Agenda Summary Report (ASR)

Franklin County Board of Commissioners

DATE SUBMITTED: 10/23/2023	**PREPARED BY:** Margot Wilder
Meeting Date Requested: 10/25/2023	**PRESENTED BY:** Margot Wilder
ITEM: (Select One) **X** Consent Agenda	Brought Before the Board **Time needed:**

SUBJECT:
Premera Group Membership Application, Lincoln Group Insurance Application and United Healthcare Cancellation Notification

FISCAL IMPACT:
Budgeted expense for employee benefits, currently $1657.52/month for medical and dental coverage. This requested action does not have a fiscal impact, as it does not modify the County's contribution to employee benefits coverage.

BACKGROUND:

On 10/18/2023, the Board gave consensus approval to move forward with Premera Blue Cross plans for 2024 employee medical and dental insurance. The Premera Group Master Application is the document required to execute the group policy. It is also necessary to cancel our current group policy with United Healthcare and we are required to provide United Healthcare written notice of cancellation.

The Board also gave consensus to move forward with additional ancillary coverages from Lincoln Financial Group and those coverage options are also requiring a signed application

COORDINATION: Cheryl Hanks & Brandon Cleary at HUB International completed the Applications in partnership with Margot Wilder, HR Director.

RECOMMENDATION: Approve the resolution authorizing the Chair to sign the Group Applications for Medical and Dental benefits.

ATTACHMENTS: **(Documents you are submitting to the Board)**

ASR –Resolution- two applications & Cancellation Notification

HANDLING / ROUTING: **(Once document is fully executed it will be imported into Document Manager. Please list name(s) of party(s) that will need a pdf.)**
Original : Clerk of the Board Teresa Alvarez & Human Resources

I certify the above information is accurate and complete.

Name: _____ Margot Wilder, HR Director

FRANKLIN COUNTY RESOLUTION _____

BEFORE THE BOARD OF COUNTY COMMISSIONERS
FRANKLIN COUNTY, WASHINGTON

MEMBERSHIP APPLICATIONS FOR 2024 EMPLOYEE MEDICAL, DENTAL AND ANCILLARY INSURANCE

WHEREAS, the Board of Franklin County Commissioners has selected Premera Blue Cross and Lincoln Financial Group plans for 2024 employee medical, dental and ancillary insurance; and

WHEREAS, it is necessary to cancel our current group membership with Untied Healthcare to be effective December 31, 2023; and

WHEREAS, Premera Blue Cross and Lincoln Financial Group require an Group Application for new plans before they can be executed on January 1, 2024; and

WHEREAS, the Board of Franklin County Commissioners constitutes the legislative authority of Franklin County

NOW, THEREFORE IT IS HEREBY RESOLVED the Premera Blue Cross Group Master Application, the Lincoln Financial Group Application for Group Insurance and United Healthcare Cancellation Letter are approved by the Board of Franklin County Commissioners; and

BE IT FURTHER RESOLVED, the Board of Franklin County Commissioners authorizes the Chair of the Board to sign the Premera Blue Cross Group Master Application, the Lincoln Financial Group Application for Group Insurance and United Healthcare Cancellation Letter as the Group's Representative

DATED this _____ day of _____, 2023.

BOARD OF COUNTY COMMISSIONERS
FRANKLIN COUNTY, WASHINGTON

_____
Chair

_____
Chair Pro Tem

ATTEST:

_____
Member

_____
Clerk of the Board

FRANKLIN COUNTY
HUMAN RESOURCES DEPARTMENT

◦ 1016 N. 4th Avenue ◦ Pasco, WA 99301 ◦
◦ Phone: 509-546-5813 ◦ Fax: 509-546-5814◦
www.franklincountywa.gov/262/Human-Resources

October 23, 2023

UnitedHealthcare

Attn: Megan Miller: megan_j_miller@ UHC.com
Meagan Mansfield: meagan.mansfield@uhc.com

RE: Cancellation Notification – Franklin County Group #9525796

This letter is formal notification to inform **UnitedHealthcare**, that effective midnight **December 31, 2023,** we are canceling our **medical and dental coverage under Group #9525796** with your company.

Thank you for your past service. If you have questions or need additional information, please reach out to our broker, Brandon Cleary.

Sincerely,

Clint Didier
Franklin County Chairman of the Board

Cc: Brandon Cleary, HUB International Northwest

PREMERA | BLUE CROSS

P.O. Box 327
MS 315
Seattle, WA 98111-0327

Group Master Application

Application is made to Premera Blue Cross (hereafter referred to as "we," "us," or "our") for a new Health Care Contract, the provisions of which shall be made available to all eligible classes of employees. Your group can't be enrolled prior to our receipt date of this completed and signed application.

Group ID: _____
(Completed by Premera Blue Cross)

1. PURPOSE

■ New Group: Complete this application and submit with enrollment forms prior to the effective date of coverage.
☐ Renewal: Complete this application and Benefit Selection Report in its entirety.
☐ Other _____

Effective Date From: 01/01/2024 To: 01/01/2025 Annual Contract Renewal Month January

2. GROUP INFORMATION

A.
Legal Name: Franklin County
Common Name (Required if Legal Name exceeds 50 characters and spaces): _____
Physical Address: 1016 North Fourth Avenue
City: Pasco State: WA ZIP: 99301 County: Franklin

B. Mailing Address ■ Same as Physical ☐ Separate Address, complete the following:
Street/ P.O. _____
City _____ State _____ ZIP _____ County _____

C. Billing Address ☐ Same as Mailing ■ Same as Physical ☐ Separate Address, complete the following:
Street/ P.O. _____
City _____ State _____ ZIP _____ County _____
Billing Contact Person: Alexis Finke Title: Accounting Assistant II
Phone No. (509) 545-3556 Fax No. (___) ___-____
E-mail Address: alexisf@franklincountywa.gov

D.
Group Benefit Administrator: Margot Wilder Title: Human Resource Direc
Phone No. (509) 546-5817 Fax No. (509) 546-5814
E-mail Address: mawilder@franklincountywa.gov

E. Do you use a COBRA Administrator? ☐ No ■ Yes, complete the following: ☐ Same as Billing Address and Contact Person (same contact as section 2C & 2D)
Retiree Billing Statement will also go to Verde Services

Retiree & COBRA Administrator Billing Address 3911 Castlevale Rd, Suite 109

City Yakima State WA ZIP 98902 County Yakima

COBRA Administrator Contact Person Teresa Harper Title COBRA Administrator

Phone No. (509) 972-7417 Fax No. (___)___-____

E-mail Address teresah@tbsmga.com

F.

Employer Identification Number (EIN) 91-600135 NAICS # 921190

Type of Business Governmental Agency (County) SIC # 9199

G.

Is the group a subsidiary of or affiliated with another company or headquartered outside the State of Washington?

■ No ☐ Yes, complete the following:

Legal Name _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

H.

In the past 36 months has the group or any affiliated entity filed for protection or operated under Federal/State Bankruptcy laws?

■ No ☐ Yes

In the past 36 months has any creditor filed or threatened to file a petition requesting the group or any affiliated entity to be put into bankruptcy?

■ No ☐ Yes

I.

Is worker's compensation coverage provided for all employees? ■ Yes ☐ No, please list employees not covered and reason

_____

J. Group Authorized Contract Signer

Name _____ Email _____

3. EMPLOYEE ELIGIBILITY REQUIREMENTS

If all of your employees must work the same hours, meet the same probationary period, and will have the same benefit options available to them, complete section A, skip section B, then continue to sections C, D and E.

If you are differentiating your employees by class (i.e., Managers, Hourly, etc.) complete section B, skit section A, then continue to sections C, D and E.

A. All Employees in One Class SEE ATTACHED FILES WITH CLASSES AND ELIGIBILITY

1. Minimum Work Hours

All employees who normally work a minimum of 30 hours* per week and have satisfied the probationary period are eligible.

*Employees must work at least 20 hours per week to qualify for health coverage. The group may choose to set the minimum number of work hours per week higher for employees to be eligible.

2. **Probationary Period Information**

All eligible employees are effective on the:

☐ 1st of the month following ☐ 1st of the month following or coinciding with the date of hire ■ 1st of the month following date of hire ☐ Next day following ☐ Exact date of hire

☐ 30 days ☐ 60 days ☐ ____ days from (enter date) * _____

***Note**: Probationary period can't be more than 60 days.

B. Employees Differentiated by Class

Minimum Work Hours and Probationary Period Information

Only employees in a specific class or classes who normally 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. If you have differentiated your benefit coverage selection by class of employee on your Benefit Coverage Selection Worksheet – those same classes must be represented.

*Employees must work at least **20 hours** per week to qualify for health coverage. The group may choose to set the minimum number of work hours per week higher for employees to be eligible.

☐ **Management (M)**	☐ **Salaried (S)**	☐ **Hourly (H)**	☐ **Part-time (P)**	☐ **Full-time (F)**	☐ **Other (O) Please specify** _____
Minimum hours ___	Minimum hours ___	Minimum hours ___	Minimum hours ___	Minimum hours ___	Minimum hours ___
☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:	☐ 1st of the month following:
☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire	☐ Date of hire
☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days	☐ 30 days
☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days	☐ 60 days
☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire	☐ Exact date of hire

C. Waive Probationary Period—to be completed by New Groups Only

☐ Waive the probationary period on all current qualifying employees.

■ Apply the probationary period to all employees (current qualifying employees must satisfy the balance of the above probationary period).

☐ Waive the probationary period for rehired employees

☐ Apply to probationary period to all rehired employees

D. Coverage will end

☐ Last day of the month for which subscription charge is paid

■ Other employees must work 40 hours in the last month of employment to qualify for benefits

E. Domestic Partners

Domestic Partner coverage is standard for all fully insured groups with 51 or more employees. All domestic partners, including same sex, opposite sex, and state-registered will be considered eligible dependents. Domestic partner eligibility will include eligibility for COBRA continuation coverage.

If you would like to limit domestic partner coverage to state-registered domestic partners and/or choose not to extend COBRA coverage for domestic partners, please contact your Premera sales representative. If your group is self-funded, please contact your sales representative for your options.

4. EMPLOYEE ENROLLMENT

A.	Total number of employees on payroll (regardless of hours worked)	271

Note: For 4B and 4C count each employee in only one category

B. Employees not eligible to enroll

1.	Employees who work less than the minimum hours per week (as specified in section 4A)	0
2.	Employees who are temporary or seasonal	0
3.	Employees who are in a probationary period	0
4.	Employees who are not in a covered class (employees not specified as eligible in 3A)	0
	Total of section 4B	

C. Employees not enrolling due to coverage under:

1.	A government plan (e.g., Medicare, CHAMPUS/Tricare, Military)	
2.	Other group coverage	56
3.	A collective bargaining agreement (union)	0
	Total of section 4C	56
D.	Total number of employees eligible to enroll (sections 4A – 4B – 4C)	215
E.	Eligible employees waiving enrollment without other coverage	
F.	Total number of eligible employees enrolling (sections 4D – 4E)	215
G.	Total number of retirees eligible for benefits 15 Dental /5 Medical	
H.	Total number of COBRA/Continuation of Coverage subscribers	0
I.	Do you have eligible employees employed outside the State of Washington?	■ No ☐ Yes, complete the table below

State/Country	Number of Employees

J. Calculated Actual % of participation (completed by Premera Blue Cross) _____

5. EMPLOYEE PARTICIPATION AND EMPLOYER CONTRIBUTION

A. Minimum Employee & Dependent Participation Requirements
Please refer to underwriting assumptions to verify minimum participation requirements are being met.

B. Employer Contribution Requirements – **TO BE COMPLETED BY EMPLOYER**

Note: Waivers of coverage are not allowed for eligible employees of non-contributory groups. If dependent coverage is also non-contributory, no waivers of coverage are allowed.

1. Effective date of Contribution 01/01/2024 (month / day / year)

2. The employer will contribute the following percentage or dollar amount toward the cost of eligible employee and dependent coverage: See Attached Contribution Worksheet

Note: If you differentiate contributions by class of employee, those same classes must be represented here.

	Medical	Dental	Vision
Employee			
Spouse / Domestic Partner			
Dependent Child (1 child)			
Dependent Children (2 or more)			

C. Employer Contribution Changes – Impact on Grandfathering

☐ Employer Contribution towards the cost of any tier of coverage has not been decreased by more than 5 percentage points since March 23, 2010

■ Employer Contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010

Note: If the Employer contribution towards the cost of any tier of coverage has decreased by more than 5 percentage points since March 23, 2010, the plan ceases to be grandfathered.

We reserve the right to review payroll records or comparable reports to ensure that eligibility and enrollment requirements are met.

6. FEDERAL REQUIREMENTS

Helpful Hint: We strongly urge you to consult legal counsel in answering the questions below. 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 Premera immediately if facts change which would cause the group's answers below to change.

A. Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a spouse's) current employment status who have Medicare due to age?

1. ■ Yes. This plan will pay primary to Medicare as required by federal law. ☐ No. Under 20 employees.

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

Helpful Hint: These laws do not apply to any employer who did not employ 20 employees or more for each working day in each of 20 or more calendar weeks in either the current **or** preceding calendar year. For these small group plans, Medicare pays primary to the group plan.

"Employees" include all full-time and part-time employees as well as those employees on disability and subject to FICA taxes. Also count leased employees if they would be counted as employees under §414(n)(2) of the Internal Revenue Code (IRC), and count employees employed by an "affiliated service group" under IRC §414(m) or by employers considered to be a "single employer" under IRC §52(a) or (b).

B. Is the group subject to COBRA?

■ Yes ☐ No. Give the legal reason for exemption _____

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 a part-time employee as a fraction of a full-time employee.

C. Is the group subject to the federal Medicare Secondary Payer (MSP) laws that prohibit discrimination against individuals with group coverage based on their (or a family member's) current employment status who have Medicare due to disability?

1. ■ Yes. This plan will pay primary to Medicare as required by federal law. ☐ No. Under 100 employees.

2. Please also provide the number of employees who now meet Medicare's definition of "employee." _____

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 in 6A above for a definition of "employee" for this purpose.

D. Is the group subject to ERISA?

☐ Yes. Enter the month the ERISA plan year ends Month: _____

■ No. Give the legal reason for exemption ■ Government or Public Plan ☐ Church Plan

☐ Other, please specify _____

Helpful Hint: Generally, ERISA applies to all employer health plans except governmental, public or church plans. Non-profit status alone does not exempt an employer from ERISA.

7. CURRENT COVERAGE INFORMATION

A. Is this Premera Blue Cross plan intended to replace any existing coverage? ☐ No, skip to section 7B ■ Yes, complete the following:

1.	Name(s) of current Medical carrier(s)	United Health Care	Proposed termination date	12/31/2023 (mm/dd/yyyy)
2.	Name(s) of current Vision carrier(s)		Proposed termination date	/ / (mm/dd/yyyy)
3.	Name(s) of current Dental carrier(s)	United Health Care	Effective date of coverage	01/01/2022 (mm/dd/yyyy)
			Proposed termination date	12/31/2023 (mm/dd/yyyy)
	Does your current dental coverage include orthodontia? ☐ No ■ Yes		If yes, effective date of orthodontia coverage	01/01/2018 (mm/dd/yyyy)

B. Are you offering a plan from a carrier other than Premera Blue Cross? ☐ No, skip to section 8 ■ Yes, more than one carrier's plan is offered:

Name(s) of other Medical carrier(s)		Name(s) of other Dental carrier(s)	Name(s) of other Vision carrier(s)
Indicate if other plan is an HSA	HSA?		
	☐ No ☐ Yes	Willamette Dental	
	☐ No ☐ Yes		
	☐ No ☐ Yes		

C. When selecting a Premera plan, coverage for Temporomandibular Joint Disorder (TMJ) will be offered under the medical plan or stand-alone dental plan. Please see your plan benefit for specific TMJ benefit coverage.

8. GROUP MATERIALS

Electronic copies of benefit booklets are available online at premera.com. Please indicate if you would like printed copies sent.

Printed copies should be sent to:

Producer:	☐ Contract ☐ Benefit Booklet(s)	Number of booklets: _____
Group Administrator:	☐ Contract ☐ Benefit Booklet(s)	Number of booklets: _____

9. PRODUCER AGREEMENT TO CONTRACT

A. 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, the effect of misrepresentations, termination provisions and subscription charge billing administration.

Producer Signature *Brandon Cleary* Date 10/17/2023 (mm/dd/yyyy)

Producer of Record (print name) Brandon Cleary

Producer Number 229610

E-mail Address brandon.cleary@hubinternational.com

Name of Firm/Agency HUB International Northwest

Effective Date Producer is Appointed for this Group 01/01/2024

Commission: ■ PEPM ☐ %

B. ☐ Split Commission

Secondary Producer Name | Secondary Producer Number

Commissions are split between the primary and secondary producer as follows: Primary: % Secondary: %

10. GROUP AGREEMENT TO CONTRACT

You, the group named in section 2 of this application, understand and agree to the following.

A. **This application becomes part of the contract to provide health care coverage after:**
- The application is signed by you;
- The application is received and approved by us; and
- We receive the initial month's subscription charges.

You may not assign this contract without our written consent. Any attempt to do so will not have any binding effect on us. You agree to promptly deliver materials and notifications, including benefit booklets, received from us to all covered employees. You also agree to provide notification regarding the plan's special enrollment rights to all eligible employees before their enrollment. You attest to have read this application and certify that all statements are true and complete.

You agree to the terms and obligations stated in this application. It is understood that provisions of the Health Care Contract, including subscription charges, may be amended, or changed from time to time, upon our notice to you. All prior applications, to the extent that you have not made changes to them in this application, remain in full force and effect. The producer listed in section 9 will remain effective until written notice is given by either party. We are authorized to pay, on your behalf, commission, if any, for which you are liable to the above-named producer.

B. You may elect to allow the producer listed above to act as a group benefit administrator beginning on the group's effective date. This means that the producer/administrator will be able to access membership and billing functions and obtain information about group members via the Web on behalf of the group.

These functions may include, but are not limited to:
- Reinstate Terminated Members
- Inquire on Invoice
- Order ID Cards for an Individual or Whole Family
- Request Invoice
- Inquire on Eligibility
- View Group Demographic Information
- Search for a Member
- Enroll a Member
- Cancel a Member
- View Benefit Detail

Do you elect and authorize Premera Blue Cross to provide such information to the producer? ☐ No ■ Yes

C. New non-grandfathered groups with a plan effective date in the middle of the calendar year can ask Premera to apply credit toward members' out-of-pocket maximum on the group's new Premera plan. When the group provides the data, Premera will credit the members' coinsurance, copays, and deductible amounts required by the group's prior plan that the members paid in the same calendar year as the group's effective date under the new Premera plan.

D. I affirm that this group has a physical location outside Clark County in the State of Washington, and I am authorized to sign on behalf of the group.

Signature of Group's Representative

Date / / (mm/dd/yyyy)

Group's Representative (print name)

Title _____

Please note: 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 Lincoln National Life Insurance Company
Group Insurance Service Office
8801 Indian Hills Drive, Omaha, NE 68114
Phone: 800-423-2765 Fax: 877-573-6177

APPLICATION FOR GROUP INSURANCE

is made to THE LINCOLN NATIONAL LIFE INSURANCE COMPANY (the Company).

A. Group Name & Address

Applicant's Full Legal Name (exactly as to be shown in Group Policy)

Franklin County

Main Office Address (physical location and group situs state)

Street Address	City	State	Zip
1016 North Fouth Avenue	Pasco	WA	99301

E-Mail Address (if available)	Phone	Fax
mawilder@franklincountywa.gov	(509) 546-5817	(509) 546-5814

B. Requested Insurance

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each.

Group Insurance	Requested Effective Date	Group Insurance	Requested Effective Date
☐ Life & AD&D	___/___/___	☐ Voluntary Life	___/___/___
☐ Short Term Disability (STD)	___/___/___	☐ Voluntary Life & AD&D	___/___/___
☐ Long Term Disability (LTD)	___/___/___	☐ Voluntary AD&D	___/___/___
☐ Dental	___/___/___	☐ Voluntary Short Term Disability	___/___/___
☒ Accident	1/1/24	☐ Voluntary Long Term Disability	___/___/___
☒ Critical Illness	1/1/24	☐ Voluntary Dental	___/___/___
☐ Hospital Indemnity	___/___/___		

C. Business Information

Nature of Business (Please specify)	Years in Business	Federal Tax ID No.
Governmental Agency (County)	140	91-600135

Business is Organized as (Select one)

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Non-Profit Organization
☐ Labor Union ☐ Association ☐ Trust ☒ Other Governmental Agency (County)

Financial Risk (If Yes to any part, please explain below.)

Has Applicant ever filed for bankruptcy? ☐ Yes ☒ No
Does Applicant anticipate ceasing or materially reducing active business operations? ☐ Yes ☒ No
Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation? ☐ Yes ☒ No

Explanation: _____

Binder payment submitted: Amount $_____ (if applicable)

D. Replacement Insurance

Will all or part of this insurance **replace** any similar insurance? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.** ☐ Yes ☒ No

Insurance Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date
		___/___/___	___/___/___
		___/___/___	___/___/___
		___/___/___	___/___/___
		___/___/___	___/___/___
		___/___/___	___/___/___
		___/___/___	___/___/___

E. Fraud Warning/State Disclosure(s)

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.

F. Agreement

The Applicant applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

(a) be issued only if the requested insurance is acceptable to the Company and is legally permissible;
(b) be issued under a group Policy or Policies in the language customarily used by the Company;
(c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
(d) be subject to all exclusions, limitations, and other provisions of the Policy; and
(e) take effect on the date determined by the Company, in accord with the provisions of the Policy.

The Applicant understands that no producer has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to any Active Work requirement. The Applicant agrees not to:

(a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
(b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law. Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms and provisions, including its exhibits, riders, endorsements, or amendments, if any. If this Application is approved, it will be made a part of any Policy issued.

Producer's Signature Brandon Cleary

Typed or Printed Name Brandon Cleary

License Number 229610 State WA

Signed by Applicant's Authorized Representative:

Signature _____

Typed or Printed Name _____

Title _____

State Signed _____ Date ___/___/___
Must be signed prior to Effective Date