



# MASTER CONTRACT APPLICATION

Washington Small Group  
2009 Contract Year

Date \_\_\_\_\_

Group Name \_\_\_\_\_

Type of Business \_\_\_\_\_ Original Business Start Date (mm/dd/yy) \_\_\_\_\_

Requested Effective Date \_\_\_\_\_

Previous PHP Group - Yes  No  If yes, Previous PHP Group # \_\_\_\_\_

Contract Contact \_\_\_\_\_

Billing Contact \_\_\_\_\_

Phone \_\_\_\_\_

Billing/Mailing Address \_\_\_\_\_

Fax \_\_\_\_\_

Email \_\_\_\_\_

Physical Address \_\_\_\_\_

Business Fed Tax ID # (required) \_\_\_\_\_

City \_\_\_\_\_

Business License # \_\_\_\_\_

State/Zip \_\_\_\_\_

CMS Group Size # (required) \_\_\_\_\_

### Eligibility/Contribution

Subject to COBRA (Company Size >20)

Dependents eligible to age 25; Students eligible to age 25.

or  State Continuation (Company Size <20)

Employer will contribute: \$ \_\_\_\_\_ or \_\_\_\_\_ % toward employee premium, and \$ \_\_\_\_\_ or \_\_\_\_\_ % toward dependent premium.

**Employer must contribute a minimum of 50% toward the employee premium**

Minimum hours required per week \_\_\_\_\_  Employee Only Contract

### New Hire Eligibility:

Date of Hire

Waive probationary period at initial enrollment?  Yes  No

**OR**

First of the month following:  30 Days  60 Days  90 Days  Date of Hire

Eligibility/Contribution Remarks: \_\_\_\_\_

Previous Carrier \_\_\_\_\_ Previous Group # \_\_\_\_\_

Remarks: \_\_\_\_\_

### Providence Health Plans

Portland Office: PO Box 4327  
Portland OR 97208-4327  
Phone: 503-574-6665 or 877-245-4077  
Fax: 503-574-7543

Eugene Office: 1500 Valley River Dr Ste 200  
Eugene OR 97401  
Phone: 541-242-9012 or 877-245-4077  
Fax: 800-889-8218



## Washington Small Group Plan Options

MEDICAL PLANS Open Option (OP)	
<input type="checkbox"/> 10/10/20/1700 250 cd	<input type="checkbox"/> 25/20/40/3000 3000 cd
<input type="checkbox"/> 10/20/30/1200 250 cd	<input type="checkbox"/> 20/20/40/2500 750 cd
<input type="checkbox"/> 15/20/40/2000 500 cd	<input type="checkbox"/> 20/20/40/4000 5000 cd
<input type="checkbox"/> 15/30/50/2500 1000 cd	<b>HSA Qualified Plans</b>
<input type="checkbox"/> 15/30/50/2500 1500 cd	
<input type="checkbox"/> 20/20/30/3000 2000 cd	
<input type="checkbox"/> 25/20/30/2500 1500 cd	
<input type="checkbox"/> 25/20/40/3000 500 cd	
<input type="checkbox"/> 20/20/40/5000 2600 cd	<input type="checkbox"/> 20/20/40/4000 2000 cd
<input type="checkbox"/> 20/20/40/3000 1500 cd	

MEDICAL PLANS Personal Option (PE)	
<input type="checkbox"/> 10/20/1200	<input type="checkbox"/> 20/20/2500 750 Ded
<input type="checkbox"/> 10/20/1700 250 Ded	<input type="checkbox"/> 20/20/4000 5000 Ded
<input type="checkbox"/> 15/20/2000 250 Ded	<input type="checkbox"/> 25/20/3000 3000 Ded
<input type="checkbox"/> 15/20/2000 500 Ded	<input type="checkbox"/> 25/30/3000 2000 Ded
<input type="checkbox"/> 25/20/3000 250 Ded	<input type="checkbox"/> 10/10/1700 250 Ded
<input type="checkbox"/> 25/20/3000 500 Ded	<input type="checkbox"/> 20/20/2000 500 Ded
<input type="checkbox"/> 25/30/2500 1500 Ded	<input type="checkbox"/> 15/30/2500 1500 Ded
<input type="checkbox"/> 15/30/3000 2000 Ded	

Dual Option Plans	
<p><b>Dual Option 1</b></p> <input type="checkbox"/> OP 25/20/40/3000 3000 cd <input type="checkbox"/> OP 15/30/50/2500 1000 cd	<p><b>Dual Option 5</b></p> <input type="checkbox"/> PE 15/20/2000 500 Ded <input type="checkbox"/> OP 10/10/20/1700 250 cd
<p><b>Dual Option 2</b></p> <input type="checkbox"/> OP 20/20/30/3000 2000 cd <input type="checkbox"/> OP 20/20/40/2500 750 cd	<p><b>HSA Qualified Dual Option 1</b></p> <input type="checkbox"/> HSA 20/20/40/5000 2600 cd <input type="checkbox"/> OP 15/20/40/2000 500 cd
<p><b>Dual Option 3</b></p> <input type="checkbox"/> PE 25/30/2500 1500 Ded <input type="checkbox"/> OP 20/20/40/2500 750 cd	<p><b>HSA Qualified Dual Option 2</b></p> <input type="checkbox"/> HSA 20/20/40/3000 1500 cd <input type="checkbox"/> OP 15/20/40/2000 500 cd
<p><b>Dual Option 4</b></p> <input type="checkbox"/> PE 15/30/2500 1500 Ded <input type="checkbox"/> OP 15/20/40/2000 500 cd	

Value Based Open Option (VBOP)	
<input type="checkbox"/> 10/20/30/40/3000 250 cd	<input type="checkbox"/> 10/20/30/40/3000 1000 cd
<input type="checkbox"/> 10/20/30/40/3000 500 cd	<input type="checkbox"/> 10/20/30/40/3000 2000 cd
<input type="checkbox"/> 10/20/30/40/3000 750 cd	

RIDERS
<b>Vision</b>
<input type="checkbox"/> 200
<input type="checkbox"/> 300

Rx PLANS	
<input type="checkbox"/> 10/20	<input type="checkbox"/> Rxtra 15/30
<input type="checkbox"/> 15/30	<input type="checkbox"/> Rxtra 15/45
<input type="checkbox"/> 20/40	<input type="checkbox"/> 5/10/30/50/2000
<input type="checkbox"/> 15/50	<input type="checkbox"/> 5/10/50/50/2000
<input type="checkbox"/> 10/50/1000	<input type="checkbox"/> 5/15/30/50/2000
<input type="checkbox"/> 15/45	<input type="checkbox"/> 5/15/40/50/2000

Endorsement
<input type="checkbox"/> Domestic
<input type="checkbox"/> Partner

For Providence Use Only			RATES				For Providence Use Only	
Tier	Medical	In Net	Out Net	Rx	Vision	Chiro	Alternative	TOTAL
S								
SS								
SSC								
SC								

Tier Key: S = Subscriber, SS = Subscriber & Spouse, SSC = Subscriber & Spouse & Child(ren), SC = Subscriber & Child(ren)

Small Group Representative \_\_\_\_\_ Account Specialist \_\_\_\_\_

Check Amt \$ \_\_\_\_\_ Check # \_\_\_\_\_ Premium \_\_\_\_\_

Providence Health Plans  
 Portland Office: PO Box 4327  
 Portland OR 97208-4327  
 Phone: 503-574-6665 or 877-245-4077  
 Fax: 503-574-7543

Providence Health Plans  
 Eugene Office: 1500 Valley River Dr Ste 200  
 Eugene OR 97401  
 Phone: 541-242-9012 or 877-245-4077  
 Fax: 800-889-8218

## AGENT INFORMATION

Agent \_\_\_\_\_ Commission Schedule = PMPM  
Firm \_\_\_\_\_ Phone \_\_\_\_\_ Tax ID#/SSN \_\_\_\_\_  
Full Address \_\_\_\_\_  
Original contract mailed to Group  Agent  Copy mailed to Group  Agent

## AGENT STATEMENT

I certify that all the information contained in this application is correct to the best of my knowledge. I also certify that:

1. This firm is a bona fide business establishment.
2. All participation requirements have been met.
3. Coverages, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been fully explained and understood by the employer.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Agent Signature

## EMPLOYER STATEMENT

1. We wish to apply to enroll our firm as a group with Providence Health Plan. We understand payment of premium will be deemed to be assent to all terms of the group contract, including modifications and renewals that are sent to us.
2. We understand that the final rates will be based on actual enrollment and may be different than the rates originally quoted.
3. We understand that coverage is provided on a sole carrier basis only.
4. Minimum participation requirements for specific coverage(s) have been fully explained in detail, and we understand that they must be met and maintained in order for the group to remain eligible for coverage.
5. The broker/agent stated above is our agent of record for Providence Health Plan and will remain such until this application is rescinded in writing.
6. To the best of our knowledge and belief, the foregoing statements are true and complete and, along with the group application, shall be the basis for the issuance of coverage under the group policy and shall become part thereof.
7. We understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company; and such intent to defraud may be subject to criminal and civil penalties and Providence Health Plan (PHP) may cancel the group account and refuse to pay claims.
8. We understand that 30 days' notice is required to change this agreement.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Authorized Group Signature

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