



FOR OFFICE USE ONLY

Dent Area: _____

Eff. Date: _____

Group #: _____

Misc: _____

GROUP MASTER APPLICATION (GMA) FOR INSURANCE COVERAGE

Company Information:

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

Medical Coverage - BlueCross BlueShield of Arizona (BCBSAZ)

Medical Plan Options

BCBSAZ Network Options: Statewide w/Mayo Clinic (SW+M) , Statewide w/o Mayo Clinic (SW) , Alliance (ALL) , PimaConnect(PC)**Plan Combinations:** Groups may select up to 4 plans with no minimum enrollment per plan. For groups choosing multiple non-Prosano plans on the Statewide network, a Statewide with Mayo plan may not be combined with a Statewide without Mayo plan.**Exception:** Any Prosano plan may be combined with a Statewide+Mayo plan.

Select Medical Plan(s) and Network Pairing:

Plan Design	Network	Plan Design	Network
☐ PPO 100 \$5000	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ PPO 70 \$1000	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 100 \$7900	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ PPO 70 \$2000	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 90 \$500	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ PPO 70 \$3000	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 90 \$1000	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ PPO 70 \$4000	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$500	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ PPO 70 \$6000	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$750	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ PPO 70 \$7500	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$1000	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ HSA 100 \$3500	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$1500	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ HSA 100 \$7900	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$2000	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ HSA 80 \$1700	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$2500	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ HSA 80 \$3400	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$3000	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ HSA 80 \$4500	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$4000	☐ SW+M ☐ SW ☐ ALL ☐ PC	☐ HSA 70 \$6000	☐ SW+M ☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$5000	☐ SW+M ☐ SW ☐ ALL ☐ PC		
☐ PPO 80 \$6000	☐ SW+M ☐ SW ☐ ALL ☐ PC		

Blue Signature Prosano Plans - NEW!

Plan Design	Network
☐ PPO 80 \$1000	☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$2500	☐ SW ☐ ALL ☐ PC
☐ PPO 80 \$5000	☐ SW ☐ ALL ☐ PC
☐ PPO 70 \$7000	☐ SW ☐ ALL ☐ PC

If a Mayo Clinic network is selected, please confirm your acceptance of the rates that include Mayo Clinic providers. ☐ YesWill this coverage replace existing group coverage with BCBSAZ ☐ Yes ☐ No

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

If an HSA plan is selected, will your group use Health Equity through BCBSAZ? ☐ Yes ☐ NoWill the group use Health Equity for FSA services? ☐ Yes ☐ No

Vision – VSP Vision Care Inc.

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

Dental Coverage - BlueCross BlueShield of Arizona

Optional Dental: ☐ DHMO High ☐ PPO 50|1000 A Value ☐ PPO 50|1500 A Value ☐ PPO 50|1500 P290 Optimum☐ PPO 50|1500 A2 Optimum ☐ PPO 25|2000 A2 Optimum + 1500 Adult and Child Ortho ☐ PPO 50|1000 A90 Value ☐ Decline**Dental Dual Choice:** Groups of 10 or more enrolled employees may select up to 2 dental plans, one of which must be the DHMO High plan option.

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 – CuraLinc Healthcare - 3 visits included in medical plan

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)* ☐ Other (Check or Online Payment via SIMON)

**If you choose EFT, you must also complete the EFT form*

Membership Requirement – 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

COBRA and FMLA

COBRA Administration: Regardless of size, all groups insured by the 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.

☐ 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?

Current Calendar Year?

☐ Yes ☐ No

Preceding Calendar Year?

☐ 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 or preceding calendar year?

☐ Yes ☐ No

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?

Avg # of Employees During Prior 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

■ Minimum 70% Employee Participation of all eligible employees

■ Minimum 50% Employer Contribution for 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

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 (US and worldwide) Eligible Employees: _____

How many total employees does your company have regardless of benefits eligibility?

Arizona Eligible Employees: _____ Non-Arizona (US and worldwide) Eligible Employees: _____

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 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 – PLEASE ENTER A NUMBER ON EACH LINE

Total number of active 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 a **spouse's or parent's similar group medical plan,**

○ Covered by **TRICARE (CHAMPUS), Medicaid or coverage through the Exchange,**

○ 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

Arizona Technology Council Employee Benefit 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 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 Plans, and that such service providers may be a member of the AZTC.

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 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.

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 AUTHORIZED EMPLOYER REPRESENTATIVE

DATE

Insurance Producer 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: _____
Phone Number: _____

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

- ☐ 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 Authorized Employer Representative

Date

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

Coverage Underwritten by:

Medical and Dental Insurance Benefits:

Blue Cross Blue Shield of Arizona | 2444 W Las Palmaritas Dr | Phoenix, AZ 85021

Vision Insurance Benefits:

VSP Vision Care, Inc. (HCSC); 3333 Quality Drive; Rancho Cordova, CA 95670

Life AD&D Benefits:

Metropolitan Life Insurance Co., 200 Park Avenue, New York, NY 10166

Employee Assistance Program:

CuraLinc Healthcare, 314 West Superior Street, Chicago, IL 60654



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

