LifeWISE
A PREMERA HEALTH PLAN, INC.

Employer / Group Agreement
Large Group (100+)

IMPORTANT: This document becomes a part of the Master Insurance Contract when accepted by LifeWise. Any change requires written notification and acceptance by LifeWise.

EMPLOYER INFORMATION

Name of Employer: _____

Full Legal Name of Business (as it is to be shown in your Policy): _____

_____

Federal I.D. Number _____ Phone _____

Street Address: _____
Street City State Zip

Billing Address, if different: _____
P.O. Box or Street City State Zip

Name of Group Administrator: _____ Phone: _____

Name of Contact for Billing Purposes: _____

Type of Industry: _____

AFFILIATES

List names and location of any affiliates to be insured or attach a separate sheet. _____

_____

EMPLOYER'S CONTRIBUTION (please list dollar amount or percentage):

	Medical	Dental	Vision
Employee's Premium			
Dependent's Premium			

Other: _____

_____

EMPLOYER'S ELIGIBILITY PERIODS

1. Minimum number of hours worked per week for employee eligibility: _____ Hours
2. Employees and dependents are eligible for coverage the FIRST OF THE MONTH following:

❑ Day of Hire ❑ 30 Days ❑ 60 Days ❑ 90 Days ❑ 180 Days

❑ Other: _____

EMPLOYEES: EMPLOYEE ROSTER CONTAINING DATE-OF-HIRE INFORMATION IS REQUIRED.

Total Number of Employees including COBRA (include listing of COBRA employees on next page): _____

Less the number of part-time or temporary employees: — _____

Less the number of employees who have not yet completed the probationary period, at the time of the requested effective date of coverage: — _____

Less the number of employess declining coverage (Signed Refusal Form must be included): — _____

Attach completed applications for each employee.

Total Number of Employees To Be Covered: = _____

Form: LW-EGA LG 4/97

By using this form you agree to the following conditions: You may not alter or modify this form in any manner. The most recent version of this form supercedes all prior versions. We may modify this form without notice to you and we reserve the right to accept only the current version.

INSURANCE BENEFITS REQUESTED

REQUESTED EFFECTIVE DATE: _____ , 20____

MEDICAL BENEFITS REQUESTED:

1. Plan Type: ❑ Traditional UCR ❑ Preferred Provider
   ❑ Copay Plan Identify Provider Panel(s): _____
   Mark as appropriate and explain further details: _____
   _____
2. Deductible: _____ / _____ ❑ Not Applicable
   Single Aggregate
3. Stop / Loss: $ _____ or Maximum Out-Of-Pocket $ _____
4. Coinsurance:
   ❑ 80% ❑ 90% / 70% ❑ 80% / 60%
   ❑ Other: _____
5. Benefit Options:
   Women's Health Exams: $15.00 Copay
   Physician Office Call: ❑ Basic Copay: _____ ❑ Major Medical
   Preventive Care: ❑ None ❑ Basic Copay: _____ ❑ Major Medical Annual Max: _____
   Chiropractic Benefits: ❑ None ❑ Basic Copay: _____ ❑ Major Medical Annual Max: _____
   Alternative Care: ❑ None ❑ Basic Copay: _____ ❑ Major Medical Annual Max: _____
   Prescription Drugs: ❑ None ❑ Basic* ❑ Major Medical
   *Copayment(s): Generic: _____ Brand Name: _____ Mail Order: _____ (90-day supply)
   *Coverage: MAC Plan _____ Injectables: ❑ Yes ❑ No Contraceptives: ❑ Yes ❑ No
   Additional Accident Benefits: ❑ None ❑ Standard ❑ Other Please Explain: _____

DENTAL BENEFITS REQUESTED: ❑ None

1. Deductible: $ _____ Deductible waived for Preventive Care? ❑ Yes ❑ No
2. Coinsurance for: Preventive Benefits (Part I) _____
   Basic Services (Part II) _____
   Major Services (Part III) _____
3. Annual Maximum: _____
4. Waiting Periods: ❑ Per contract ❑ Other: _____
5. Orthodontia: ❑ None ❑ See Attached Summary

VISION BENEFITS REQUESTED: ❑ None ❑ 80% UCR ❑ Scheduled ❑ 100% UCR ❑ Other _____

Explain any Non-standard Benefits: _____

FORMER EMPLOYEES CURRENTLY ON COBRA OR STATE CONTINUATION:

List employees currently on COBRA or State Continuation: (Attach additional page if necessary)

Name	State Continuation	COBRA	Qualifying Event & Date	COBRA / CONTIN-UATION END DATE

OCCUPATIONAL COVERAGE (available for Owners ONLY - this is NOT a replacement for Workers' Compensation)

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

NOTE: EXACT DUTIES OF EACH PERSON LISTED ABOVE MUST BE SUBMITTED IN A SIGNED LETTER FROM THE EMPLOYER, ON THE EMPLOYER'S LETTERHEAD. AN ADDITIONAL SURCHARGE WILL BE ADDED TO THE PREMIUM FOR OWNERS WITH APPROVED COVERAGE.

IS THE GROUP REPLACING AN EXISTING MEDICAL INSURANCE PLAN?

❑ Yes ❑ No If yes, name, address and group number of medical insurance carrier and include copy of benefit booklet.

_____

_____

_____

Workers' Compensation Carrier: _____

IS THE GROUP REPLACING AN EXISTING DENTAL INSURANCE PLAN?

❑ Yes ❑ No If yes, name, address and group number of medical insurance carrier and include copy of benefit booklet.

_____

_____

_____

Did the prior dental plan have a waiting period on any services? Yes ❑ No ❑

If yes, length of time: _____ Type of services: _____

COMPREHENSIVE MAJOR MEDICAL OUTLINE OF COVERAGE:

Read the Policy Carefully - This outline of coverage provides a very brief description of the important features of the policy. Please note that this outline is not intended to be a part of the insurance contract. Only the actual policy provisions are final and binding. This policy itself sets forth in detail your rights and obligations as well as those of the insurance company. PLEASE READ THE POLICY CAREFULLY!

Major Medical Expense Coverage - Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care, subject to any deductibles copayment provisions or other limitations that may be set forth in the policy.

BENEFITS: PLEASE REFER TO THE ATTACHED BENEFIT SUMMARY.

Additional Information: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If You Are Considering Replacing Your Current Coverage: Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtain your current policy from another agent or a representative of another company, ask that agent or representative any questions you may have about that policy.

Questions? If you have any questions that are not answered by this outline of coverage, be sure to ask your agent or insurer representative.

Read Your Policy. If you purchase the offered policy, read it carefully as soon as you receive it.

Employer's Signature_____ **Date**_____

Title_____

Agent Signature_____ **Date**_____

THIS SECTION FOR LIFEWISE USE ONLY

Class		PREMIUMS Medical	+ Dental	+ Vision	= Sub Totals	Number of Eligible Employees	TOTALS
Employee T1						X	
Employee & Spouse T2						X	
Employee & Family T3						X	
Employee & Children T4						X	
Composite Rate						X	

Total number of contracts: _____ _____ (Total Monthly Premium) X 12 = _____ (Total Annual Premium)

Occupational Rate: _____

Comments: _____

_____

MARKETING & UNDERWRITING DEPARTMENT

Rate Guaranteed Until: _____

Agent Name: _____ Number: _____

Agent Address: _____

Commission Rate: _____

Renewal Notification: ❑ Standard ❑ Other: _____

Premium Check: _____ # _____

Sales Executive: _____

Account Executive: _____

Marketing Coordinator: _____

Date: _____ Team Code: _____

Underwriter: _____ Date: _____

Reporting Requirements:

_____

_____

ENROLLMENT DEPARTMENT

Comments: _____

_____

Assigned Policy Number: _____

Claims Notified: ❑ Yes ❑ No

Enrollment Tech: _____ Date: _____

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