

KPS
health plans
400 Warren Avenue
Bremerton, WA 98337
800-552-7114

 **DELTA DENTAL**
Washington Dental Service
9706 Fourth Avenue NE
Seattle, WA 98115-2157
800-367-4104


GroupHealth
Group Health Options Inc
320 Westlake Avenue North,
Suite 100
Seattle, WA 98109-5233
888-901-4636



2011 Participation Agreement

SELECTED MEDICAL PLAN(S):

- Platinum Plan (*Alliant Plus*)
- Gold Plan (*Alliant Plus*)
- Silver Pre-Deductible Plan (*Alliant Plus*)
- Bronze Plan (*Alliant Plus*)
- 750 Plan
- 1250 Plan

SELECTED DENTAL PLAN:

- Plan I
- Plan II
- Plan IV
- Plan V
- Plan VI

ADMINISTRATIVE USE

COVERAGE EFFECTIVE DATE: _____

RATE BAND: _____

NOTES:

EMPLOYER INFORMATION

Legal Name _____

'dba' Name _____

Business Address _____

City _____ State _____ Zip Code _____ County _____

Billing Address (if different) _____

City _____ State _____ Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Phone Number _____ Fax Number _____

Tax Identification Number (TIN) _____ NAICS Code _____

Industry _____

WRA or WLA Member ID Number: _____

Caution: Under the Patient Protection and Affordable Care Act, excluding certain employees from eligibility could cause your plan to fail non-discrimination requirements under federal law. To avoid potential penalties, employers should consult with their own advisors before excluding employees from eligibility. HIIIT and the carriers are not able to give employers legal or tax advice.

ELIGIBILITY & PARTICIPATION:

The following categories of employees are not required to participate in the plan but may choose to participate as eligible employees: employees covered by TriCare, Medicare, an HMO or another similar plan.

Eligible Active Employees:

Number of Full Time **Eligible** Employees _____ Working _____ Hours per Week (minimum 32 hours)

Number of Part Time **Eligible** Employees _____ Working _____ Hours per Week (minimum 20 hours)

Total Number of **Eligible** Employees _____

Total Number of **Eligible** Employees in Probationary Period _____

Total Number of **Eligible** Employees Waiving Coverage _____ (Must sign waiver form)

Total Number of **Eligible** Enrolled Employees _____ (Less valid waivers)

Percentage of enrolled employees to total eligible employees must be at least 50%.

Percentage of enrolled employees to total **Eligible** employees _____

Total Number of **ALL** Employees on Payroll _____ (including non-eligible).

**Note: Only list employees below who are deemed eligible at time of initial enrollment or renewal
Do not include employees who are deemed ineligible at time of initial enrollment or renewal (i.e. seasonal)**

EMPLOYEE CLASSIFICATION – Please Circle Choice

Class I: First of the Month Following: Date of Hire, 3, 6, 9 months or other _____ (not to exceed 36 months)

Class II: First of the Month Following: Date of Hire, 3, 6, 9 months or other _____ (not to exceed 36 months)

Class III: First of the Month Following: Date of Hire, 3, 6, 9 months or other _____ (not to exceed 36 months)

**The probationary period in effect at the time an employee is hired must be met before they are eligible for group coverage. Any probationary period changes made at future open enrollments apply to new hires going forward.*

MINIMUM EMPLOYER CONTRIBUTION AND EMPLOYEE PARTICIPATION

The minimum employer contribution percentage to participate in the Trust is 50% of the amount due for the employee. The Patient Protection and Affordable Care Act has additional participation, eligibility and benefit minimum requirements to satisfy non-discrimination rules. Employers should consult with their own legal and tax advisors to determine how these rules may impact their plan.

% of Employee rate paid by the employer _____ % of Dependent rate paid by the employer _____

Waiving Employer Probationary Period (For Groups New To the Association Only)

- Yes, waive the employer probationary period for all current eligible employees
- No, the employer probationary period, as stated, will apply to all current eligible employees

Employee Transfers From Part-Time to Full-Time Status:

- Employer probationary period begins upon the date an eligible employee transfers to full-time status
- Employer probationary period is retroactive to an eligible employee's original date of hire.

Employee Return from Lay-off or Leave of Absence:

- Employer probationary period begins upon the date an eligible employee returns to work
- Employee is effective the 1st of the month following return to work if rehired within 3 months. Otherwise employer probationary period begins again.

Include Coverage for Domestic Partners who are not registered with the State of Washington and their Dependents (there is no cost difference)

- Yes
- No

Did your company employ 20 or more full time and/or part time employees for at least 50% of the workdays of the preceding calendar year (January – December) and is it subject to federal COBRA laws?

- Yes
- No

Participation Requirements

1. Group Health Options Inc, KPS Health Plans & Washington Dental Service will be the sole carriers.
2. H.I.H.I.T. benefit coverage is available to current members of the Washington Restaurant Association and the Washington Lodging Association and their Allied members. Membership is required within either WRA or WLA to participate in a H.I.H.I.T plan. Membership must be maintained during your enrollment in H.I.H.I.T. Groups must be domiciled in Washington State.
3. Participant coverage obtained through this application may be terminated for the following reasons:
 - a. Non-payment of premiums
 - b. Participant eligibility requirements are no longer met
 - c. Membership with either Washington Restaurant Association or Washington Lodging Association is terminated
4. Failure to return a completed Participation Agreement prior to the effective date will result in coverage delays. For renewing groups, participation agreement must be received by the 1st of the renewal anniversary month and may be subject to cancellation due to non-acceptance of renewal terms. For new business, enrollment forms and full payment must be received no later than the 25th of the month prior to the month in which coverage becomes effective. Enrollment after the 25th will require signed Late Enrollment form by the employer. Failure to provide all required information may delay implementation of eligibility and benefit coverage.
5. After the initial payment, regular monthly payments are due no later than the 28th of the month prior to the month of coverage. Participating employers are subject to late payment fees and termination of participation in the Trust if payments are not received timely.
6. Enrollment application forms and full payment of said applicant must be received by NW Administrators within 30 days of effective date. Applications received after this time period will be declined and eligible employee must wait until open enrollment
7. Six (6) medical programs and Five (5) dental programs are available within the Trust.
8. Rates are based upon the number of employees actually enrolled in the Group Health Options Inc or KPS Health Plans medical plan. Rates are guaranteed for 12 months.
9. At least three (3) eligible employees must initially enroll in the plan to establish an employer account in the Trust. Plans with no enrollment will be terminated at the end of the plan year. An employer/employee relationship must exist, with the employee represented on the payroll as receiving a wage or commission.
10. Each employer establishment determines if part-time employees are eligible for coverage. Part-time employment is 20 to 31 hours per week; full-time employment is 32 to 40 or more hours per week.
11. Coverage for new employees becomes effective the first of the month following the probationary period, as defined by the employer. Up to three (3) separate classes of employees may be established by the employer. Probationary periods for employees must be non-discriminatory.
12. The employee, their legal spouse, and/or children up to the age of 26 are eligible to enroll. Domestic partners who are not registered with the State of Washington can also be eligible dependents under the Trust, if the employer elects to include them, by marking "yes" on the domestic partner election option on the Participation Agreement.
13. The employer must contribute at least fifty percent (50%) of the employee's healthcare premium. There is no minimum contribution requirement for dependent coverage.
14. At least fifty percent (50%) of an employer's eligible employees must enroll in the plan to establish an employer account in the Trust.
15. Plan changes by the employer may only be made during the open enrollment period. Plan changes by the employee and dependents may only be made during the open enrollment period unless a special enrollment entitlement has been met.
16. For out of state participants, please contact H.I.H.I.T. prior to group enrollment.
17. All employer groups are subject to COBRA-like benefits. It is the responsibility of the employer group to distribute the COBRA general notice.
18. All plans will be considered *non-grandfathered by the carriers*. Provisions of the Federal Patient Protection and Affordable Care Act will result in certain changes to benefits as plans renew beginning 1/1/2011. *Final guidance has not been issued for this legislation. Additional benefit changes may be necessary once final guidance is received and additional rate impact for these changes may apply.*

COBRA and TEFRA

COBRA provides for a self-payment continuation of benefit coverage in certain circumstances. TEFRA requires that the coverage of the active employees, who are age 65 or older and who are covered by their employer's health plan and by Medicare, be primary to Medicare. There are 'small employer exceptions' to both COBRA and to TEFRA. **The trustees have decided not to invoke the exception and will treat all employers as subject to COBRA-like benefits and to TEFRA.**

ACCOUNTABLE OFFICER'S AGREEMENT AND CERTIFICATION

By execution of this Participation Agreement and Participation Requirements, the participating employer agrees to be bound by all terms and conditions of the Participation Requirements, Insurance Contracts, current Trust Agreement and by any existing or future amendments to the Trust Agreement governing the Hospitality Industry Health Insurance Trust, including, without limitation, paying the required monthly premium, paying any late fees imposed by the plan administrator on account of employer's late payment of contributions and furnishing necessary information on covered persons. Copies of these documents are on file with the Hospitality Industry Health Insurance Trust. I hereby certify that the enclosed information is applicable and complete:

Authorized Group Signature _____ Date _____

Print Name _____ Title _____

INSURANCE PRODUCER INFORMATION – Must be authorized by H.I.H.I.T. (See Definitions)

Name of Producer

Producer Number

Address (Street, City, State, Zip)

Phone Number

I verify that _____ has been appointed as Insurance Producer with respect to the coverage described in this application effective _____.

This agreement will serve as notice of cancellation of any previous Producer agreement. This new appointment will remain effective until either party gives written notice.

Signature of Participating Party Authorized Representative

Date

DEFINITIONS

* "Insurance Producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate Insurance. "Insurance Producer" does not include title insurance agents. RCW 48.17.010

Signature of Insurance Producer

As an authorized representative of the Participating Party, I have read this application and agree to the terms and certify that all my statements are true and complete. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company (RCW 48.135.080). Penalties include imprisonment, fines, and denial of insurance benefits.

Signature

Date

Print Name of Insurance Producer

Title