LifeWISE
A PREMERA HEALTH PLAN, INC.
IT'S UP TO YOU.

Employer / Group Agreement
Small Group (2 - 50)

LifeWise Group #:

I. GENERAL INFORMATION

Legal Name of Employer / Group: _____

dba (if any): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Mailing Address (if different from above): _____

Phone #: _____ Fax #: _____ E-mail: _____

Name of Contact: _____ Title: _____

Type of Business: _____ SIC#: _____ Tax ID: _____

Check one: ❑ Corporation ❑ Partnership ❑ Limited Partnership ❑ Association
❑ Sole Proprietorship ❑ Not-for-Profit ❑ LLC

In which state is your company headquartered? _____

II. SMALL EMPLOYER CLASSIFICATION

Are you an Oregon Small Employer or a HIPAA Small Employer (see definitions below; please select one.)

❑ **Oregon Small Employer:** Any person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent (50%) of its working days during the preceding year employed no more than 25 Eligible Employees (those with a normal work week of 17.5 or more hours) and no fewer than two (2) Eligible Employees: and
- The majority of whom are employed within this state; and
- A bona fide partnership, independent contractor, or employer-employee relationship exists.

For purposes of determining if an employer is an Oregon Small Employer, the proprietor or partners of a business may be included as employees as provided in ORS 743.730. Small Employer also includes companies that are eligible to file a consolidated tax return pursuant to ORS 317.715.

❑ **HIPAA Small Employer:** A Small Employer as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 42, U.S.C. 300gg-91), who does not otherwise qualify as an Oregon Small Employer and who:
- Employed at least two (2) and no more than 50 part-time and full-time employees on business days during the preceding calendar year; and
- Employed at least two (2) employees on the first day of the Plan year.

For purposes of determining if an employer is a HIPAA Small Employer, the proprietor or partners of a business are not included as employees, as provided in federal regulations at 29 CFR 2510.3-3.

1. Total number of employees: (must include all persons employed regardless of enrollment status) _____
2. Less the number of employees working less than 17.5 hours per week: − _____
3. Less the number of temporary, contract, or seasonal employees: − _____
4. **Total number of permanent employees working more than 17.5 hours per week:** = _____
5. Of the total number of employees listed on Line 1, how many employees worked a minimum of 17.5 hours per week for at least 50% of the prior 12 months: _____

III. EMPLOYEE PARTICIPATION / ELIGIBILITY

LifeWise requires 100% participation of eligible employees and 25% participation of eligible dependents.

1. Total number of employees from line 4, Section II above: _____
2. Less the number of employees not eligible due to working less than the employer's minimum required hours: − _____
3. Less the number of employees who have not satisfied their eligibility waiting period: − _____
4. Less the number of employees waiving due to other group coverage: − _____
5. **Total actual number of employees enrolling:** = _____

Groups with 5 or fewer enrolling employees must submit one of the following:
Business Employment Verification Statement, completed by a CPA or CMA; or Oregon State Wage & Tax form (form 132)

Is LifeWise to cover your out of state employees? ❑ Yes ❑ No

Number of employees working outside of Oregon *and* more than 17.5 hours per week: _____ *
*If this number is more than 50% of line 4 in Section II, the group will be classified as a HIPAA group for rating purposes.

(Maximum out of state participation allowed: 20% of total eligible employees enrolled.)

List state(s) and number of employees employed in each: *(Provide additional sheet if necessary.)*

State	# of employees	State	# of employees	State	# of employees	State	# of employees

IV. PLAN INFORMATION

1. Requested Effective Date: _____
2. Hours per week employees must work to be eligible for benefits: _____

   *If applicable, define separate classes of employees and contribution levels in section VII.
   (Available for HIPAA Small Employers only, and subject to Underwriting Guidelines.)
3. Employees will be eligible for benefits after completing the following waiting period

   • First of the month following: ❑ 30 days ❑ 60 days ❑ 90 days ❑ Date of Hire

   ❑ Other:_____ days *(Available for HIPAA Small Employers only; subject to Underwriting Guidelines.)*
4. What percentage of the premium is contributed by Employer / Group:*

   *If applicable, define separate classes of employees and contribution levels in section VII.
   (Available for HIPAA Small Employers only, and subject to Underwriting Guidelines.)

   Employee: Medical_____ % Vision_____ % Dental _____ %

   Dependent: Medical_____ % Vision_____ % Dental _____ %

   (The employer must contribute at least 50% of the aggregate "employee only" monthly premium.)
5. Do you currently have any former employees and / or dependents that have elected or are covered under COBRA / State continuation who will be covered under this plan?: ❑ Yes ❑ No *(If Yes, please indicate on employee's application.)*

V. EXISTING INSURANCE INFORMATION

Workers compensation / state industrial carrier: _____ Policy #: _____

Are you replacing existing group health coverage:

❑ Yes ❑ No If Yes, attach Creditable Coverage information and provide carrier name: _____

Are you replacing existing group dental coverage:

❑ Yes ❑ No If Yes, attach proof of prior coverage credit and provide carrier name: _____

VI. BENEFIT PLANS REQUESTED

Medical *(If applicable, please indicate plans by class of employee in Section VII; subject to Underwriting Guidelines.)*

❑ **LW 2** $10/250/5000 ❑ **LW 21** $15/250/7500 ❑ **LW 31** $15/1000/10000 ❑ **LW 51** TRADITIONAL

❑ **LW 3** $10/500/7500 ❑ **LW 22** $15/500/10000 ❑ **LW 32** DED/SL ❑ State Basic Plan

Prescription Drug *(Please select one of the following. All medical plans except the State Basic Plan require prescription drug coverage. If one is not specifically selected, the 150DED $5 / 25 / 45 will be issued.)*

❑ **$10 / 20 / 40** ❑ **$15 / 25 / 40** ❑ **150DED $5 / 25 / 45** ❑ **250DED $10 / 25 / 45**

Vision *(Not available with the Basic Plan.)*

❑ **V100** ❑ **V150** ❑ No Coverage

Dental *(A minimum of 5 employees must be enrolled at all times; not available with the Basic Plan.)*

❑ **D1** $25*/100-80-50/1000 ❑ **D3** $50/80-80-50/1000 ❑ **D5** $50*/100-80-50/1000 ❑ No coverage

❑ **D2** $25*/100-80-50/1500 ❑ **D4** $50/80-80-50/1500 ❑ **D6** $50*/100-80-50/1500

* Deductible waived for preventive

Orthodontia *(Available only to groups of 26+ enrolled eligible employees; subject to Underwriting Guidelines.)*

❑ **01** under 19 / $1000 ❑ **03** any age / $1000 ❑ No coverage

❑ **02** under 19 / $1500 ❑ **04** any age / $1500

24-Hour Coverage *(Subject to Underwriting Guidelines.)*

Total number of owners:_____

24-hour coverage is provided for owners, sole proprietors, officers, or partners not covered by Workers' Compensation. The names of individuals eligible for 24-hour coverage must be provided to us upon group or individual enrollment in order for the coverage to be valid. Eligibility for 24-hour coverage **WILL NOT** be made retroactively.

Name _____ Title _____

Name _____ Title _____

VII. SPECIAL PROVISIONS

Please provide any additional provisions or conditions for this group (i.e., special billings, key contacts).

_____

_____

_____

_____

_____

_____

VIII. EMPLOYER / GROUP AGREEMENT

You, the Employer / Group, agree by signature or by payment of the required premium, to the following:

I understand and agree that the first month's estimated premium and fully completed enrollment information for all eligible persons requesting coverage must be submitted to LifeWise, A Premera Health Plan, Inc. with this Agreement before action is taken on this Agreement. You should not cancel any prior coverage based solely upon the completion of this Agreement.

LifeWise, A Premera Health Plan, Inc. will return the premium deposit submitted with the Agreement, if this Agreement is declined.

I understand and agree that no special agent has the authority to waive a complete answer to any question, make or alter any contract or waive any rights or requirements.

I represent and agree that all answers and statement in this Agreement are full, complete and true to the best of my knowledge and belief, and understand that these answers and statement form the basis upon which coverage will be made effective. I understand that omissions or misrepresentations may result in LifeWise, A Premera Health Plan, Inc. voiding or terminating an individual's or employer / group coverage.

Date: _____ **By:** _____

Name (please print)**:** _____

Title: _____

You, the agent(s), certify that you have met with the Employer / Group submitting this Agreement and that you have fully explained its contents. You have discussed coverage, eligibility, any Pre-existing Condition Exclusion Periods, the effect of misrepresentations, termination provisions and premium billing administration.

Agent of Record (please print)**:** _____ **Agent Number:** _____

Agency Name: _____

Agent Signature: _____

Phone Number: _____ **Fax Number:** _____ **E-mail:**_____

LifeWISE
A PREMERA HEALTH PLAN, INC.

IT'S UP TO YOU.

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Small Group Quote Request

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