FOR OFFICE USE ONLY

Dent Area:_____

Eff. Date: _____

Group #: _____

GA:_____

GROUP MASTER APPLICATION (GMA) FOR INSURANCE COVERAGE

Legal Company Name:	Requested Effective Date:		❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Other
dba (if applicable)	NAICS:	SIC:	
Type of Business:	Federal Tax ID:	State Tax ID:	
Headquarters Address: (street, city, state, zip)		Incorporated in Arizona? ❑ Yes ❑ No	
Billing/Mailing Address: (if different)			
Group Benefits Administrator (Billing/Eligibility) Contact:	Phone: Fax:	Email:	

Medical Coverage - BlueCross BlueShield of Arizona *(requires 2+ enrolled employees)*

Medical Plans and Networks

Plan Combinations: *Groups may select up to 4 plans with no minimum enrollment per plan. For groups choosing dual choice on the Statewide network, a Statewide with Mayo plan may not be combined with a Statwide without Mayo plan.*

Plan Design	Network			Plan Design	Network		
❑ PPO 80|$500	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ PPO 70|$1000	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$750	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ PPO 70|$2000	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$1000	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ PPO 70|$3000	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$1500	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ PPO 70|$4000	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$2000	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ PPO 70|$5000	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$2500	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ PPO 70|$6000	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$3000	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ HSA 80|$1600**	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$4000	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ HSA 80|$3200**	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$5000	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ HSA 80|$3500**	❑ Statewide*	❑ Alliance	❑ PimaConnect
❑ PPO 80|$6000	❑ Statewide*	❑ Alliance	❑ PimaConnect	❑ HSA 80|$4500**	❑ Statewide*	❑ Alliance	❑ PimaConnect
				❑ HSA 100|$4000**	❑ Statewide*	❑ Alliance	❑ PimaConnect
				❑ HSA 100|$6900**	❑ Statewide*	❑ Alliance	❑ PimaConnect

* If Statewide Network is selected, will Mayo providers be considered in-network? ❑ Yes ❑ No

If yes, please confirm your acceptance of the rates that include Mayo providers. ❑ Yes

***Note** : If selecting multiple plans, all plans must either include or exclude Mayo Clinic providers.*

** If an HSA plan is selected, will the group use BCBS's CDH account vendor? ❑ Yes ❑ No

A monthly per member per month account fee will apply

Life/AD&D Coverage - Equitable *(enrollment must match medical)*

Optional Buy-Up Life/AD&D (All plans include $15,000 Life/AD&D)

❑ $25,000 ❑ $50,000 ❑ $75,000 ❑ Dependent Life

Vision Coverage - VSP *(enrollment must match medical)*

❑ Exam Plus ❑ Basic ❑ Preferred ❑ Enhanced

Dental Coverage - BlueCross BlueShield of Arizona *(requires 2+ enrolled employees, may be uncommon with medical)*

❑ DHMO High ❑ PPO 50|1000 AV ❑ PPO 50|1500 AV ❑ PPO 50|1500 A2O w/ortho ❑ PPO 50|1500 P290 O ❑ PPO 50|1000 A90 V

Dental Dual Choice: *Groups of 10 or more enrolled employees may select up to 2 dental plans with no minimum enrollment per plan, but one plan must be the DHMO plan (PPO plans may not be combined).*

Late Fee Policy – *Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of $20 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.*

Payment Options: ❑ Electronic Funds Transfer (EFT)* ❑ Other (Check or Online Payment via SIMON)
**If you choose EFT, please also complete the EFT form*

CAWA Membership – *A Membership with CAWA is required to obtain coverage through CAWA Arizona Health Trust. If your group is not currently a member, please complete a Membership Application. Membership must be maintained to continue coverage under the plan. Membership dues are not used to provide plan benefits and are not consider plan assets. Any membership fees received by CAWA Arizona Health Trust will be forwarded to CAWA.*

Current CAWA Member: ❑ Yes ❑ No

COBRA and FMLA

COBRA Administration: Regardless of size, all groups insured by CAWA Arizona Health Trust are eligible for COBRA. Vimly Benefit Solutions will administer COBRA for all CAWA 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?
❑ **Yes** ❑ **No**	**Medicare vs. Employer as Primary Coverage for Disabled Individuals:** Did your company have more than 100 or more full and part-time employees, (count all employees throughout the U.S.), for at least 50% of the working days during the preceding calendar year?
_____	**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 Arizona and employees in any state from any affiliated company. Remember to include business owners, corporate officers, and partners if they are also employees.

Eligibility and Enrollment

Participation and Contribution Requirements (All Lines of Coverage)	■Minimum 70% Employee Participation of all eligible employees ■Minimum 50% Employer Contribution for Employee Coverage	
Employer Contribution	Employee: %	Dependent: %
Domestic Partner Coverage	Domestic Partners to be covered: ❑ Yes (BCBSAZ guidelines apply) ❑ No	

Eligible Employees are required to work _____ hours per week
(Minimum Requirement: 20 hours per week, administered on a non-discriminatory basis, based on conditions of employment)
On a typical business day how many employees are eligible for health benefit plan coverage?
Arizona Eligible Employees: _____ Non-Arizona Eligible Employees: _____
How many total employees does your company have regardless of benefits eligibility?
Arizona Eligible Employees: _____ Non-Arizona Eligible Employees: _____

Eligible Employee Classifications:

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

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

Probationary period should be effective on the 1st of the month following or coinciding with:

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

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

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 70%)**	-
• Less employees waiving coverage because they are covered by **Medicare**, at the request of the Medicare enrollee. **(Proof of coverage required if participation falls below 70%)**	-
• Equals total number of employees eligible to enroll	=
• Number of employee applications being submitted (70% participation required)	
• Are any enrolling employees not actively at work due to an employer approved leave of absence? If yes, please indicate number of employees on leave. Additional info may be required to determine eligibility.	
• Number of employees covered by your group under provisions of COBRA	

CAWA Arizona Health Trust - 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 CAWA Arizona Health Trust or its respective carriers.

Sponsor – The undersigned Employer acknowledges and agrees that CAWA is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. CAWA may charge a service fee for services performed on behalf of Trust. Additionally, CAWA may charge a membership fee for participating in the Trust. Membership fees are not used to provide health plan benefits and are not considered Trust or Plan assets.

Authority of Trustees – The undersigned Employer acknowledges and agrees that all Trustees appointed under the Trust Agreement shall have all rights and powers described here under and as set forth in the Trust Agreement.

Producers – The undersigned Employer acknowledges that it may hire a producer to represent the Employer when joining the Trust. The undersigned Employer authorizes the Trust to recognize any fee/commission arrangement between the Employer and its producer and to receive and pay such fees/commissions to the producer. Producer fees/commissions received by the Trust shall not be used to provide Plan benefits and are not considered Trust or Plan assets.

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 Plans, and that such service providers may be a member of the CAWA.

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.

Termination – This 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 terminate this Agreement. Such Employer shall have the rights and duties specified in the Trust Agreement. 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, or (b) shall be in breach of any of its other obligations under the Trust Agreement.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trust, its Trustees and the Sponsor from any and all loss, damages or liability resulting from the undersigned Employer's negligence, misrepresentation, breach of contract or dishonesty. In the event that the Trust, its Trustees or the Sponsor are made a party to any legal proceeding arising from the undersigned Employer's negligence, misrepresentation, breach of contract or dishonesty, the undersigned Employer agrees to indemnify and hold them harmless from any and all liability and expenses (including reasonable attorneys' fees) resulting therefrom.

G**overning Law** – This Agreement shall be construed and enforced in accordance with ERISA and, to the extent applicable, the laws of the State of Arizona.

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 Trust's insurers will rely on each answer in making coverage and rating determinations. If the Trust's insurers continues their Contracts 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 or Employer no longer qualifies for the rate quoted, I understand that the Trust or insurer will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Employer will be required to pay the rate adjustment within 30 days of the date of notice by the issuer. In addition, the Trust or insurer will have the right to collect any claims payments or other damages.

Group Signature Section:

SIGNATURE & TITLE OF AUTHORIZED EMPLOYER REPRESENTATIVE **DATE**

Insurance Producer Application

A business applying for insurance coverage through the CAWA Arizona Health Trust may appoint their own Insurance Producer to represent them as noted below.

Broker Name: _____

Agency: _____

Street Address: _____

City, State, Zip: _____

E-mail: _____

Phone Number: _____

General Agent's Name (if applicable): _____

Agency: _____

Street Address: _____

City, State, Zip: _____

E-mail: _____

Phone Number: _____

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 Authorized Employer Representative

_____ _____

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

Coverage Underwritten by:

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association

Medical and Dental Insurance Benefits are underwritten by:
Blue Cross Blue Shield of Arizona | 2444 W Las Palmaritas Dr | Phoenix, AZ 85021
Vision Insurance Benefits are underwritten by:
VSP Vision Care Inc.; 3333 Quality Drive; Rancho Cordova, CA 95670
Life AD&D Benefits are underwritten by:
The Standard Insurance Company; 900 SW 5th Ave, Portland, OR 97204

VSP VISION

EQUITABLE