FOR OFFICE USE ONLY
Med RB: _____
Dent RB: _____
Eff. Date: _____
Group #: _____

MASTER APPLICATION FOR INSURANCE COVERAGE

Return application to NATA@dimarinc.com

Company Information:

Legal Name of Business:	Requested Effective Date:	❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other
dba (if applicable)	Employer Tax ID Number (EIN):	
Type of Business:	NAICS Code:	

Billing Address: (street, city, state, zip)

Physical Address: (if different)

Billing/Eligibility Contact:	Phone: Fax:	Email:

Medical Coverage – Choose either Health Net Health Plan of Oregon or Kaiser Permanente

Health Net

PPO Advantage:

- ❑ 80 | $750 (A20-750-2-3750)
- ❑ 80 | $1,000 (A25-1000-2-4000)
- ❑ 80 | $1,500 (A25-1500-2-4500)
- ❑ 80 | $2,000 (A20-2000-2-5000)
- ❑ 80 | $3,000 (A30-3000-2-5600)
- ❑ 80 | $5,000 (A35-5000-2-5600)

Essential:

- ❑ 80 | $3,000 E (E35-3000-2-5600)
- ❑ 80 | $5,000 E (E35-5000-2-5600)

Community Care:

- ❑ 70 | $1,500 (CC3T 10-1500-2-4500DX)
- ❑ 70 | $2,000 (CC3T 20-2000-3-5600ES)
- ❑ 70 | $3,000 (CC3T 25-3000-3-5600ES)
- ❑ 70 | $5,000 (CC3T 35-5000-3-5600ES)

HSA Plan (Rx included):

- ❑ 80 | $2,600 (HDE26008060 w/HD80)

Choose a prescription plan for your PPO Advantage, Essential or Community Care plan:

- ❑ 10 | 50 | 75 (NMSL 10-50-75-1,000 & 2,000)
- ❑ 15 | 30% | 50% (NMSL 15-30%-50%-1,000 & 2,000)

Kaiser Permanente

DHMO (Rx included):

- ❑ 80 | $500
- ❑ 80 | $750
- ❑ 80 | $1,000
- ❑ 80 | $1,500
- ❑ 80 | $2,000
- ❑ 80 | $3,000
- ❑ 80 | $4,000
- ❑ 80 | $5,000

POS (Rx included):

- ❑ POS | $500
- ❑ POS | $2,000
- ❑ POS | $4,000

HSA Plan (Rx included):

- ❑ 80 | $2,600

Vision Rider – Health Net Health Plan of Oregon or Kaiser Permanente (must match with medical carrier)

Vision: ❑ Health Net Vision Rider Preferred 1025-2/15 ❑ Kaiser Permanente Vision Rider

Dental – Regence BlueCross BlueShield of Oregon or LifeMap Assurance Company

Regence Group Dental: ❑ Expressions Dental Plan 1 ❑ Expressions Dental Plan 2

LifeMap Voluntary Dental: ❑ Voluntary 1 ❑ Voluntary 2 (Minimum enrollment requirement on voluntary dental is 5 employees)

Prior Coverage

Will this coverage replace existing group coverage with another carrier? ❑ Yes ❑ No

(NEW GROUPS ONLY): If yes, name of carrier: _____

Late Fee Policy – *Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of $25 or 1.5% of the amount owed, whichever is greater. The fee will be added to the next month's billing statement. Unpaid balances may be referred to collections. The employer will be responsible for any fees, attorney fees or other fees, associated with the collections process.*

Pay Via: ❑ Electronic Funds Transfer (EFT) ❑ Other
**If you choose EFT as your payment option you must also complete the EFT form*

NATA Membership – *A membership with NATA is required to obtain coverage through Northwest Automotive Trades Association Health Plan. If you are not a current member, please complete a NATA Membership Application. Membership must be maintained to continue coverage under the plan.*

Current Member: ❑ Yes ❑ No

COBRA and FMLA	
	COBRA Administration: Regardless of size, all groups insured by Northwest Automotive Trades Association Health Plan are eligible for COBRA. Benefit Solutions, Inc. will administer COBRA for all NATA lines of coverage at no additional cost.
❑ **Yes** ❑ **No**	**FMLA:** Did your company employ 50 or more full and/or part-time employees during each of the 20 calendar weeks in the current or preceding calendar year, and is it subject to federal TEFRA laws?
_____	**Affordable Care Act Required Information:** Please enter the average number of employees that were employed by your company during the prior calendar year (January – December). This count should include: full-time, part-time, seasonal, and union employees that work inside or outside the state of Oregon and employees in any state from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.

CMS Statement	
❑ **Yes** ❑ **No**	If you are part of a multi-employer group health plan and you want Medicare to be primary, has CMS approved a Small Employer Exception for your Group?

Eligibility and Enrollment

Participation and Contribution Requirements	■Minimum 75% Employee Participation of all eligible employees ■Minimum 50% Employer Contribution for Employee Coverage	
Employer Contribution	Employee: %	Dependent: %

Eligible Employees are required to work _____ hours per week
(Minimum Requirement: 17.5 hours per week, administered on a non-discriminatory basis, based on conditions of employment)

Eligibility Look Back Measurement/Stability Period:
Has your company adopted a look back measurement/stability period under the ACA for the employee classification referenced above?
❑ Yes ❑ No
If Yes, the Measurement Period is ___ months and the Stability Period is ___ months. Please confirm that this measurement period is being applied due to a good faith uncertainty about whether the employee meets the eligibility criteria referenced above: ❑ Yes

Are there more than one Eligible Employee Classifications: ❑ Yes ❑ No

Class 1:_____Eligibility Requirements (other than hours):_____

Class 2:_____Eligibility Requirements (other than hours):_____

Is there a probationary period: ❑ Yes ❑ No
If yes, the probationary period is effective on the 1st of the month following:

Class 1: ❑ Date of Hire* ❑ 30 Days ❑ 60 Days – not to exceed 90 Days

Class 2: ❑ Date of Hire* ❑ 30 Days ❑ 60 Days – not to exceed 90 Days

***If 'Date of Hire' (DOH) is selected above, choose how DOH will be administered**
❑ Effective date will always be 1st of month following DOH, even if DOH is the 1st of the month
❑ Effective date will be 1st of the month following DOH, with the exception of when the DOH is the 1st of the month.

NEW GROUPS ONLY - Is probationary period waived on group's initial enrollment?
❑ Yes (Probationary period applies only to future full-time employees)
❑ No (Probationary period applies to all current and future full-time employees)

For employees transferring from part-time to full-time status, the probationary period specified should apply

❑ Retroactive to the original date of hire **OR** ❑ Beginning on the date transferred to full-time status

Group Participation

Total number of employees on payroll regardless of hours worked. (Do not include COBRA participants)	
• Less employees working fewer than the **minimum hours** required	-
• Less employees not in an **eligible class**	-
• Less employees who have not completed the **probationary period**	-
• Less employees paid via IRS Form **1099, or temporary, seasonal or substitute** employees	-
• Less employees waiving coverage because they are covered by **TRICARE (CHAMPUS), Medicaid or coverage through the Exchange**	-
• Less employees waiving coverage because they are covered by a spouse's or parent's **similar group medical plan. (Proof of coverage required if participation falls below 75%).**	-
• Less employees waiving coverage because they are covered by **Medicare as primary**, at the request of the Medicare enrollee. **(Proof of coverage required if participation falls below 75%).**	-
• Equals total number of employees eligible to enroll	=
• Number of employee applications being submitted (75% participation required)	
• Number of employees covered by your group under provisions of COBRA	

Northwest Automotive Trades Association Health Plan - Subscription Agreement Language

Understanding of the Terms & Provisions of Participation

The undersigned Employer agrees to adhere to the terms, conditions and limitations of coverage as set forth in the health service contracts, insurance policies, service contracts, benefit booklets and certificates of insurance issued by Northwest Automotive Trades Association Health Plan or Northwest Automotive Trades Association Health Plan's respective carriers.

We agree, in the event this application is accepted, to cooperate with the Plan in complying fully with the requirements of section 2715 of the Public Health Service Act to disclose summary plan and benefit information to eligible and renewing plan participants and beneficiaries. Applicant acknowledges that it has received information provided by the Plan's "Summary of Benefits and Coverage to Eligible and Covered Persons' Instructions for Reproduction and Distribution" and agrees to assume the responsibilities assigned to the "Group" thereunder. We understand a member's coverage terminates the last day of the month in which that member ceases to be eligible under group eligibility provisions. We understand that there will be one open enrollment period per contract year. The period will be for 30 days prior to the renewal effective date.

Sponsor – The undersigned Employer acknowledges and agrees that Board of Trustees of the Northwest Automotive Trades Association Health Trust is the Plan Sponsor and shall have all rights and powers described in the Trust Agreement.

Third Party Administrator – The undersigned Employer agrees that the Trust may select one or more service providers to act as a third party administrator ("TPA") for the Trust and/or the welfare benefits plans.

Contributions – The undersigned Employer agrees to pay the contributions established by the Trust every month. The undersigned Employer further understands and agrees that benefits for employees shall not be provided by the Trust during any month for which contributions are not paid. Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of $35 or 1.5% of the amount owed, whichever is greater. The fee will be added to the next month's billing statement. Unpaid balances may be referred to collections. The employer will be responsible for any fees, including attorney fees, associated with the collections process.

Termination – This Adoption Agreement may be terminated by the undersigned Employer, which may withdraw from participation in the Trust by giving thirty (30) days written notice of intent to withdraw to the Trustees. This Agreement may be terminated by the Trust, in the event that the undersigned Employer: (a) fails or refuses to pay contributions due to the Trust in accordance with the Trust Agreement; (b) breaches any of its other obligations under the Trust Agreement of this Adoption Agreement, and such breach has not been cured within ten (10) days after the undersigned Employer receipt of written notice thereof; or (c) fails to meet the eligible requirements for participation in the Trust set forth in this Group Master Application or otherwise adopted by the Trust.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trustees from any and all loss, damages or liability incurred in the course and scope of their respective duties as described in this Agreement, except those resulting from their gross negligence, willful misconduct or dishonesty. In the event that the Trustees are made a party to any legal proceeding of any kind or nature arising out of their respective duties hereunder, directly or indirectly, the undersigned Employer agrees to indemnify and hold them harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting there from. Any damages assessed or expenses required to be paid or incurred by reason of this indemnification shall be borne by the Employer, unless it shall be determined that the damages, expenses or losses incurred result directly from the actions or inactions of a another party. In such event, that specific party shall be primarily responsible for payment, with the Employer only being responsible in the event of the other party is financial insolvent.

Governing Law – This Agreement shall be construed and enforced in accordance with ERISA and, to the extent applicable, the laws of the State of Oregon. We understand the eligibility rules applicable to employee enrollment and guaranteed renewability except for nonpayment and other reasons allowed by Oregon law. Failure to maintain these minimum contribution and minimum participation requirements may result in termination or nonrenewal.

Anti-Fraud Statement

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I agree that all information completed on this application is true, correct, and complete. 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. I understand that the issuer will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Trust after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Trust no longer qualifies for the Rate quoted, I understand that the issuer will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the impacted employers will be required to pay the Rate adjustment within 30 days of the date of notice by the issuer. In addition, the issuer will have the right to collect any claims payments or other damages.

Group Signature Section: Applicant's signature below confirms: a) Applicant's agreement to all the terms and conditions set out in this Application, including the Conditions of Enrollment and Underwriting Assumptions; and b) the accuracy and completeness of the information that the Applicant has entered in this Application.

_____

SIGNATURE & TITLE OF EMPLOYER REPRESENTATIVE **DATE**

Insurance Producer Application

A business applying for insurance coverage through the Northwest Automotive Trades Association Health Plan may appoint their own Insurance Producer to represent them as noted below.

Name of Insurance Producer: _____

Name of Producers Brokerage/Agency: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number: _____Fax Number: _____

E-mail Address: _____

We hereby appoint the above named Insurance Producer as our firm's Producer of Record.
This agreement will serve as notice of cancellation of any previous Insurance Producer agreement. This new appointment will remain effective until written notice is given by either party of a change. No changes may be made retroactively.

_____ _____
Name of Employer Signature of Employer Representative

_____ _____
Date Name & Title (**PRINTED)** of Employer Representative

Coverage Underwritten by:

Medical and Vision Insurance Benefits are underwritten by:
Health Net Health Plan of Oregon, Inc.; 13221 SW 68th Parkway Suite 200, Tigard, OR 97223-8328
Kaiser Foundation Health Plan of the Northwest; 500 N.E. Multnomah Street Suite 100, Portland, OR 97232-2099
Dental Insurance Benefits are underwritten by:
Regence BlueCross BlueShield of Oregon; P.O. Box 1271 MS WW2-25, Portland, OR 97207-1271
LifeMap Assurance Company; 100 Southwest Market Street, Portland, OR 97201

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