

**Group Master Application
July 2010-December 2010
Health Alliance for Technology**



Company Information	
Company Name: <input type="checkbox"/> Use for ID cards & billing	dba (if applicable): <input type="checkbox"/> Use for ID cards & billing
Employer Tax ID (EIN)#:	Effective Date:
<input type="checkbox"/> Corp. <input type="checkbox"/> Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Other	Business Nature: NAICS/SIC: _____
Endorsed Sponsor Membership: Yes <input type="checkbox"/> No <input type="checkbox"/>	Endorsed Sponsor Membership ID #:
Endorsed Sponsor Name:	Endorsed Sponsor Membership Paid Through Date:
Group Benefits Administrator:	Billing Contact:
Phone: () - () - Fax: () - () -	Phone: () - () - Fax: () - () -
Street Address: City State Zip	Billing Address: City State Zip
Benefits Administrator Email:	Billing Representative Email:

Base Product Selections
Compulsory benefits require Medical and a minimum of \$15,000 Basic Life and AD&D coverage.

Medical and Prescription Drug Plans Underwritten by United Healthcare Insurance Company

Choice Plus TECH 1 Plan Options	
<input type="checkbox"/> WKF \$10 Choice Plus \$0/90% \$1500 max.	<input type="checkbox"/> WKI \$15 Choice Plus \$0/80% \$2000 max.
<input type="checkbox"/> WKH \$10 Choice Plus \$250/90% \$1250 max.	<input type="checkbox"/> WKK \$15 Choice Plus \$250/90% \$2250 max.
<input type="checkbox"/> WKJ \$15 Choice Plus \$250/80% \$2250 max.	<input type="checkbox"/> WKL \$15 Choice Plus \$500/90% \$1500 max.
<input type="checkbox"/> WKG \$10 Choice Plus \$500/80% \$2500 max.	<input type="checkbox"/> WKM \$15 Choice Plus \$500/90% \$3000 max.
<input type="checkbox"/> WKO \$20 Choice Plus \$500/90% \$3500 max.	<input type="checkbox"/> WKN \$20 Choice Plus \$750/80% \$2750 max.
<input type="checkbox"/> WKP \$25 Choice Plus \$1000/80% \$3000 max.	

Choice Plus TECH 2 Plan Options	
<input type="checkbox"/> WKR \$15 Choice Plus \$0/90% \$2000 max.	<input type="checkbox"/> WKT \$20 Choice Plus \$0/80% \$2500 max.
<input type="checkbox"/> WKS \$15 Choice Plus \$250/90% \$2500 max.	<input type="checkbox"/> WKV \$20 Choice Plus \$250/90% \$3000 max.
<input type="checkbox"/> WKU \$20 Choice Plus \$250/80% \$3000 max.	<input type="checkbox"/> WKW \$20 Choice Plus \$500/90% \$2500 max.
<input type="checkbox"/> WKQ \$15 Choice Plus \$500/80% \$3000 max.	<input type="checkbox"/> WKX \$20 Choice Plus \$500/90% \$3000 max.
<input type="checkbox"/> WKZ \$25 Choice Plus \$500/90% \$3500 max.	<input type="checkbox"/> WKY \$25 Choice Plus \$750/80% \$3500 max.
<input type="checkbox"/> WOR \$30 Choice Plus \$1000/80% \$4000 max.	

Choice Plus TECH 3 Plan Options	
<input type="checkbox"/> WOT \$20 Choice Plus \$500/80% \$2500 max.	<input type="checkbox"/> WOX \$30 Choice Plus \$750/80% \$3500 max.
<input type="checkbox"/> WOU \$30 Choice Plus \$1250/80% \$4500 max.	<input type="checkbox"/> WOV \$30 Choice Plus \$1500/80% \$5000 max.
<input type="checkbox"/> WOW \$30 Choice Plus \$2000/80% \$5000 max.	<input type="checkbox"/> WOS \$0 Choice Plus \$0/50%

Choice Plus Consumer Driven High Deductible Plan Options
<input type="checkbox"/> WOY Choice Plus HRA \$1000
<input type="checkbox"/> WRL Choice Plus HSA \$1500

Prescription Drug Options	
<input type="checkbox"/> K6 \$10/\$20/\$40 \$0 ded.	<input type="checkbox"/> OP \$10/\$20/\$40 \$100 ded.
<input type="checkbox"/> N7 \$7/\$25/\$50 \$0 ded.	<input type="checkbox"/> OO \$10/\$25/\$50 \$100 ded.
<input type="checkbox"/> F5 \$10/\$25/\$45 \$0 ded.	
<input type="checkbox"/> H9 \$10/\$30/\$50 \$0 ded.	<input type="checkbox"/> OL \$10/\$30/\$50 \$100 ded.
<input type="checkbox"/> EM \$15/\$30/\$60 \$0 ded.	<input type="checkbox"/> NR \$10/\$35/50% \$0 ded.

Groups with employees out of UHC service area
<input type="checkbox"/> WCW \$20 Non-differential \$1000 (out of area only)

NOTE: If an HSA Plan is selected, please indicate the employer contribution percentage (0% - 80%) % of the deductible to the HSA Fund. HSA maximum contribution is 80% of the deductible of the plan selected.

RX Plan MUST BE TAKEN WITH PPO and HRA except as noted. Separate RX Plan is NOT AVAILABLE with HSA Plans.

Wellness Plan Participation Yes No

Buy-Up Plan Selections

Life/AD&D, Short and Long Term Disability Plans Underwritten by Unimerica Life Insurance Company

BASIC LIFE AND AD&D OPTIONS

<input type="checkbox"/> Option 1 - \$30,000 (additional \$15,000)	<input type="checkbox"/> Option 2 - \$50,000 (additional \$35,000)	<input type="checkbox"/> Option 3 - 1 x Base Annual Earnings to \$200,000
<input type="checkbox"/> Option 4 - 2 x Base Annual Earnings to \$250,000	<input type="checkbox"/> Employer Paid Dependent Basic Life	<input type="checkbox"/> Voluntary Basic Life and AD&D

Bundled Plan Selections

Dental Plans Underwritten by United Healthcare Insurance Company

<input type="checkbox"/> Plan A - P0015	<input type="checkbox"/> Plan B - P3432
<input type="checkbox"/> Plan C - P3436	<input type="checkbox"/> Plan D - P3177
<input type="checkbox"/> Plan E - P3439	<input type="checkbox"/> Plan F - P3352
<input type="checkbox"/> Decline Dental Option	

Vision Plans Underwritten by Vision Service Plan

<input type="checkbox"/> Signature Plan B	<input type="checkbox"/> Choice Plan A	<input type="checkbox"/> Decline Vision Option
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Short and Long Term Disability Options Underwritten by Unimerica Life Insurance Company

<input type="checkbox"/> STD Option 1 - 60%, \$750 Maximum Weekly Benefit	<input type="checkbox"/> STD Option 2 - 60%, \$1,000 Maximum Weekly Benefit
<input type="checkbox"/> LTD Option 1 - 60%, \$4,000 Maximum Monthly Benefit	<input type="checkbox"/> Decline STD Option <input type="checkbox"/> Decline LTD Option

Eligibility and Participation Requirements

Definition of Eligible Employee:

Eligible Employees must be regular (not seasonal or temporary) active employees on company payroll working a minimum of 20 hours per week to be eligible for coverage.

- All full-time Employees working a minimum of _____ hours per week (not less than 20)
- All part-time Employees working a minimum of _____ hours per week (not less than 20)
- All Employees working in a specific class(es), working a minimum of _____ hours per week *

*If the last box is checked, please specify class, such as hourly, salaried, covered or not covered by collective bargaining, etc.: _____

Probationary Period Information:

Coverage for newly hired/eligible will become effective the first of the month following the completion of the probationary period.

- Date of Hire 30 days 60 days 90 days Other: _____

Employees Differentiated by Class:

Only employees in a specific class of classes who work the specified minimum hours per week that have met the probationary period are eligible. Complete the minimum work hours and probationary period information for each designated class of employee.

<input type="checkbox"/> Management	<input type="checkbox"/> Salaried	<input type="checkbox"/> Hourly	<input type="checkbox"/> Part-time	<input type="checkbox"/> Full-time	<input type="checkbox"/> Other
Minimum Hours _____ 1 st of the month following	Minimum Hours _____ 1 st of the month following	Minimum Hours _____ 1 st of the month following	Minimum Hours _____ 1 st of the month following	Minimum Hours _____ 1 st of the month following	Minimum Hours _____ 1 st of the month following
<input type="checkbox"/> Date of Hire	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> Date of Hire	<input type="checkbox"/> Date of Hire
<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days
<input type="checkbox"/> 60 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 60 days	<input type="checkbox"/> 60 days
<input type="checkbox"/> 90 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 90 days	<input type="checkbox"/> 90 days
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Waive Probationary Period: new groups only

For employees transferring from part-time to full-time status, the probationary period above should apply

- Retroactive to the original date of hire Beginning at the date of transfer

Employer Contribution and Employee Participation Requirements: The employer must contribute the minimum percentages shown below toward the cost of coverage and must meet the minimum participation requirements. Minimum Contribution/Participation Requirements:

75% Employer Contribution- 75% Employee Participation or 100% Employer Contribution- 100% Employee Participation.

Please list employer contribution below (Must be expressed as a percentage).

Medical

Employee: _____ %
Dependent: _____ %

Dental

Employee: _____ %
Dependent: _____ %

Employee Enrollment

Total number of employees on payroll regardless of hours worked: _____ (A)

Employees not eligible to enroll:

- Working less than the min. hrs: _____
- Temporary or seasonal: + _____
- In probationary period: + _____
- Not in a covered class: + _____ = _____ (B)

Employees not enrolling due to coverage under:

- Medicare, CHAMPUS/Tricare, Military: _____
- Other group coverage: + _____
- Union: + _____ = _____ (C)

Total number of eligible employees (A)-(B)-(C) = _____ (D)

Eligible employees waiving enrollment without other coverage: _____ (E)

Total number of eligible employees enrolling (D)-(E) = _____

Current Medical Plan Information (New Groups Only)

Is this plan intended to replace any existing coverage? Yes No

If yes, complete the following:

Name of prior medical carrier _____ Original Effective Date: _____ Term Date: _____
Name of prior dental carrier _____ Original Effective Date: _____ Term Date: _____

COBRA/TEFRA/OBRA/FMLA Designation

We strongly urge you to consult with legal counsel in answering the following questions. The summaries below are not intended to be or to replace legal advice on your particular group. It is the group's responsibility to inform the carrier immediately if facts change which would cause the group's answers below to change.

COBRA Employer? Default COBRA ADMIN IS THROUGH ALLTECH. If requesting third-party administrator, COBRA WAIVER must be completed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Helpful Hint: Generally, these laws apply to any non-church employer that employed 20 or more employees on at least 50% of its working days in the preceding calendar year. "Employees" are full-time and part-time common-law employees. Self-employed workers as defined in IRC §401(c)(1), corporate directors, or independent contractors should not be counted unless they qualify as common-law employees. "Employees" may also include leased employees who qualify as common-law employees. Please see COBRA regulations at 26 CFR §54.4980b-2 Q/A 5 for guidance on counting part-time employee as a fraction of a full-time employee.
TEFRA/OBRA (Please mark box to confirm policy)	<input type="checkbox"/> I Agree	TEFRA and OBRA eligibility will be assumed for all participating member companies regardless of size; however it will be the responsibility of the member to inform Medicare of their status so that claims will be properly adjudicated.
FMLA Employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Helpful Hint: Generally, these laws apply to any employer that employed at least 100 employees on 50% or more of its working days in the preceding calendar year. See the helpful hint of COBRA above for definition of "employee" for this purpose.

Rates

For medical, list 3 digit plan code below	Employee:	Emp/Sp:	Emp/Sp/Child(ren):	Emp/Child(ren):
Medical Option 1: Risk Level:	\$	\$	\$	\$
RX for Option 1:	\$	\$	\$	\$
Medical Option 2: Risk Level:	\$	\$	\$	\$
RX for Option 2:	\$	\$	\$	\$
Dental Plan: Risk Level:	\$	\$	\$	\$
Vision Plan:	\$	\$	\$	\$
Basic Life/AD&D:		N/A	N/A	N/A
STD (Per \$10 of Weekly Benefit):	\$	N/A	N/A	N/A
LTD (Per \$100 of Covered Payroll):	\$	N/A	N/A	N/A

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

As a condition for participation in ALLtech, the undersigned Employer does hereby adopt the Trust Agreement governing ALLtech through the Associated Employers Trust, and agrees to abide by its terms and the terms and conditions of any benefit program provided through the Trust, and designates and appoints the Trustee serving there under, and any successor Trustee duly appointed under the terms of the Trust Agreement.

The undersigned Employer understands that any change to the selections made on the Master Application for Insurance Coverage shall occur only at the renewal date and are subject to approval by ALLtech.

The undersigned Employer acknowledges the receipt of the Group Administrative Guide and agrees at all times to adhere to the established rules and procedures of the Program as set forth in the Group Administrative Guide including, but not limited to the terms, conditions and limitations described in the initial Underwriting and Administrative Guidelines, billing and administrative guidelines, and other applicable administrative guidelines. The undersigned Employer understands that 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.

The undersigned Employer acknowledges and agrees that full payment of premium to ALLtech is due on the first day of the month for which coverage is purchased, that any payment of premium received by the Program after the 10th day of the month is late and is subject to enforcement of the Premium Delinquency Policy described in the Group Administrative Guide. Any premium received by the Program more than 30 days after the due date will be returned to the undersigned Employer and the Employer's group life and health insurance coverage under the Program will be terminated as of the last day of the last month for which full payment was received timely.

The undersigned Employer acknowledges and agrees that once its application has been approved and accepted by ALLtech, any request to rescind its application must be made in writing and must be received by the Program not later than the close of business on the last business day at least 48 hours before the effective date of coverage under the Program. If a proper request to rescind is not received timely, the Program will not refund any premiums or deposits and the coverage will be in effect as approved and accepted by the Program.

Fraud and HIPAA Statements

FRAUD STATEMENT:

I have provided these answers as part of the application procedure required by United Healthcare Insurance Company to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that United Healthcare Insurance Company will rely on each answer in making coverage and rating determinations. If United Healthcare Insurance Company 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 United Healthcare Insurance Company will have the right to adjust the rates.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. 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.

HIPAA STATEMENT:

I acknowledge and understand my health plan may request or disclose health information about persons who are eligible for benefits coverage and are listed on the enrollment forms for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health Information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist, or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or other group health plan. Health Information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes.

Producer Designation and Signature Section

Accredited Producer Agreement to Contract

You, the producer(s), certify that you have met with the group submitting this agreement and that you have fully explained its contents. You have discussed coverage, eligibility, any pre-existing condition waiting periods, the effect of misrepresentations, termination provisions and subscription charge billing administration. ****ALL FIELDS REQUIRED FOR COMMISSION PAYMENT SET UP****

Accredited Producer Signature	Date	UHC Sales Office <input type="checkbox"/> WA-199 <input type="checkbox"/> OR-871
Accredited Producer of Record (Print Name)	Legal Name of Firm/Agency for Commissions and Reporting	
Firm/Agency Mailing Address	Producer Phone Number () -	
Producer E-mail Address	Firm/Agency Tax Identification Number (TIN)	

Employer Signature Section

I certify that the information on this agreement is complete and accurate. I also agree to be bound by the terms, conditions, and provisions of coverage as set forth by Health Alliance for Technology and the carriers' plan booklets and contracts. With my signature, I also hereby appoint the above named producer as our company's producer of record.

I understand there is no coverage in effect until ALLtech accepts this Application, premium is deposited, and an effective date of coverage is established. Final rates are subject to the execution of the Group Subscriber Agreement/ Group Policy. If this Application is not accepted, the premium deposit will be refunded. THE PARTICIPATING EMPLOYER UNDERSTANDS AND AGREES THAT THE EMPLOYER SHOULD KEEP PRIOR COVERAGE IN FORCE UNTIL NOTIFIED OF ACCEPTANCE IN WRITING. IT IS UNDERSTOOD AND AGREED THAT NO PRODUCER HAS THE AUTHORITY TO: a. modify this Application; b. waive the answer to any question; c. bind us in any way by giving or receiving any date which is not written on this Application; or d. bind us by making any promise or representation contrary to ALLtech published underwriting guidelines and marketing collateral.

Group Representative's Signature	Date
Group Representative (Print Name)	Title

Please Return Form to: Wells Fargo Insurance Services, 601 Union Street, Ste 1300 Seattle, WA 98101, Attn:ALLtech Team, Seattle, WA 98101

or fax to: 866.972.2957 or email to: programservices@wellsfargo.com

UnitedHealthcare
9900 Bren Road East
Minnetonka, MN 55343

Unimerica
6300 Olson Memorial Hwy
MN010-W115
Golden Valley, MN 55427

UnitedHealthcare Benefit Services
250 North Patrick Blvd. Suite 125
Brookfield, WI 53045

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Program Management provided by Wells Fargo Insurance Services