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Employer Agreement

| General Business Information | | | | |
|---|--------------|-----------------------|------------|---------------------|
| Business Legal Name | | Federal Tax ID Number | UBI Number | |
| Business Address | | City | State | ZIP Code County |
| Mailing Address (if different than above) | | City | State | ZIP Code |
| Primary Contact Name | Phone Number | Fax Number | | Email Address |
| Nature of Business | | | | SIC Code (optional) |

| Selection of Health Plan (Check One) | |
|---|--|
| <p>Asuris</p> <p><input type="checkbox"/> Asuris Embark 80/60/60 - \$250</p> <p><input type="checkbox"/> Asuris Embark 80/60/60 - \$500</p> <p><input type="checkbox"/> Asuris H.S.A. Healthplan - \$2,500</p> <p><input type="checkbox"/> Asuris Embark 80/60/60 - \$2,000</p> <p>Group Health Options Inc.</p> <p><input type="checkbox"/> Group Health Options Welcome 200 - '09</p> <p><input type="checkbox"/> Group Health Options Balance 500 - '09</p> <p><input type="checkbox"/> Group Health Options Balance 1000 - '09</p> <p><input type="checkbox"/> Group Health Options HealthPays 2500 - '09</p> | <p>Premera</p> <p><input type="checkbox"/> Premera Your Balance \$1,000</p> <p><input type="checkbox"/> Premera Your Future \$2,500</p> <p><input type="checkbox"/> Premera Your Value \$3,500</p> <p>Regence</p> <p><input type="checkbox"/> Regence Innova 80/60/60 - \$250</p> <p><input type="checkbox"/> Regence Innova 80/60/60 - \$500</p> <p><input type="checkbox"/> Regence HSA Healthplan - \$2,500</p> <p><input type="checkbox"/> Regence Innova 80/60/60 - \$2,000</p> <p><input type="checkbox"/> Regence Engage 80/80/80 - \$5,000</p> |

| Employer Contribution |
|--|
| The minimum employer contribution for employee coverage is 40% and does not apply to employees' dependents. |
| Employer contribution amount for employee (must be at least 40%) % _____ |
| Employer contribution amount for dependent(s) (optional) % _____ |

| Electronic Payment of Monthly Premium Statements |
|--|
| Would you like to receive information on how to pay your monthly premiums electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No |

(continued on next page)

Employer Agreement and Certification

I agree and represent that:

- I currently do not offer health insurance coverage to my employees, including insurance purchased through the small group and association health plan markets, self-funded plans, and multiple employer welfare arrangements;
- At least 50% of my employees are low-wage as defined by the HIP as earning wages no more than \$10 per/hour or \$1,733.41 per month;
- At least 75% of eligible employees will enroll in the health plan selected;
- I will establish a Section 125 Premium Only Plan as defined by the Federal Internal Revenue Service that enables employees to use pretax dollars to pay their share of their health benefit plan premium.

I understand that:

- The HIP will mail my invoice to me on the 10th business day of the month prior to coverage;
- Final payment is due on or before the 20th of the month prior to coverage;
- If I don't pay the group premium when it is due, I will be disenrolled from the HIP, and all employees participating in my group plan who are receiving subsidies will lose their subsidy. The HIP will send a notice of disenrollment to me and all subsidy-eligible employees. This notice will outline the HIP disenrollment process and provide contact information for the health insurance carrier. I may contact the carrier to get options available for continuing group coverage.

I have read, and I understand the information provided to me with the HIP Employer Agreement. I declare that the information I have given in this application is true, correct, and complete to the best of my knowledge. I understand that incorrect information may delay or prevent my enrollment in the HIP.

Authorized Representative Signature

Printed Name

Date

X _____