



Asuris Northwest Health
 1800 Ninth Avenue
 PO Box 91130
 M/S S313
 Seattle, Washington 98111

Group Master Application - For Group Size 100+

Please complete and submit this application to our office **no later than 15 days prior to the effective date** or there may be delays to the processing and activation of your group. If additional space is needed, please attach a separate sheet of paper.

NEW/RENEWAL COVERAGE FOR GROUPS OF 100+

Requested Effective Date _____

SECTION 1 - GROUP INFORMATION			
Group's Legal Name		Company Structure Sole Proprietorship Corporation Partnership Other _____	
Doing Business As (DBA)	Name to be used by Asuris Legal DBA	Location of Business Headquarters	Date Business Started
Federal Tax ID Number (EIN)	State Tax ID Number (UBI, required for WA new groups)	SIC Code and Industry Description 	
Name and Title of President, Owner, CEO		Group's Primary Language (if other than English)	
Physical Business Address Required (No PO Box or PMB)		Mailing Address (if different from Physical Business Address)	
City, State and ZIP Code		City, State and ZIP Code	
County	Phone Number () Fax Number ()	County	Phone Number () Fax Number ()
PRIMARY GROUP CONTACT			
Name (First, MI, Last)		Title	
Phone Number ()	Fax Number ()	E-mail Address	
GROUP ADMINISTRATOR (if different from primary contact)			
Name (First, MI, Last)		Title	
Phone Number ()	Fax Number ()	E-mail Address	
OTHER CARRIER INFORMATION			
MEDICAL: Does your group have current Medical coverage? No Yes If yes, name of carrier _____ Date coverage will end _____		WORKERS' COMPENSATION: Does your group have Workers' Compensation coverage? No Yes If yes, name of carrier _____	
PHARMACY: Does your group have current Pharmacy coverage? No Yes If yes, name of carrier _____ Date coverage will end _____		DENTAL: Does your group have current Dental coverage? No Yes If yes, name of carrier _____ Date coverage will end _____	
Will you be offering more than one medical insurance carrier to your employees? No Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>		Will you be offering more than one dental insurance carrier to your employees? No Yes * Name of Carrier(s) _____ <i>* This option is not allowed in all instances.</i>	
PRODUCER (AGENT) INFORMATION			
Agency Name		Producer's (Agent) Name	
Producer's E-mail Address		Producer's Phone Number	Producer's Number
Secondary Producer's Name (if applicable)		Secondary Producer's Phone Number	Secondary Producer's Number
Producer's Medical Commission: Flat _____% PEPM \$ _____ PMPM \$ _____ None		Commission Split %: Producer #1 _____% Producer #2 _____%	
Producer's Dental Commission: Flat _____% PEPM \$ _____ PMPM \$ _____ None		Commission Split %: Producer #1 _____% Producer #2 _____%	



SECTION 1 - GROUP INFORMATION (continued)

BILLING

Please select desired billing location: Physical Mailing Other		Do you require separate billing invoices by location? No Yes (If yes, please complete Additional Billing Location section(s) below)
(Please indicate any differences to page one in spaces below)		
Business Name	Additional Billing Location Business Name	Additional Billing Location Business Name
Billing Address	Billing Address	Billing Address
City, State and ZIP Code	City, State and ZIP Code	City, State and ZIP Code
Phone Number () Fax Number ()	Phone Number () Fax Number ()	Phone Number () Fax Number ()
Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)	Contact and Title (if different than primary group contact)
Payment Type		Payment Type
Pay by Check Surepay (EFT)*		Pay by Check Surepay (EFT)*
* Please submit Surepay document		* Please submit Surepay document

EMPLOYER CENTER

Employer Based Reporting No Yes* Online Enrollment and eBilling No Yes*

*Primary Group Administrator for Employer Center: Name (First, MI, Last)	E-mail Address	Phone Number ()
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If more than two Secondary Group Administrators for Employer Center are required, indicate the number desired _____

For Online Enrollment, complete the following:
 Allow employees to enroll themselves and update family information online No Yes
 If Yes, allow employees to change their address online No Yes

FEDERAL MANDATES

COBRA:
 Group subject to COBRA? No Yes
 If you employed 20 or more full-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal COBRA laws. To the degree permitted by those laws, part-time employees may be counted as a fraction of a full-time employee.

OBRA:
 Group subject to OBRA? No Yes
 If you employed 100 or more full-time and/or part-time employees for at least 50% of the workdays of the preceding calendar year (January - December) you are subject to federal OBRA 1989/OBRA 1993 laws.

TEFRA/DEFRA:
 Group subject to TEFRA/DEFRA? No Yes
 If you employed 20 or more full-time and/or part-time employees during each of the 20 calendar weeks in the current or preceding calendar year (January - December) you are subject to federal TEFRA/DEFRA laws.

ERISA:
 Group subject to ERISA? No Yes
 Is your plan year different than your renewal date? No Yes, list date _____
 Virtually all health plans of employers of any size (except church entities and government entities) are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA). This federal law sets minimum standards for the protection of individuals in these entities, as well as most voluntarily established pension plans.

Schedule A / Form 5500 information required?
 No Yes If yes, reporting time frame required _____



SECTION 2 - ELIGIBILITY INFORMATION

GROUP ELIGIBILITY (for purposes of determining group classification)

- Employee Count** - Please enter the average number of employees that were employed during the previous calendar year January - December. Your Employee Count should include: employees from any affiliated company, business owners, corporate officers, full-time, part-time, partners, seasonal, union employees and employees that work outside the state of Washington. Your Employee Count should not include **contracted (1099)** individuals.
- Group Eligibility** - Will you employ at least two employees on the intended effective date that your healthcare coverage renews? No Yes
- Is the group a subsidiary or affiliate of another company? No Yes If yes, please explain _____
- Do you have employees employed outside the state of Washington? No Yes If yes, please indicate below
Note: Group members who reside in the state of Hawaii are not eligible for coverage.

Number of Employees Out of State	State 1	State 2	State 3	State 4	State 5	State 6
State						
Employee Count						

EMPLOYEE ELIGIBILITY (for purposes of determining who is eligible for group benefits)

- Note:** The minimum number of hours for eligibility are 20 hours in a normal work week.
- This plan covers employees working the minimum number of hours required for coverage. No Yes
 The minimum number of hours to be eligible for coverage are: _____
 - This plan provides domestic partner coverage: Registered Only Registered and Non-Registered
 - This plan provides COBRA eligibility for domestic partners covered by the group: No Yes

4. New Hire Probationary Periods: Groups may list employees in different classifications (e.g. hourly, salaried) for the purpose of offering different probationary periods to each employee classification. If you have chosen to do this, describe each job classification below. All employees must be accounted for. (If there are no classes, please enter all information in space provided for Class 1).	Actual Date of Hire	DAYS							
		First of the month following (place an X in box)							
		Date of hire	30	60	90	120	180	365	Other
Class 1:									
Class 2:									
Class 3:									

- Is new hire probationary period waived on group's initial enrollment: No Yes
- For employees transferring from part-time to full-time status, the probationary period specified above should apply:
 Beginning on the date transferred to full-time status Retroactive to the original date of hire

SECTION 3 - EMPLOYER CONTRIBUTION

The employer will pay the following percentages/dollars toward the monthly rate. If different classes are chosen, please indicate classes and contribution for each.
Note: Employer must contribute a minimum of 75% of the employee rate for insurance. There is no minimum employer contribution percentage for dependents.

	Class 1		Class 2		Class 3	
	Medical	Dental	Medical	Dental	Medical	Dental
Employee	% or \$	% or \$	% or \$	% or \$	% or \$	% or \$
Dependent	% or \$	% or \$	% or \$	% or \$	% or \$	% or \$

SECTION 4 - GROUP PARTICIPATION

Note: There is a minimum participation requirement of 75% after valid waivers. If the employer contributes 100% of the employee premium, we require 100% participation after valid waivers.

- Total number of employees on payroll regardless of hours worked (Do not include COBRA participants).
- Less individuals not eligible for coverage on this plan:
 - Employees working fewer than the minimum hours described in Section 2 Eligibility Information including those whose class is ineligible for group coverage.
 - Employees who are temporary, seasonal or substitute employees.
 - Employees who are fulfilling their New Hire Probationary Period described in Section 2 Eligibility Information.
 - Individuals paid via IRS Form 1099.
- Equals subtotal number of employees eligible to enroll.
- Less number of employees waiving for **other qualifying coverage**.
- Equals total number of employees eligible to enroll.
- Number of employees who are **declining coverage**. (No other qualifying coverage).
- Number of employee applications being submitted (for new groups only).
- Number of former and current employees covered by your group under COBRA.
- Number of former and current employees and/or their dependents who are currently eligible for COBRA but have not yet applied.
- Number of former and current employees not eligible for COBRA who are covered by a group extension plan.

-	
-	
-	
-	
	=
Medical	Dental
-	-
=	=



SECTION 5 - BENEFITS AND RATES

MEDICAL - Please mark the benefits for the plan(s) you are purchasing.

If offered by class, specify Employee Classification _____
 Dual Option - Refer to the Dual Option Guidelines for associated rules.

EMBARK - MEDICAL PLAN CHOICES

Upfront Office Visits			Upfront Office Visit Copay		
4 Visits	6 Visits	Unlimited Visits	\$20 / \$35 Copay	\$30 / \$45 Copay	
Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$250	\$2,000	90/70/70	\$2,000	\$5/\$25/\$50 OOP \$3,000	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
\$500	\$3,000	80/60/60	\$3,000	\$7/25%/50% OOP \$4,000	
\$750	\$5,000	70/50/50	\$4,000	\$10/35%/50% OOP \$5,000	
\$1,000	\$7,500		\$6,000	\$10/\$35/\$75 No OOP	
\$1,500				\$0 Brand Deductible \$250 Brand Deductible \$500 Brand Deductible	
Rate Tier Label					
Rates					

VANTAGE - MEDICAL PLAN CHOICES

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$0	\$2,000	80/80/80	\$2,000	\$5/\$25/\$50 OOP \$3,000	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation Preventive Care
\$250	\$3,000	70/70/70	\$3,000	\$7/25%/50% OOP \$4,000	
\$500	\$5,000	50/50/50	\$4,000	\$10/35%/50% OOP \$5,000	
\$1,000	\$7,500		\$6,000	\$10/\$35/\$75 No OOP	
				\$0 Brand Deductible \$250 Brand Deductible \$500 Brand Deductible	
Rate Tier Label					
Rates					

MOTIVATE - MEDICAL PLAN CHOICES

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$1,500		80/60/60	\$3,000	\$5/25%/50% No OOP	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
\$2,000			\$4,000	\$7/30%/50% No OOP	
\$3,000			\$6,000	\$10/\$35/\$75 No OOP	
				10%/30%/50% No OOP	
				\$250 Deductible \$500 Deductible \$1,000 Deductible	
Rate Tier Label					
Rates					

HSA HEALTHPLAN 2.0 - MEDICAL PLAN CHOICES

Deductible (includes Pharmacy)		Coinsurance Levels	Out of Pocket Maximum	Optional Benefits
\$1,500 single/\$3,000 family	\$3,500 single/\$7,000 family	80/60/60	\$5,000/\$10,000	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
\$2,500 single/\$5,000 family	\$5,000 single/\$10,000 family - 100% Coinsurance Only			
\$3,000 single/\$5,000 family (embedded family deductible)				
\$3,000 single/\$7,000 family (embedded family deductible)				
Rate Tier Label				
Rates				

Please continue making your selections on the next page.



SECTION 5 - BENEFITS AND RATES (continued)

PREFERRED - MEDICAL PLAN CHOICES

Office Visit Copay

None \$20 / \$35 Copay \$30 / \$45 Copay

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$250	\$2,000	90/70/70	\$2,000	\$5/\$25/\$50 OOP \$3,000 \$7/25%/50% OOP \$4,000 \$10/35%/50% OOP \$5,000 \$10/\$35/\$75 No OOP \$0 Brand Deductible \$250 Brand Deductible \$500 Brand Deductible	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
\$500	\$3,000	80/60/60	\$3,000		
\$750	\$5,000	70/50/50	\$4,000		
\$1,000	\$7,500		\$6,000		
\$1,500					
Rate Tier Label					
Rates					

Additional Information

MEDICAL - Please mark the benefits for the second plan that you are purchasing.

Employee Classification - Please specify the additional classification if applicable _____

Dual Option - Please indicate the second plan option if applicable.

EMBARK - MEDICAL PLAN CHOICES

Upfront Office Visits (Must follow Dual Choice Rules)

Upfront Office Visit Copay

4 Visits 6 Visits Unlimited Visits \$20 / \$35 Copay \$30 / \$45 Copay

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$250	\$2,000	90/70/70	\$2,000	\$5/\$25/\$50 OOP \$3,000 \$7/25%/50% OOP \$4,000 \$10/35%/50% OOP \$5,000 \$10/\$35/\$75 No OOP \$0 Brand Deductible \$250 Brand Deductible \$500 Brand Deductible	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
\$500	\$3,000	80/60/60	\$3,000		
\$750	\$5,000	70/50/50	\$4,000		
\$1,000	\$7,500		\$6,000		
\$1,500					
Rate Tier Label					
Rates					

VANTAGE - MEDICAL PLAN CHOICES

Deductible		Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$0	\$2,000	80/80/80	\$2,000	\$5/\$25/\$50 OOP \$3,000 \$7/25%/50% OOP \$4,000 \$10/35%/50% OOP \$5,000 \$10/\$35/\$75 No OOP \$0 Brand Deductible \$250 Brand Deductible \$500 Brand Deductible	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation Preventive Care
\$250	\$3,000	70/70/70	\$3,000		
\$500	\$5,000	50/50/50	\$4,000		
\$1,000	\$7,500		\$6,000		
Rate Tier Label					
Rates					

Please continue making your selections on the next page.



SECTION 5 - BENEFITS AND RATES (continued)

MOTIVATE - MEDICAL PLAN CHOICES

Deductible	Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$1,500 \$2,000 \$3,000	80/60/60	\$3,000 \$4,000 \$6,000	\$5/25%/50% No OOP \$7/30%/50% No OOP \$10/\$35/\$75 No OOP 10%/30%/50% No OOP \$250 Deductible \$500 Deductible \$1,000 Deductible	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
Rate Tier Label				
Rates				

HSA HEALTHPLAN 2.0 - MEDICAL PLAN CHOICES

Deductible (includes Pharmacy)	Coinsurance Levels	Out of Pocket Maximum	Optional Benefits
\$1,500 single/\$3,000 family \$2,500 single/\$5,000 family \$3,000 single/\$5,000 family (embedded family deductible) \$3,000 single/\$7,000 family (embedded family deductible)	\$3,500 single/\$7,000 family \$5,000 single/\$10,000 family - 100% Coinsurance Only	80/60/60 \$5,000/\$10,000	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
Rate Tier Label			
Rates			

PREFERRED - MEDICAL PLAN CHOICES

Office Visit Copay				
None \$20 / \$35 Copay \$30 / \$45 Copay				
Deductible	Coinsurance Levels	Coinsurance Maximum	Pharmacy (Select Copay and Deductible)	Optional Benefits
\$250 \$2,000 \$500 \$3,000 \$750 \$5,000 \$1,000 \$7,500 \$1,500	90/70/70 80/60/60 70/50/50	\$2,000 \$3,000 \$4,000 \$6,000	\$5/\$25/\$50 OOP \$3,000 \$7/25%/50% OOP \$4,000 \$10/35%/50% OOP \$5,000 \$10/\$35/\$75 No OOP \$0 Brand Deductible \$250 Brand Deductible \$500 Brand Deductible	Vision Employee Asst Program (EAP) Unlimited Spinal Manipulation
Rate Tier Label				
Rates				

Additional Information

Please continue making your selections on the next page.



SECTION 5 - BENEFITS AND RATES (continued)

DENTAL - Please mark the benefits for the plan(s) you are purchasing.

If offered by class, specify Employee Classification _____

DENTAL PLAN CHOICES

Deductible and Annual Maximum

Aspire 80/50/0	\$0 Deductible Classes I - II; \$500 Annual Maximum		\$25 Deductible Classes I - II; \$750 Annual Maximum	
	\$50 Deductible Classes I - II; \$500 Annual Maximum		\$50 Deductible Classes I - II; \$750 Annual Maximum	
Enhance 100/80/50	Deductible and Annual Maximum			
	\$25 Deductible Classes II - III; \$1,000 Annual Maximum		\$50 Deductible Classes II - III; \$1,500 Annual Maximum	
	\$50 Deductible Classes II - III; \$1,000 Annual Maximum		\$25 Deductible Classes II - III; \$2,000 Annual Maximum	
Optional Benefits	TMJ		Orthodontia (Available with Enhance Plans)	
	TMJ \$1,000		\$1,000	\$1,500
Rate Tier Label				
Rates				

DENTAL - Please mark the benefits for the second employee classification you are purchasing.

Employee Classification - Please specify the second plan choice if applicable _____

DENTAL PLAN CHOICES

Deductible and Annual Maximum

Aspire 80/50/0	\$0 Deductible Classes I - II; \$500 Annual Maximum		\$25 Deductible Classes I - II; \$750 Annual Maximum	
	\$50 Deductible Classes I - II; \$500 Annual Maximum		\$50 Deductible Classes I - II; \$750 Annual Maximum	
Enhance 100/80/50	Deductible and Annual Maximum			
	\$25 Deductible Classes II - III; \$1,000 Annual Maximum		\$50 Deductible Classes II - III; \$1,500 Annual Maximum	
	\$50 Deductible Classes II - III; \$1,000 Annual Maximum		\$25 Deductible Classes II - III; \$2,000 Annual Maximum	
Optional Benefits	TMJ		Orthodontia (Available with Enhance Plans)	
	TMJ \$1,000		\$1,000	\$1,500
Rate Tier Label				
Rates				

Additional Information



SECTION 6 - ACKNOWLEDGEMENTS AND CERTIFICATIONS

If you have any questions about the benefits and services that are covered, provided, limited or excluded under the group coverage(s) to which this application applies, please contact your Sales Representative before signing this application.

Note: The Company as used here means the group applying for coverage as indicated in Section 1 of this application.

I certify that I am an officer or employee of the Company, that I am duly authorized to execute this application on behalf of the Company, and that the Company:

- a) Applies for the group coverage(s) selected in Section 5 of this Group Master Application.
- b) Authorizes any person or other entity to release to Asuris Northwest Health any information requested by Asuris Northwest Health in connection with this application's processing.
- c) Acknowledges, where permitted by law, that Asuris Northwest Health may choose not to approve this application and any premium deposit will be returned if the application for group coverage(s) is not approved.
- d) Acknowledges that coverage is not in effect until Asuris Northwest Health accepts this application, establishes an effective date of coverage and issues the group contract(s) to the Company.
- e) Acknowledges that, if it is approved by Asuris Northwest Health, this application will form a part of the group contract(s) issued by Asuris Northwest Health and agrees that the Company will be bound by the terms and the conditions of entire group contract(s).
- f) Acknowledges that eligibility standards (e.g., waiting period, minimum hours, etc.) must be established at the time of initial application, may be changed only at contract renewal, and must be adhered to for all employees and dependents.
- g) Acknowledges that it has selected the group coverage(s) to be offered to its employees, that its selection of this group coverage(s) was based upon written information provided by Asuris Northwest Health, and that no producer or consultant was or is authorized to modify the terms of the offer or to agree to changes. All material terms of coverage are set forth in the group contract(s), of which this application, if accepted, is but one part.
- h) Agrees to make payroll and other records directly related to employee participation levels or to employees' coverage, premiums, or contributions under the group contract(s) available to Asuris Northwest Health for inspection. This provision shall survive the termination of the group contract(s). Upon renewal or anytime throughout the contract period, the Company agrees to provide Asuris Northwest Health, upon its request verifications of employee participation levels.
- i) Agrees that, except with regard to a statutory continuation of coverage or unless the change is approved in writing by an authorized representative of Asuris Northwest Health, at no time shall any employee be permitted or required to make contributions for coverage at a rate higher than the employee contribution rate represented herein.
- j) Agrees the group contract(s) will determine the contractual provisions, including procedures, exclusions, and limitations, relating to the coverage and will govern in the event of conflict with any benefits comparison, summary, or other description of the coverage.
- k) Agrees to deliver, or otherwise make available to enrollees, all Asuris Northwest Health paper or online member documents and other coverage-related materials upon request by Asuris Northwest Health.
- l) Agrees to make all coverage options available to all eligible employees and dependents who satisfy eligibility requirements.
- m) Acknowledges that benefits may be added or deleted only at the time of initial application, at contract renewal, when required by law, or as mutually agreed between the Company and Asuris Northwest Health in accordance with the group contract(s).
- n) Acknowledges that Asuris Northwest Health must be notified (in the manner described in the group contract(s)) when there is a change to Company information (e.g., name, address, phone number, contact person, ownership status, etc).
- o) Acknowledges that contracting physicians, hospitals, and other health care providers are independent contractors and are neither producer's nor employees of Asuris Northwest Health, that Asuris Northwest Health does not provide health care services, and that Asuris Northwest Health cannot guarantee any results or outcomes of care. We are responsible for the quality of health care you receive only as provided by law.
- p) Certifies under penalty of perjury that all statements made and information provided in this application are accurate and complete to the best of its knowledge or belief and acknowledges that Asuris Northwest Health will rely in part on the information in this application as the basis for Asuris Northwest Health's decision on whether to approve this application and issue any group contract(s). It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. In addition, Asuris Northwest Health will have the right to collect any claims payments or other damages. If Asuris Northwest Health continues a group contract with the Company after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Company no longer qualifies for the rate quoted, I understand that Asuris Northwest Health will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Company will be required to pay the rate adjustment within 30 days of the date of notice by Asuris Northwest Health.
- q) Agrees that any controversy or claim between the Company and Asuris Northwest Health arising out of or relating to the group contract(s), or the breach thereof, whether involving a claim in tort, contract, or otherwise, shall be subject to final resolution through binding arbitration. The Company and Asuris Northwest Health agree that the arbitrator's award shall be binding, may include an apportionment of attorney fees and other fees and costs, and may be enforced in any court with the requisite jurisdiction. Any such arbitration shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association and in King County, Washington (WA), unless mutually agreed otherwise by the parties. If any enrollee or former enrollee (or person claiming to be an enrollee or former enrollee) makes any claim or brings any action or proceeding arising out of or relating to the group contract(s) to which Asuris Northwest Health or the Company becomes a party, Asuris Northwest Health and the Company agree to cooperate in the defense of such claim, action, or proceeding and to resolve any controversy or claim between Asuris Northwest Health and the Company through arbitration under this paragraph only after the resolution of the enrollee's (or alleged enrollee's) claim.
- r) Appoints the producer of record indicated in Section 1 - Group Information (if any) to represent it in matters of group coverage benefits provided by Asuris Northwest Health. This appointment is in effect on the same day as the group coverage(s) and remains in force until rescinded in writing.
- s) Acknowledges that if the Company has a producer, that producer may receive bonuses, commissions, administrative services fees, or other compensation, including non-cash compensation from Asuris Northwest Health. Incentives may be based on any of several factors, including the size of the Company's business, the products the Company purchases, the producer's volume of business with Asuris Northwest Health, and other services the producer provides to the Company. These incentives may have an indirect impact on the Company's rates. For more information please contact the producer or the Company.
- t) Acknowledges that the option has been presented to include or exclude TMJ as a covered benefit.

SIGNATURE

Group Authorized Signature

Official Title

Signature Date

