as may be due to the gross neglect or willful misconduct of such person.

**Section 5.**

The Trustee may be reimbursed out of the Fund for all reasonable and necessary expenses which it may incur in the performance of its duties.

**Section 6.**

If the Trustee resigns it shall forthwith turn over the principal office of the Fund, any and all records, books, documents, monies and other property in its possession or under its control which belong to the Fund or which were received by it in its capacity as Trustee.

**Section 7.**

No decision shall be made by the Trustee in the administration of the Fund or the Plan that is unreasonably discriminatory under the provisions of the Internal Revenue Code, or under any other applicable law or regulation.

**ARTICLE 6**

**GENERAL PROVISIONS**

**Section 1.**

Subject to the provisions of the actions of the Individual Employers, the employees and their dependents and the Trustee, shall be governed by the provisions of this Trust and the Plan and any insurance policies or contracts procured or executed pursuant to this Trust.

**Section 2.**

No employee or other beneficiary shall have any right or claims to benefits under the Plan, except as specified in the policy or policies, or contract or contracts, procured or entered into pursuant to this Trust. Any dispute as to eligibility, type, amount or duration of benefit shall be resolved whenever possible by the appropriate insurance carrier or hospital-medical service organization under and pursuant to the policy or contract, and the employee or other beneficiary shall have no right or claim with respect thereto against the Fund or the Trustee. The Trustee shall not be liable for the failure or omission for any reason to pay any benefits under the Plan.

**Section 3.**

When a dispute arises which cannot be resolved by the appropriate insurance carrier or hospital-medical service organization, the employee or other beneficiary shall have certain rights of appeal. These shall be as established by the Trustee from time to time and shall be as set forth

in the booklet given to each participating employee outlining benefits afforded and setting forth the Summary Plan Description.

**Section 4.**

Any notice required to be given under the terms of this Trust shall be deemed to have been duly served if delivered personally to the person to be notified in writing, or if mailed in a sealed envelope, postage prepaid, to such person at his last known address as shown in the records of the Fund, or if sent by wire to such person at said last known address.

**Section 5.**

This Trust shall be binding upon and inure to the benefit of all Individual Employers which voluntarily subscribe to the Plan and which make contributions to the Fund on behalf of their employees, and the heirs, executors, administrators, successors, purchasers and assigns of the Individual Employers, and the Trustee.

**Section 6.**

All questions pertaining to this Trust, the Fund or the Plan, and their validity, administration and construction, shall be determined in accordance with the laws of the State of Washington and with any pertinent laws of the United States.

**Section 7.**

If any provision of this Trust, the Plan, the rules and regulations made pursuant thereto, or any step in the administration of the Fund or the Plan is held to be illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining portions of the Trust, the Plan or the rules and regulations, unless such illegality or invalidity prevents accomplishment of the objectives and purposes of the Trust and the Plan. In the event of any such holding, the parties shall immediately remedy any such defect.

**Section 8.**

All facts and all matters of record shall be made available and open to examination and inspection of the Trustee. Except to the extent necessary for the proper administration of the Fund or the Plan, all books, records, papers, reports, documents, or other information obtained with respect to the Fund or the Plan shall be confidential and shall not be made public or used for any other purpose.

**ARTICLE 7**

**AMENDMENT AND TERMINATION**

**Section 1.**

The provisions of this Trust may be amended or modified at any time, or from time to time, by the Trustee. The Trustee shall provide at least 30 days advance written notice of any such amendment or modification to the Individual Employers then participating in the Plan. All Individual Employers shall be bound by such amendments and/or modifications.

**Section 2.**

The provisions of this Trust shall continue in effect until revoked by action of the Trustee.

**Section 3.**

In no event shall the trust established by the agreement continue for a longer period than is permitted by law.

**Section 4.**

Upon the termination of the trust herein provided, any and all monies remaining in the Fund after the payment of all expenses shall be used for the continuance of one or more benefits of the type provided by the Plan, until such monies have been exhausted.

Executed as of the day and year first above written.

**ACCEPTANCE OF OFFICE BY TRUSTEE**

The undersigned hereby accepts the office of Trustee pursuant to the foregoing Trust and agrees to act under and be subject to all of the terms and conditions of said Trust. The undersigned hereby declares that it shall hold the Fund created by said Trust in trust for the uses and purposes set forth in the Trust.

Dated 2/23, 2011.

TRUSTEE

  
\_\_\_\_\_  
Chele Dimmett

**JOINDER AGREEMENT**

The undersigned "Individual Employes" hereby agrees to become a party and bound by the terms and provisions of the Pacific Health Trust, a copy of which is attached hereto.

Dated \_\_\_\_\_, 20\_\_\_\_.

INDIVIDUAL EMPLOYER

Name: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

This joinder is accepted this 23rd day of February, 2011, by the Trustee of  
Pacific Health Trust.

TRUSTEE



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Chete Dimmett

# Master Application 2011



OFFICE

Group Number: _____
Med RL: _____ RX RL: _____
Trust Fee: <input type="checkbox"/> Attached <input type="checkbox"/> Waived

Medical, RX, Dental and Vision plans offered under Pacific Health Trust are underwritten and administered by Health Net Health Plan of Oregon, Inc., Guardian and VSP®, respectively.

## Company Information

Effective Date Requested: \_\_\_\_\_

Association Membership: \_\_\_\_\_ Member since: \_\_\_\_\_

Company: \_\_\_\_\_ Tax ID: \_\_\_\_\_

DBA (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Benefits Administrator Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Billing Contact (if different): \_\_\_\_\_ Title: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Premiums will be paid by:  EFT (complete enclosed form)  Check (requires additional 2% admin fee)

Type of Organization:  Corporation  Partnership  Sole Proprietorship  Other SIC Code: \_\_\_\_\_

Nature of Business: \_\_\_\_\_ Date of Inception: \_\_\_\_\_ Previous Medical Carrier: \_\_\_\_\_

## Participation Requirements

Total employees: \_\_\_\_\_ Total working 20+ hours a week: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Please check the appropriate box for total # of employees including: Full-time, Part-time and seasonal employees:

0-19 employees  20-99 employees  100+ employees

*Please note: Federal regulations require you must promptly notify Health Net if the number of employees change from 0-19, 20-99, or 100+.*

Since you are part of a multi-employer group health plan, have you obtained a small group employer exception from CMS so that Medicare become primary rather than your health plan, Health Net?  Yes  No

Number of employees eligible per employer guidelines to enroll in the plan: \_\_\_\_\_

Number of employees enrolling: \_\_\_\_\_ Number of dependents enrolling: \_\_\_\_\_ Number of employees waiving: \_\_\_\_\_

## Employer Contribution and Eligibility Provisions

Employee Coverage: \_\_\_\_\_% of Monthly Rate OR \$ \_\_\_\_\_ toward Monthly Rate

Dependent Coverage: \_\_\_\_\_% of Monthly Rate OR \$ \_\_\_\_\_ toward Monthly Rate

*Employees must enroll within 31 days of eligibility. Eligibility provisions may only be changed at annual contract renewal.*

Eligible Employees: Regular active full-time employees scheduled to work at least \_\_\_\_\_ hours per week (min 20 hrs, max 40 hrs)

Newly Eligible Employees: First day of the month following \_\_\_\_\_ days from date of hire. (0, 30, 60, 90, 180)

Employees rehired within \_\_\_\_\_ (0 – 6) months are not required to complete a new probationary period.

## COBRA

Are you subject to COBRA?  Yes  No

A group 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.

If Yes, Please Choose:

Trust Administration – No Charge (BSI Agreement must be filled out. Form can be found on our website at: www.pacifichealthtrust.com)

Self-Administration

**Coverage Applied For** (check plans that apply):

**Enrollment Packets Needed:**

Medical \_\_\_\_\_ Dental: \_\_\_\_\_

**Does your group fund any portion of the employee/members' deductible through an HRA or other type of funding arrangement?**  Yes  No (Rates will increase 1 tier level from quoted rates if HRA or funding arrangement is used.)

If Yes, How much do you fund? \_\_\_\_\_

### Health Net Medical Plans

- Groups under 10 choose one plan
- Groups with 10+ enrolled may choose two plans (minimum of 3 enrolled in each plan)

<input type="checkbox"/> PPO 250 (WPT152V2LX) <input type="checkbox"/> PPO 500 (WPT155V2DX) <input type="checkbox"/> PPO 750 (WPT207V2DX)  <input type="checkbox"/> PPO 1000 (WA25-1000-2-2500D)  <input type="checkbox"/> PPO 1500 (WPT2515V2DX) <input type="checkbox"/> PPO 2500 (WPT3025V2DX) <input type="checkbox"/> HDHP 2000 (HD2000 Single/ HD4000 Family – HSA Qualified) <input type="checkbox"/> Value 500 (WA20-500-2-2500V) <input type="checkbox"/> Value 1000 (WA30-1000-3-3500V) <input type="checkbox"/> Value 2000 (WA35-2000-3-3500V)	<b>Health Net RX Plan</b> Choose one option <input type="checkbox"/> Rx \$10 / \$20 / \$40 <input type="checkbox"/> Rx \$15 / \$30 / \$50 <input type="checkbox"/> Rx \$15 / \$35 / \$60 <input type="checkbox"/> Rx \$15 / 30% / 50% - \$5,000 OOP Max <input type="checkbox"/> No Rx	<b>VSP Vision Plan</b> Choose one option <input type="checkbox"/> VSP \$0 / \$10 <input type="checkbox"/> VSP \$10 / \$25 <input type="checkbox"/> No Vision
<i>Note: Pharmacy &amp; Vision enrollment must match the medical enrollment.</i>		
<b><u>Guardian Dental Plans</u></b>		
<input type="checkbox"/> Plan 1000 (\$1,000 Max) <input type="checkbox"/> Plan 1500 (\$1,500 Max) <input type="checkbox"/> Plan 2000 (\$2,000 Max)  <input type="checkbox"/> No Dental		
<b>Optional Benefits:</b> <input type="checkbox"/> Domestic Partner Coverage - No Charge–Select to add benefit only at renewal <input type="checkbox"/> 24 Hour Owner Coverage – No Charge - Attach a list including full names for all owners/officers excluded from Workers Comp. <input type="checkbox"/> Employee Assistance Program through RFL (\$0.54 per employee charge) <input type="checkbox"/> LifeBalance Card (\$.86 per employee charge)		

### Lifewise Assurance Life / AD&D Buy-up

(Base \$10K Life/AD&D is included on all employees enrolling in the medical plan )

**Life enrollment Election: (Must Choose one of the following options):**

Medical Enrollees Only  All Eligible

<input checked="" type="checkbox"/> Base \$10K Life / AD&D (required) <input type="checkbox"/> \$20K Life / AD&D (Optional Buy-up)	<input type="checkbox"/> \$30K Life / AD&D (Optional Buy-up) ** <input type="checkbox"/> \$40K Life / AD&D (Optional Buy-up)** <input type="checkbox"/> \$50K Life / AD&D (Optional Buy-up)** ** Available to groups of 10 or more eligible employees
<b>Flexible Spending Account</b>	
<b>Election:</b> If yes to any of the below options, please complete and attach the BSI enrollment form. Additional charges apply.	
FSA Yes <input type="checkbox"/> No <input type="checkbox"/>	HRA Yes <input type="checkbox"/> No <input type="checkbox"/>
DCAP Yes <input type="checkbox"/> No <input type="checkbox"/>	HSA Yes <input type="checkbox"/> No <input type="checkbox"/>





# RENEWAL APPLICATION 2011

OFFICE USE ONLY	Group Number: _____
	Med RL: _____ Rx RL: _____

Medical, RX, Dental and Vision plans offered under Pacific Health Trust are underwritten and administered by Health Net Health Plan of Oregon, Inc., Guardian and VSP®, respectively.

## Company Information

Renewal Date: \_\_\_\_\_

Association Membership: \_\_\_\_\_ Member since: \_\_\_\_\_

Company: \_\_\_\_\_ Tax ID: \_\_\_\_\_

DBA (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Benefits Administrator Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Billing Contact (if different): \_\_\_\_\_ Title: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Premiums will be paid by:  EFT (complete enclosed form)  Check (requires additional 2% admin fee)

New Enrollment Packets Needed\*: HealthNet: \_\_\_\_\_ Guardian: \_\_\_\_\_

\*If Packets are needed for Open Enrollment, please contact the TPA Fulfillment Center @ 877-694-8291 or email pht@bsitpa.com

## Participation Requirements

Total employees: \_\_\_\_\_ Total working 20+ hours a week: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Please check the appropriate box for total # of employees including: Full-time, Part-time and seasonal employees:

0-19 employees  20-99 employees  100+ employees

Please note: Federal regulations require you must promptly notify Health Net if the number of employees change from 0-19, 20-99, or 100+.

Since you are part of a multi-employer group health plan, have you obtained a small group employer exception from CMS so that Medicare become primary rather than your health plan, Health Net?  Yes  No

Number of employees eligible per employer guidelines to enroll in the plan: \_\_\_\_\_

Number of employees enrolling: \_\_\_\_\_ Number of dependents enrolling: \_\_\_\_\_ Number of employees waiving: \_\_\_\_\_

## Employer Contribution and Eligibility Provisions

Employee Coverage: \_\_\_\_\_% of Monthly Rate OR \$ \_\_\_\_\_ toward Monthly Rate

Dependent Coverage: \_\_\_\_\_% of Monthly Rate OR \$ \_\_\_\_\_ toward Monthly Rate

*Employees must enroll within 31 days of eligibility. Eligibility provisions may only be changed at annual contract renewal.*

Eligible Employees: Regular active full-time employees scheduled to work at least \_\_\_\_\_ hours per week (min 20 hrs, max 40 hrs)

Newly Eligible Employees: First day of the month following \_\_\_\_\_ days from date of hire. (0, 30, 60, 90, 180)

Employees rehired within \_\_\_\_\_ (0 – 6) months are not required to complete a new probationary period.

**COBRA**

**Are you subject to COBRA?**  Yes  No

A group 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.

**If Yes, Please Choose:**

- Trust Administration – No Charge (BSI Agreement must be filled out. Form can be found on our website at: www.pacifichealthtrust.com)
- Self-Administration

**Coverage Applied For** (check plans that apply):

**Does your group fund any portion of the employee/members’ deductible through an HRA or other type of funding arrangement?**  Yes  No (Rates will increase 1 tier level from quoted rates if HRA or funding arrangement is used.)

If Yes, How much do you fund? \_\_\_\_\_

**Health Net Medical Plans**

- Groups under 10 choose one plan
- Groups with 10+ enrolled may choose two plans (minimum of 3 enrolled in each plan)

<input type="checkbox"/> PPO 250 (WPT152V2LX) <input type="checkbox"/> PPO 500 (WPT155V2DX) <input type="checkbox"/> PPO 750 (WPT207V2DX)  <input type="checkbox"/> PPO 1000 (WA25-1000-2-2500D)  <input type="checkbox"/> PPO 1500 (WPT2515V2DX) <input type="checkbox"/> PPO 2500 (WPT3025V2DX) <input type="checkbox"/> HDHP 2000 (HD2000 Single/ HD4000 Family – HSA Qualified)	<b>Health Net RX Plan</b> <i>Choose one option</i> <input type="checkbox"/> Rx \$10 / \$20 / \$40 <input type="checkbox"/> Rx \$15 / \$30 / \$50 <input type="checkbox"/> Rx \$15 / \$35 / \$60 <input type="checkbox"/> Rx \$15 / 30% / 50% - \$5,000 OOP Max <input type="checkbox"/> No Rx	<b>VSP Vision Plan</b> <i>Choose one option</i> <input type="checkbox"/> VSP \$0 / \$10 <input type="checkbox"/> VSP \$10 / \$25 <input type="checkbox"/> No Vision
<i>Note: Pharmacy &amp; Vision enrollment must match the medical enrollment.</i>		
<b><u>Guardian Dental Plans</u></b>		
<input type="checkbox"/> Value 500 (WA20-500-2-2500V) <input type="checkbox"/> Value 1000 (WA30-1000-3-3500V) <input type="checkbox"/> Value 2000 (WA35-2000-3-3500V)	<input type="checkbox"/> Plan 1000 (\$1,000 Max) <input type="checkbox"/> Plan 1500 (\$1,500 Max) <input type="checkbox"/> Plan 2000 (\$2,000 Max)  <input type="checkbox"/> No Dental	

**Optional Benefits:**

- Domestic Partner Coverage - No Charge–Select to add benefit only at renewal)
- 24 Hour Owner Coverage – No Charge - Attach a list including full names for all owners/officers excluded from Workers Comp.
- Employee Assistance Program through RFL (\$0.54 per employee charge)
- LifeBalance Card (\$.86 per employee charge)

**Lifewise Assurance Life / AD&D Buy-up**

(Base \$10K Life/AD&D is included on all employees enrolling in the medical plan )

**Life enrollment Election: (Must Choose one of the following options):**

- Medical Enrollees Only  All Eligible

<input checked="" type="checkbox"/> Base \$10K Life / AD&D (required)	<input type="checkbox"/> \$30K Life / AD&D (Optional Buy-up) **
<input type="checkbox"/> \$20K Life / AD&D (Optional Buy-up)	<input type="checkbox"/> \$40K Life / AD&D (Optional Buy-up)**
	<input type="checkbox"/> \$50K Life / AD&D (Optional Buy-up)**

\*\* Available to groups of 10 or more eligible employees

**Flexible Spending Account**

**Election:** If yes to any of the below options, please complete and attach the BSI enrollment form. Additional charges apply.

- FSA Yes  No  HRA Yes  No
- DCAP Yes  No  HSA Yes  No

## Participation/ Eligibility Requirements

Company must enroll at least 2 eligible employees and must meet the definition of a "business group" under Washington state law. All enrolled employees must have a bona fide employee relationship with the Employer. If the employer requires employees to contribute to the employee-only premium, a minimum of 75% of all eligible employees must enroll in the plan. A Refusal of Enrollment / Change / Waiver Form must be submitted for all employees and dependents declining coverage. Eligible employees must be full-time employees as defined on page 1 of the application.

## Agent Statement

I certify that all information contained in this application is correct to the best of my knowledge. I also certify that: This firm is a bona-fide business establishment. All participation requirements have been met. Coverage's, enrollment provisions, eligibility requirement, benefits, limitations, and exclusions have been fully explained and understood by the applicant or employer. Co-payments (if applicable) have been fully explained and understood by the employer. I know of no reason why the Plan coverage should not be offered, and I recommend that such coverage be offered.

Agent Name: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

## Employer Statement

- We wish to enroll our firm as a group account with the Pacific Health Trust. We understand that the Pacific Health Trust is the purchasing group that sponsors this plan, and that medical benefits are underwritten and administered by Health Net of Oregon, a Washington-licensed health care service contractor. Benefits and eligibility provisions are specified in the contract between the Pacific Health Trust and Health Net of Oregon, of which this application forms a part. We also understand that vision benefits are provided by VSP®, and VSP® is solely responsible for administration of those benefits.
- We understand the eligibility rules applicable to employee enrollment.
- We understand premiums are prepaid and are due no later than the first day of each month.
- We certify that we have received a fully completed and unaltered Enrollment / Change / Waiver Form from each eligible employee and that we will keep these forms on file in their original state indefinitely. They will be immediately available for use by the Plan Administrator or Carrier.
- We understand an individual's coverage terminates the last day of the month in which employee or dependent ceases to be eligible under eligibility provisions.
- There will be one open enrollment period per contract year 30 days prior to the renewal effective date.
- We understand that this plan contains a pre-existing conditions exclusion period for enrollees over age 19, which will be reduced by any applicable creditable coverage in accordance with Washington state and federal regulations
- This Agreement consisting of the Plan Contract/Group Policy as supplemented by the Group Application has been entered into between Pacific Health Trust and the Employer Group in order to provide eligible subscribers and eligible dependents electing to enroll hereunder with the health care benefit as specified in the Plan Contract/Group Policy.

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

Executed at \_\_\_\_\_ Date accepted \_\_\_\_\_  
(City, ST)

\_\_\_\_\_  
Signature of Authorized Employer Group Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title



# Pacific Health Trust Enrollment / Change / Waiver Form

GROUP NAME: \_\_\_\_\_ GROUP ID: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 MEDICAL PLAN: \_\_\_\_\_ DENTAL PLAN:  1000  1500  2000 VISION PLAN: \_\_\_\_\_

**New Enrollment**  **Enrollment Change**  **Address Change**  **Name Change** Reason: \_\_\_\_\_  
**Enrollment Reasons:** *New Employee, Rehired Employee, Open Enrollment, Transfer From Other Plan Offered by Group, Employee Entered Eligible Class (Part-time to Full-time, Temporary to Permanent, Job Title Change), Marriage, Divorce, Adoption (Legal Documents May Be Required), Dependent Change, and Involuntary Loss of Other Coverage (Prior Coverage Certificate required)*

**1. GROUP INFORMATION (TO BE COMPLETED BY THE GROUP):** Date of Hire \_\_\_\_/\_\_\_\_/\_\_\_\_ or Employee entered eligible class on \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason: \_\_\_\_\_  
 Job Title: \_\_\_\_\_ Hours Per Week: \_\_\_\_\_ Work Location: \_\_\_\_\_ Class: \_\_\_\_\_

**2. EMPLOYEE INFORMATION (EMPLOYEE TO COMPLETE SECTIONS 2-10)** Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Mailing Address (If Different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Email \_\_\_\_\_

**3. DEPENDENT ENROLLMENT INFORMATION Notes:** Please check the Enroll or Delete box for each enrollee. Use a separate sheet to list additional enrollees. If Waiving Coverage go to Section 8.

Medical Enroll	Dental Enroll	Relationship to Employee	Name (Last, First, MI)	Social Security Number**	Gender M/F	BirthDate (MO/Day/YR)	Date of Event****
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Spouse/State Reg DP* <input type="checkbox"/> Domestic Partner					
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

\* Domestic Partner \*\* Federal regulation requires this information for enrollment \*\*\*Date of Marriage, Divorce, Adoption, Death, or Loss of Coverage  
 Is any child over the dependent age limit of 26 applying for coverage eligible due to disability?  No  Yes, complete and attach the Request for Certification of Disabled Dependent.

**4. MEDICARE FOR EMPLOYEE AND ALL DEPENDENTS**  
 Is any person applying covered by Medicare?  No, go to section 5  Yes, please complete the following:  
 Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason:  Age  Disability  
 Name \_\_\_\_\_ Medicare ID # \_\_\_\_\_ Effective Date: Part A \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason:  End Stage Renal Disease  Age  Disability  End Stage Renal Disease

# Pacific Health Trust Enrollment / Change / Waiver Form (continued)

## 5. CONTINUED COVERAGE FOR SPOUSE AND DEPENDENTS

Is your spouse/State Registered DP or child applying for continued coverage?  No  Yes, complete and attach a COBRA Enrollment Form.

## 6. PRIOR COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS

Have you and/or eligible dependents been covered by other medical insurance in the past six (6) months?

No, go to section 7  Yes, please complete the following section: **Notes: Some Groups have a waiting period before an employee is eligible for benefits. If you are not sure of your enrollment date, please contact your Group Benefits Administrator. Use a separate sheet to list additional prior carrier coverage.**

Prior Plan Name \_\_\_\_\_ Prior Plan Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber ID Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Will this coverage be in effect after the coverage with this plan begins?  Yes  No, enter date coverage ended \_\_\_\_/\_\_\_\_/\_\_\_\_

## 7. OTHER COVERAGE FOR ENROLLING EMPLOYEE AND ALL DEPENDENTS *Helpful Hint: Failure to complete prior coverage information could affect payment of claims.*

Will any person applying for coverage be covered under another plan after the coverage with this plan begins?  No, go to section 8  Yes, complete the following section:

Other Plan Name \_\_\_\_\_ Other Plan Phone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Date Coverage Began \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber ID Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Names of all Person(s) Covered \_\_\_\_\_

Is this person covered as a retired or laid-off employee or is this person a covered dependent of such an employee?  No, go to section 8  Yes, enter the date retired or laid-off \_\_\_\_/\_\_\_\_/\_\_\_\_

**8. DECLINING COVERAGE:** This is to confirm that I decline to participate in the Health Insurance and / or Dental Insurance program offered through my employer's group plan as follows:  
**Medical:**

I do not wish to enroll myself. I have other medical coverage. **(Please Note: If your company offers Vision coverage, Vision enrollment must match Medical enrollment.)**

I do not wish to enroll myself. I do not have other medical coverage.

I do not wish to enroll my  spouse/state registered DP  children.\* They have other medical coverage.

I do not wish to enroll my  spouse spouse/state registered DP  children.\* They do not have other medical coverage  I do not wish to enroll my children in Dental.

\*Please list the names of specific children you wish to waive if you are not enrolling all of them: \_\_\_\_\_

If you are declining health coverage enrollment for yourself or dependents (including your spouse/State Registered DP) because of other coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have **involuntarily** lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within the time period allowed (see your Certificate). If you request coverage for yourself and/or eligible dependents at a later date, coverage may be subject to late enrollment penalties.

## 9. Life and AD&D Insurance: Life & AD&D Insurance is underwritten by LifeWise Assurance Company.

Beneficiary Designation: Subject to the terms of my Group Insurance Policy, I hereby designate or amend and revoke any former beneficiary named by me, and I now designate as Beneficiary:

Name (Last, First, MI,) \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary's Mailing Address \_\_\_\_\_

Name (Last, First, MI,) \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary's Mailing Address \_\_\_\_\_

**10. EMPLOYEE SIGNATURE** In applying for enrollment as indicated on this application, I declare that to the best of my knowledge all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. PHT, Willis, BSI, and The Insurance Companies may collect, use and disclose protected personal information (PPI) about each individual enrolled under this Application in order to carry out its routine business functions, which, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. The Companies may also disclose PPI to state and/or federal agencies, or other third parties, as required by law.

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.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_/\_\_\_\_/\_\_\_\_

The medical plan imposes a preexisting condition waiting period. This means that if you have a medical condition before coming onto our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a 90-day period. Generally, this 90-day period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 90-day period ends on the day before the waiting period begins. The preexisting condition waiting period does not apply to pregnancy, a child who is enrolled in the plan within 60 days after birth, adoption, or placement for adoption, nor to enrollees under the age of nineteen (19). You can reduce the length of this waiting period by the number of days of your prior "Creditable Coverage".

Definition: "Creditable Coverage" means any of the following coverage's: Group coverage (including FEHBP and Peace Corps); Individual Coverage (including student health plans); Medicaid; Medicare; State Children's Health Insurance Program (SCHIP); TRICARE; Indian Health Service or tribal organization coverage; state high risk pool coverage; employer-provided self-funded health plans; and public health plans. Creditable Coverage does not include coverage only for a specified disease or illness or hospital indemnity (income) insurance. Coverage is Creditable only if there has not been a gap in coverage exceeding 90 days. If you are declining enrollment for yourself or your Dependents (including your spouse or State Registered Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if your employer stops contributing toward the cost of your Dependents' other coverage). However you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the cost of other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, or 60 days after the birth, adoption, or placement for adoption. If you previously declined enrollment in this plan for yourself or your Dependents because of coverage under a CHIP plan, you can enroll within 60 days of loss of such coverage. If you become eligible for premium assistance under a CHIP plan, you or your Dependents can enroll in this plan at any time once becoming eligible for premium assistance.

**IMPORTANT: THE FOLLOWING TERMS ARE A PART OF THIS APPLICATION. YOU MUST READ THEM CAREFULLY.  
DO NOT SIGN THE APPLICATION ABOVE UNTIL YOU UNDERSTAND THESE TERMS.**

I, the applicant (employee) on my behalf and on behalf of every covered Dependent listed on this form or added in the future hereby:

1. Agree that in the event any health care benefits provided to me or any covered Dependent by Health Net Health Plan of Oregon, Inc. (Health Net of Oregon) and/or its representatives are the primary responsibility of Medicare or of any coverage for work-related injuries, illness or conditions or of any third party on account of any injury, illness, condition or damage, I will fully inform Health Net of Oregon and/or its representatives and will execute such assignments, liens or other documents which may be necessary to enable Health Net of Oregon and/or its representatives to recover the value of services provided. I further agree that in the event I, or any Dependent collects benefits, damages or reimbursement from Medicare or any other third party with respect to such injury, illness, condition or damage, after being fully compensated for my general damages, I will immediately reimburse Health Net of Oregon and/or its representatives to the full extent of services provided by Health Net of Oregon and/or its representatives in accordance with the group Agreement; and
2. Agree to be bound by each and every provision of the group Agreement (including all schedules and attachments which are a part of the group Agreement) as now in effect and as may be amended in the future, and agree that all my rights are as specifically set forth in the group Agreement; and
3. Authorize my employer to deduct from my earnings any amount required to cover my share of the premiums or prepayment fees, if any, payable under the group Agreement; and
4. Acknowledge that Health Net of Oregon and/or its representatives Benefits are only available if obtained in compliance with all provisions of the group Agreement

Send this application to:  
PHT Service Center  
222 SW Columbia Street, Suite 600  
Portland, OR 97201  
service@pacifichealthtrust.com

The State of Washington adopted a standard Coordination of Benefits Regulation effective January 1, 1982. If you are separated or divorced from your spouse and have a Dependent child(ren), it is necessary for you to advise us of the following: Date of legal separation or final divorce decree, name of person awarded custody of Dependent(s), name of Dependent(s) involved, and name and address or parent required by courts to furnish medical insurance.

Health Net® is a registered trademark of Health Net, Inc. All rights reserved. Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, Inc.

# **Benefit Solutions, Inc.**

## **EFT AUTHORIZATION FORM**

For BSI Office Use Only:

Locator Number: \_\_\_\_\_

Date Received \_\_\_\_\_

**\*\*PLEASE FILL IN THE FOLLOWING INFORMATION\*\***

**Company Name:** \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Effective Date of Authorization: \_\_\_\_\_

Type of Authorization Form (check appropriate box):

- New Authorization
- Change Banking Information
- Discontinue Electronic Payment

Please debit payments from my: (check one):       **Checking Account**       **Savings Account**

**Banking Information:**

Banking Institution: \_\_\_\_\_

Routing Number: \_\_\_\_\_

*Valid Routing Number must start with a 0, 1, 2, or 3*

Account Number: \_\_\_\_\_

**AGREEMENT**

**I authorize Benefit Solutions, Inc. and Vanco Services, LLC to process variable debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.**

Authorized Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE ATTACHED VOIDED CHECK IN THIS SPACE**



**LATE SUBMISSION APPLICATION**

TO: Pacific Health Trust

FROM (BROKER NAME):

RE: (GROUP NAME)

EFFECTIVE DATE:

We are hereby applying for coverage within Pacific Health Trust as of the effective date noted above for our client. You have requested that submission materials be returned to your office by the 20th of the month prior to the effective date. We were unable to meet this deadline; however, we still wish to implement coverage on behalf of our client.

We, therefore, understand that by providing this material after your stated date that eligibility may be delayed. This could manifest itself in provider disruption for employees, including inability to obtain prescription drugs at the benefits communicated, and non-emergent procedures being delayed or disrupted while our benefits and employee data is loaded into the administrator and carrier systems. We do understand that coverage will be effective as \_\_\_\_\_ and that the disruption should not last more than 10 working days from receipt of enrollment material.

Understanding this, we will take responsibility for informing our client (group) and any remedies that may be available to them.

Authorized Broker Signature:

---

Date:

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## BSI COBRA Administration

RE: BSI COBRA Administration Services

It is important that employers be aware of their responsibilities with regard to the COBRA requirements. Generally, any employer who has twenty or more employees is obligated to offer COBRA continuation coverage to their employees. There are other unique employer scenarios that also require COBRA compliance. If there is any doubt as to whether or not your company is required to comply with the COBRA regulations, you are encouraged to seek legal counsel.

In addition to providing employers with billing and eligibility functions, Benefit Solutions, Inc., offers employers COBRA administration service at no additional charge to the employer. These services include COBRA notification and billing for your eligible COBRA employees. Specific services offered are itemized in the attached COBRA Administration Agreement.

If you wish to retain BSI as your COBRA Administrator, please review and sign the attached COBRA Administration Agreement and return to BSI. BSI will sign the Agreement and you will be mailed a copy indicating the effective date BSI will begin your COBRA administration. The effective date of the Agreement will generally be the first of the month following the BSI's last billing cycle. Do not assume that BSI will begin administration of your COBRA until you have received the signed Agreement.

For more information about BSI COBRA Administration Services please contact BSI at 206-859-2600 or email [cobra@bsitpa.com](mailto:cobra@bsitpa.com).

Sincerely,

BSI COBRA Administration Services

**BSI COBRA Administration Services**

Benefit Solutions, Inc.

P.O. Box 65 Mukilteo, WA 98275-0065

Phone 206-859-2600 Fax 425-771-1226 Email: [cobra@bsitpa.com](mailto:cobra@bsitpa.com)

## **BSI COBRA ADMINISTRATION AGREEMENT**

This COBRA Administration Agreement (this "Agreement") is made by and between

and

BENEFIT SOLUTIONS, INC.

\_\_\_\_\_  
Company Name (please print) (the "Employer")

\_\_\_\_\_  
("BSI")

*WHEREAS*, the Employer wishes to engage the services of BSI in order to comply with the group health plan continuation coverage requirements of Federal law, commonly known as "COBRA," as they relate to the group health plan benefits the Employer provides to its employees through

\_\_\_\_\_  
Company Plan Name (please print)

*WHEREAS*, in furtherance of the Employer's responsibility to comply with the requirements of COBRA, the Employer desires to delegate certain administrative functions and authority to BSI with regard to recordkeeping and accounting of qualified beneficiaries whose group health plan coverage has ceased and who are entitled to continuation coverage under COBRA.

*NOW, THEREFORE*, in consideration of the mutual covenants, conditions and agreements as hereinafter set forth, the Employer and BSI do hereby agree as follows:

### **ARTICLE I - Definitions**

- 1.1 Unless otherwise defined herein, capitalized terms used herein have the same meaning as ascribed to them in the Agreement.
- 1.2 "Continuation Coverage" means the extended health care coverage required by COBRA.
- 1.3 "Qualified Beneficiary" means an individual who is eligible for continuation coverage under COBRA as defined in Treas. Reg. § 54.4980B-3, Q/A-1 (a)(1).
- 1.4 "Monthly Contribution Amount" means the amount a Qualified Beneficiary must pay for Continuation Coverage for himself or herself and any dependents eligible for coverage.
- 1.5 "Plan" means the employee benefit plan that the Employer makes available to its employees.

### **ARTICLE II - Responsibilities of Employer**

- 2.1 During the term of this Agreement, Employer will:
  - (a) Provide an initial notice describing COBRA rights to each covered employee and each covered spouse in the form and manner and in the timeframe required by COBRA.
  - (b) Retain substantiating materials demonstrating compliance with the initial notice requirements of COBRA in a form and manner in compliance with COBRA.
  - (c) Provide COBRA eligibility information to BSI in the form and manner requested by BSI. The Employer will notify BSI of individuals who have experienced a Qualifying Event within 30 days of the Qualifying Event. The notification will be provided by noting termination or other changes of employment status on the monthly employer report, or by separate written notification to BSI. The information provided in the notification will include the following:
    - Name, Social Security Number;
    - Date and Type of Qualifying Event;
    - Current Mailing Address of Qualified Beneficiary; and,
    - Any other information reasonably requested by BSI and available to Employer.
  - (d) Provide BSI with any updated information about the eligibility of a Qualified Beneficiary or eligible dependent of a Qualified Beneficiary available to Employer, including, but not limited to: a change in address of the Qualified Beneficiary; the death or disability of a Qualified Beneficiary; the divorce or separation of a Qualified Beneficiary; and, the enrollment of the Qualified Beneficiary in Medicare or other group health plan coverage.
  - (e) Provide BSI with 30 days advance written notification prior to terminating BSI COBRA services.

### **ARTICLE III - Responsibilities of BSI**

- 3.1 During the term of this Agreement, BSI will:
  - (a) Provide COBRA election notices to Qualified Beneficiaries;
  - (b) Bill Qualified Beneficiaries for the Monthly Contribution Amounts;
  - (c) Collect Monthly Contribution Amounts from Qualified Beneficiaries and remit to the insurer;
  - (d) Provide notice of unavailability of COBRA coverage; and,
  - (e) Provide notice of early termination of COBRA coverage.
- 3.2 BSI will provide notification of the right to elect continuation coverage under the Plan to individuals who have been identified by the Employer as Qualified Beneficiaries who have experienced a Qualifying Event. BSI will mail the notice by first class mail to the mailing address provided by the Employer. A single notice, addressed to each Qualified Beneficiary, may be sent to a covered employee, covered spouse and dependents residing at the same address. The notice will be mailed within fourteen (14) calendar days from receipt of the notification from the Employer. The notice will specify coverage(s) under the Plan for which the Qualified Beneficiary is eligible, the COBRA premium amount, and due date.

- 3.3 Unless otherwise notified by the Employer in writing, BSI will be entitled to conclusively presume that a Qualified Beneficiary's eligibility for continuation of coverage under the Plan has not terminated by reason of coverage under another group health plan.
- 3.4 BSI will determine the applicable COBRA premium for each Qualified Beneficiary and may include in that premium amount an administrative fee as permitted by Internal Revenue Code § 4980B(f)(2)(C).
- 3.5 It is expressly understood that BSI is neither the "Plan Administrator" nor a "Named Fiduciary" with respect to the Plan, as defined by ERISA or the Internal Revenue Code as the result of this Agreement.

**ARTICLE IV - Fees**

- 4.1 BSI may retain as a fee for its services an administrative fee as permitted by Internal Revenue Code § 4980B(f)(2)(C). BSI will not charge the Employer a separate fee for the services described in this Agreement.

**ARTICLE V - Indemnification**

- 5.1 Employer agrees to indemnify and hold BSI harmless against any loss, damage, or expense, including penalties and reasonable attorney fees, that BSI may incur or be required to pay as a result of any claim, demand, cause of action, lawsuit or proceeding arising out of or in any way in connection with the services provided under this Agreement resulting from the willful misconduct, negligence, fraud or bad faith of Employer, its employees or agents.

**ARTICLE VI - Notices**

- 6.1 Any notices permitted or required by this Agreement shall be sent to the intended recipient by first class mail at his or her last known address.

**ARTICLE VII - Severability**

- 7.1 If any term or provision of this Agreement is held to be unlawful or invalid for any reason, such unlawfulness or invalidity shall not affect the remaining portions of this Agreement.

**ARTICLE VIII - Construction**

- 8.1 This Agreement shall be construed and interpreted in accordance the laws of the State of Washington, the Employee Retirement Income Security Act of 1974, the Internal Revenue Code and the regulations there under, and any other applicable federal and state statutes and regulations.

**ARTICLE IX - Arbitration of Disputes**

- 9.1 Any claim or controversy that arises out of or relates to this Agreement or breach of it will be settled by arbitration in the City of Seattle, in the State of Washington, in accordance with the rules then obtaining of the American Arbitration Association. Judgment upon the award rendered may be entered in the King County Superior Court in the State of Washington.

**ARTICLE X - Termination of COBRA Agreement**

- 10.1 Employer or Benefit Solutions, Inc. may terminate this Agreement only upon 30 days advance written notification.

**"Employer"**

**"BSI"**

**BENEFIT SOLUTIONS, INC.**

\_\_\_\_\_  
Company Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date Signed

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date Signed

**For Administrative Use:**

\_\_\_\_\_  
Effective date of executed agreement

\_\_\_\_\_  
Client Account #

\_\_\_\_\_  
Copy of executed agreement returned to Employer on (date)

\_\_\_\_\_  
By (name)



**Profile**

Company Name \_\_\_\_\_ Tax ID Number \_\_\_\_\_ - \_\_\_\_\_  
 Street Address \_\_\_\_\_ Company Website \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

**Contact Information**

Primary Contact \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Title \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Second Contact \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Title \_\_\_\_\_ E-mail Address \_\_\_\_\_

**Division and Classes**

Please list Divisions within the company  
 Division 1 \_\_\_\_\_ Division 2 \_\_\_\_\_  
 Division 3 \_\_\_\_\_ Division 4 \_\_\_\_\_

More than one class of employee? (example: Hourly, Salary, Executive, Administrative, etc.)  
 Class 1 \_\_\_\_\_ Waiting Period \_\_\_\_\_ Days \_\_\_\_\_ Hours/Week Coverage start date \_\_\_\_\_  
 Class 2 \_\_\_\_\_ Waiting Period \_\_\_\_\_ Days \_\_\_\_\_ Hours/Week Coverage start date \_\_\_\_\_  
 Class 3 \_\_\_\_\_ Waiting Period \_\_\_\_\_ Days \_\_\_\_\_ Hours/Week Coverage start date \_\_\_\_\_  
 (First day after waiting period, or 1st of month following waiting period)

**Plan Design**

Plan Year	From _____	To _____	Employer Contribution	Maximum Employee Contribution
Flexible Spending Account	Yes	No	\$ _____	\$ _____
Dependent Care Account	Yes	No	\$ _____	\$ _____
Health Reimbursement Account	Yes	No	\$ _____	N/A
Cover: Copays _____	Deductibles _____	Coinsurance _____	Other _____	(please provide Summary of Benefits)
Health Savings Account	Yes	No	\$ _____	\$ _____

**Banking Information**

Payroll Frequency and starting date (Please describe): \_\_\_\_\_  
 Example: 15th and last day of month, 5th and 20th of month, every other Friday, once a month..

Bank Name \_\_\_\_\_ Account Type  Checking  Savings  
 Routing Number \_\_\_\_\_  
 Account Number \_\_\_\_\_

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

Employer agrees to keep this account adequately funded for employee claim reimbursement.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**Participant Information**

Employer Name \_\_\_\_\_  
 Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Last Middle  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Day Telephone ( ) \_\_\_\_\_  
 Pay Frequency (circle one): Monthly / Semi-Monthly / Bi-Weekly (24) / Bi-Weekly (26) / Weekly / Other  
 Email Address\* \_\_\_\_\_ Hire Date \_\_\_\_\_ Hours worked / week \_\_\_\_\_  
\*Email address is mandatory, account access is provided to participants through this address.  
 Gender (Please circle one): Male / Female Marital Status (Please circle one): Married / Single

**Enrollment**

Cause for Enrollment:  Open Enrollment  New Hire  Status Change (marriage/birth/divorce/death)  
 Type of Coverage  Single  Family  Limited Family

**Dependent Information**

First Name	Last Name	Birth Date	Relationship	Gender (M or F)	Student (Y or N)

Per IRS regulations, any expenses you incur must be within the plan year. Expenses you incur may not be reimbursed by any other source, such as insurance; You must provide proper documentation to receive payment. You cannot change or revoke your election during the plan year unless there is a specific change of status and your employer allows such changes.

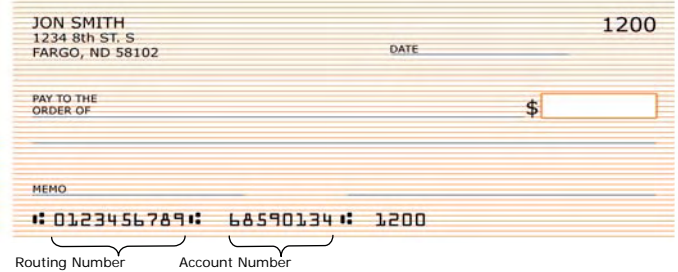
**Participant Banking Information**

Bank Name \_\_\_\_\_ Account Type  Checking  Savings  
 Routing Number \_\_\_\_\_  
 Account Number \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

(This account information is used so that claim repayments can be made by direct deposit. If Banking information is not provided then repayments for items not purchased with the benefit debit card will be made via a paper check, mailed to the participant address listed in section one )

I hereby certify the information provided on this form is accurate. Further, I understand my completion and submission of this form authorizes Benefit Solutions, Inc. to issue payment directly to the specified account unless I notify them otherwise.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_



**Employer Information (employer completes this section)**

Plan Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_  
mm/dd/yyyy mm/dd/yyyy  
 HRA Annual Total \$ \_\_\_\_\_ HRA Annual Total per Family Member \$ \_\_\_\_\_  
This is the amount the employer will fund in the current plan year per employee, and then per dependent

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Participant Information**

Employer \_\_\_\_\_ Employee Name: \_\_\_\_\_  
 Employee SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
mm/dd/yyyy  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Day Telephone ( ) \_\_\_\_\_  
 Pay Frequency (Please describe): \_\_\_\_\_  
 E-mail Address\* \_\_\_\_\_ Hire Date \_\_\_\_\_ Hours Worked/Week \_\_\_\_\_  
\*E-mail address is mandatory, account access is provided to participants through this address.  
 Gender: Male / Female Marital Status: Married / Single

**Enrollment**

**Cause for Enrollment:**  Open Enrollment  New Hire  Status Change (marriage/birth/divorce/death)

	FSA (Medical) Limit set by employer	FSA (Dependent Care) Limit set by employer up to IRS max of \$5,000	Total
Annual Election <small>(cannot exceed employer's specified amount)</small>	\$ _____	\$ _____	\$ _____
Number of Pay Periods	-----		÷
Amount Deducted per Pay Period	-----		=
Date of First Payroll	_____		
<small>mm/dd/yyyy</small>			
Participant Effective Date	_____		
<small>mm/dd/yyyy</small>			

To calculate per paycheck deduction divide annual election by number of pay periods

**Participant Banking Information**

Bank Name \_\_\_\_\_ Account Type  Checking  Savings  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Routing Number \_\_\_\_\_  
 Account Number \_\_\_\_\_  
(This account information is used so that claim repayments can be made by direct deposit. If Banking information is not provided then repayments for items not purchased with the benefit debit card will be made via a paper check, mailed to the participant address listed in section one )

**Participant Authorization**

**Accept:** I authorize my employer to reduce my pay on a per pay period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with the Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account

**Decline:** I do not want to participate. I understand that by refusing to participate, I will be unable to enroll this plan year unless I experience a qualifying event in accordance with the Internal Revenue Code Section 125 and submit the change within a reasonable amount of time as deemed by the IRS and my employer

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_





# Health Savings Account Enrollment Form

## Step 4 of 5: Designation of Death Beneficiary(ies)

All of the following information is required should you choose to designate any primary or contingent beneficiaries.

Share percentages must be whole numbers totaling 100%.

HSA beneficiaries can be updated by logging into your account

Name	Social Security Number	Birth Date	Address	Primary or Contingent	Relationship	Share %
				Primary		
				Contingent		
				Primary		
				Contingent		
				Primary		
				Contingent		

**If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary.** I understand if any primary or contingent death beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary(ies) shall be increased on a pro rata basis. If more than one primary death beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA. If I do not designate a death beneficiary, or if all of my primary and contingent death beneficiary(ies) predecease me, my estate will be the death beneficiary.

Please check one of the following:

- I am not married and designate the individual(s) listed above to receive death benefits from the plan in accordance with the plan provisions.
- I am married and I understand that if I choose to designate a primary death beneficiary other than my spouse, he or she must agree to the designation by signing below.

**Signature of Spouse**

**Date**

## Step 5 of 5: Authorized Signature

By signing this application I represent that: 1) I am covered under a high deductible health plan (HDHP); 2) I am not covered by any other health plan that is not an HDHP; 3) I am not enrolled in Medicare; and 4) I cannot be claimed as a dependent on another person's tax return. I understand that if my spouse is enrolled in a general-purpose FSA (a non-HDHP) I am not eligible to contribute to an HSA. I understand my Health Savings Account will be set up effective the first day of the month following the date the Enrollment Application is signed. Further I understand that my Health Savings Account cannot be effective prior to my HDHP coverage date.

\*Signature of Applicant

\*Date