ARIZONA TECHNOLOGY COUNCIL
a place to connect and grow

FOR OFFICE USE ONLY
Group #: _____
Eff. Date: _____
Dent Area:_____
Misc:_____

MASTER APPLICATION, PARTICIPATION AGREEMENT, AND AGREEMENT FOR INSURANCE COVERAGE

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, zip)		
Shipping Address: (if different)		
Billing Contact *(Contact for SIMON portal invitation?)*:	Phone:	Email:
Eligibility Contact *(Contact for SIMON portal invitation?)*:	Phone:	Email:

Prior BCBSAZ Coverage

Will this coverage replace existing group coverage with BCBSAZ? ☐ Yes ☐ No

Medical Coverage – BCBSAZ

1. BCBSAZ Network Options: ☐Statewide w/Mayo(SW+M) ☐Statewide w/o Mayo(SW) ☐Alliance(ALL) ☐PimaConnect(PC)

2. Select Medical Plans(s)* and Network Pairing:

☐ PPO 100|$5000	☐ PPO 80|$750	☐ PPO 80|$3000	☐ PPO 70|$2000	☐ HSA 100|$3500
☐ PPO 100|$7900	☐ PPO 80|$1000	☐ PPO 80|$4000	☐ PPO 70|$3000	☐ HSA 100|$6900
☐ PPO 90|500	☐ PPO 80|$1500	☐ PPO 80|$5000	☐ HSA 80|$1500	
☐ PPO 90|$1000	☐ PPO 80|$2000	☐ PPO 80|$6000	☐ HSA 80|$3000	
☐ PPO 80|$500	☐ PPO 80|$2500	☐ PPO 70|$1000	☐ HSA 80|$4500	

Groups can select up to 4 medical plans. If the 'Statewide with Mayo' network is selected, all Statewide plans will include Mayo.

FSA/HSA – Navia Benefit Solutions

FSA and HSA services are available at no additional cost to you or your employees when enrolled in a BCBSAZ medical plan.

☐ Yes (a Navia representative will contact you to enroll) ☐ No

Dental – BCBSAZ

Optional Dental: ☐ DHMO High ☐ PPO 50-1500 A2 Optimum ☐ PPO 50-1500 P290 O
☐ PPO 50-1000 A Value ☐ PPO 25-2000 A2 Optimum ☐ PPO 50-1000 A90 V
☐ PPO 50-1500 A Value w/ 1500 Adult and Child Ortho ☐ Decline

Groups of 10 or more enrolled employees may select up to 2 dental plans, one of which must be the DHMO High plan option.

Vision – VSP Vision Care, Inc.

Vision: ☐ Exam Plus ☐ Basic ☐ Preferred ☐ Enhanced CVC ☐ EasyOptions ☐ Decline

Life and Disability Coverage – Metropolitan Life Insurance Company

Basic Life/AD&D *(Life plan required with all medical plans)*:

☐ Plan A ($25,000) ☐ Plan B ($50,000) ☐ Plan C ($100,000) ☐ Plan D ($250,000)

Supplemental Life and AD&D: ☐Yes ☐No *(No minimum employee participation requirement)*

Short Term Disability: ☐ Yes *(salary info required)* ☐ 26-week duration ☐ 13-week duration ☐ No

100% employee participation: 60% of weekly salary. All plans Non-Contributory.

☐ **STD Plan 1**: $2500 wkly benefit; 0/7 Day Elimination Period ☐ **STD Plan 2**: $2000 wkly benefit; 7/7 Day Elimination Period

☐ **STD Plan 3**: $ 1750 wkly benefit; 7/7 Day Elimination Period ☐ **STD Plan 4**: $1250 wkly benefit; 14/14 Day Elimination Period

Long Term Disability: ☐ Yes *(salary information required)* ☐ 180-day EP ☐ 90-day EP ☐ No

100% employee participation: 60% of weekly salary; 180-day EP, 90-day EP Option if Stand-alone. All plans Non-Contributory.

☐ **LTD Plan 1**: $10,000 max; Benefit to SSNRA ☐ **LTD Plan 2**: $8,000 max; Benefit to SSNRA

☐ **LTD Plan 3**: $6,000 max; Benefit to SSNRA ☐ **LTD Plan 4**: $5,000 max; 5-Year Benefit Duration

EAP Plan – Wellspring Family Services

3 visits included in medical plan

AZTC Membership

A membership with AZTC is required to obtain coverage through AZTC Employee Benefit Trust. Please submit the AZTC Membership Application along with dues payment. Membership must be maintained to continue coverage under the plan. Membership fees are not used to provide plan benefits and are not considered plan assets. Any membership fees received by the AZTC Employee Benefit Trust will be forwarded to the AZTC. AZTC does not condition membership in the Association or participation in the Trust on any health status-related factor relating to an individual.

Current Member: ☐ Yes ☐ No

Late Fee Policy – Premiums are due by the 1st day of the coverage month. Late payments will be assessed a late fee of 2% of the amount owed. 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. ***NEW GROUPS*** *– A binder check is not required for groups that elect EFT for payment.*

Payment Options: ☐ Electronic Funds Transfer (EFT) (You must fill out the EFT form) ☐ Online ☐ Check

COBRA, Medicare, and FMLA

COBRA Administration: Regardless of size, all groups insured by Arizona Technology Council AHP Employee Benefit Trust are eligible for COBRA. Vimly Benefit Solutions, Inc. will administer COBRA for all lines of coverage at no additional cost.

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: Did your company have 20 or more full and part-time employees, (count all employees throughout the US), for 20 or more calendar weeks during the:

Current calendar year? ☐ Yes ☐ No Preceding calendar year? ☐ Yes ☐ No

Did your company have 100 or more full and part-time employees, (count all employees throughout the US), for at least 50% of the working days during the preceding calendar year? ☐ Yes ☐ No

_____

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 Washington 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	• Minimum 70% Employee Participation of all eligible employees • Minimum 50% Employer Contribution of Employee Coverage
Employer Contribution	Class 1: Employee: _____ % Dependent: _____ % Class 2: Employee: _____ % Dependent: _____ %
Domestic Partner Coverage	Domestic partners to be covered: ☐ Yes (BCBSAZ guidelines apply) ☐ No

What was the average number of total employees on business days during the calendar year prior to your effective date? _

On a typical business day, how many employees are eligible for health benefit plan coverage?
Arizona Eligible Employees: _____ Non-Arizona (US and worldwide) Eligible Employees: _____

How many total employees does your company have regardless of benefit eligibility?
Arizona Eligible Employees: _____ Non-Arizona (US and worldwide) Eligible Employees: _____

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.)

Employee Classifications: *(20+ employees required for addition of Class 2)*
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:

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

***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 month following DOH, with the exception of when the DOH is the 1st of the month

Eligibility and Enrollment (continued)

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 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?
☐ No (Probationary period applies to all current and future full-time employees)
☐ Yes (Probationary period applies only to 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 (Do not leave any blanks, if the answer is "zero" please put "0")	
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, or seasonal, or substitute** employees	- _____
• 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 as primary**, 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)	_____
• Number of employees covered by your group under provisions of COBRA	_____

Adoption of Trust, Appointment of Trustee & Understanding of the Terms of the Selection & Participation

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 Trust Agreement, health service contracts, insurance policies, service contracts, benefit booklets and certificates of insurance issued by the Arizona Technology Council Employee Benefit Trust ("Trust") or the Trust's respective carriers.

Sponsor – The undersigned Employer acknowledges and agrees that Arizona Technology Council (AZTC) is the Trust Sponsor and shall have all rights and powers described in the Trust Agreement. AZTC may also charge a service, license or other sponsorship fee for participating in the Trust. Additionally, AZTC may charge a membership fee for membership in the AZTC as a prerequisite to participating in the Trust. Membership fees are not used to provide health plan benefits and are not considered Trust or Plan assets.

Brokers – The undersigned Employer acknowledges that it may hire a broker 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 broker to receive and pay such fees/commissions to the broker. Employer broker fees/commissions received by the Trust shall not be used to provide 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.

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, and that such service providers may be one or more of the Member Companies.

Contributions – The undersigned Employer agrees to pay the contributions established by the Trust. 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 Participation Agreement may be terminated by the undersigned Employer, which may withdraw from participation in the Trust by giving thirty (30) days written notice to the Trustees of its intent to withdraw, in accordance with the Trust Agreement. Such Employer shall have the rights and duties specified therein. This Agreement may be terminated by the Trust as provided in the Trust, including but not limited to, the undersigned Employer's (a) failure or refusal to pay contributions due to the Trust in accordance with the Trust Agreement, (b) fraud or other intentional misrepresentation of material fact, or (b) breach of any of its other obligations under the Trust Agreement or of this Participation Agreement, which breach shall not have been cured within ten (10) days after the undersigned Employer's receipt of written notice thereof.

Indemnity – The undersigned Employer does hereby indemnify and hold harmless the Trustees and the Sponsor from any and all loss, damages or liability incurred in the course and scope of their respective duties as described in this Agreement and the Trust, except those resulting from the Trustee's or Sponsor's own gross negligence, willful misconduct or dishonesty. In the event that the Trustees or the Sponsor 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. The indemnity provided hereunder shall be joint and several with all of the other Participating Employers under the Trust.

Governing 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 issuer will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Group after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group 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 Group 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	
Signature & Title of Employer Representative	**Date**

Insurance Broker & General Agent Application

A business applying for insurance coverage through the Arizona Technology Council Employee Benefit Trust may appoint its own Insurance Broker and/or General Agent to represent them as noted below:

Broker Name: _____
Agency: _____
Street Address: _____
City, State, Zip: _____
E-mail: _____

General Agent's Name (if applicable): _____
Agency: _____
Street Address: _____
City, State, Zip: _____
E-mail: _____

☐ We request the above-named broker be given access to our records in the online enrollment system, SIMON. *(Employer must complete separate SIMON authorization form. Our third-party administrator will send the form to your SIMON portal contact.)*

☐ We request the above-named general agent be given access to our records in the online enrollment system, SIMON. *(Employer must complete separate SIMON authorization form. Our third-party administrator will send the form to your SIMON portal contact.)*

We hereby appoint the above-named Broker and/or General Agent as our firm's Broker and/or General Agent of Record. This agreement will serve as notice of cancellation of any previous Insurance Broker and/or General Agent 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 & Dental Insurance Benefits:	Blue Cross Blue Shield of Arizona, 2444 W Las Palmaritas Dr., Phoenix, AZ 85021
Vision Insurance Benefits:	VSP Vision Care, Inc., 3333 Quality Drive, Rancho Cordova, CA 95670
Life Insurance Benefits:	Metropolitan Life Insurance Co., 200 Park Avenue, New York, NY 10166
Navia Benefit Solutions:	600 Naches Avenue SW, Renton, WA 98057
Employee Assistance Program:	WellSpring Family Services, 1900 Rainier Ave S, Seattle, WA 98020