

Western Healthcare Insurance Trust (WHIT)

Subscription Agreement

1) **Subscribe to Trust.** As a participating member of the Western Healthcare Insurance Trust, _____ (hereafter, "Employer" or "we"), subscribes to the Western Healthcare Insurance Trust Agreement and acknowledges receipt of this Trust Agreement.

2) **Status of Trust and Status of Employer.** The Trust is a "multiple employer welfare arrangement" (MEWA) under federal law, 29 USC 1001(40), and a Group Insurance Arrangement for IRS reporting purposes. The employer is the plan fiduciary of the WHIT plans to which it subscribes, but the Employer and Trust agree in this Agreement that the Employer is delegating certain responsibilities to the Trust, as set forth herein, specifically in Section 9.

3) **Payment of monthly contributions.** The employer agrees to pay the contribution amounts established by the Trustees ON OR BEFORE THE 25th OF THE MONTH PRIOR TO THE COVERAGE MONTH for the coverage lines indicated below:

(check and initial at end of line)

- Washington Dental Service – Dental _____
- Vision Service Plan - Vision _____
- The Standard - Basic Life/AD&D _____
- The Standard - Voluntary Accident _____
- The Standard - Long-term Disability _____
- Willamette Dental - Managed Dental _____
- The Standard - Voluntary Term Life _____
- American Fidelity – Voluntary Short-term Disability _____

4) **Adjustment to contribution rates.** We understand that the Trustees have the authority to adjust the contribution rates for the benefit programs from time to time. We further understand that benefits shall not be provided by the Trust during any month for which contributions are not paid. The Trustees shall give 30 days advance written notice of changes to contribution rates.

5) **Delinquencies.** We acknowledge that in the event of contribution delinquencies, the Trust can require the participating employer to pay liquidated damages, interest, attorney fees, audit fees and other associated costs.

6) **COBRA (continuation of coverage under federal law).**

a) **General.** We understand that COBRA may apply to certain of the Trust's benefit programs for certain employers.

b) **Employer's responsibility.** We agree that we, the employer, are responsible for all COBRA administration in relation to Trust coverages, including all notices, elections, processing of contributions, etc. and that the Trust will not be sending any COBRA notices, election forms, etc. However, subject to Section 5(c) hereof, we understand that if we timely transmit lawful COBRA self-payments to the Trust, continuation coverage will be provided by the Trust.

c) **Withdrawal of employer from Trust.** We agree that in the event we terminate our participation in a Trust plan that is subject to COBRA, the Trust will not continue COBRA coverage for our employees or former employees on COBRA coverage from the Trust, but that we will be responsible for such coverage.

7) **Certify to Eligibility.** We further certify that all employees, as will be reported on the billing forms or electronic data system, meet the eligibility requirements in paragraph 7 hereof, and the criteria for participation in the benefit programs as described in the carriers' applications we complete at initial enrollment.

8) **Eligibility Rules.** The minimum eligibility requirements for participation in the Trust are:

- a) The employee must be employed in a group of employees designated by the participating employer on a basis that precludes individual selection (except for voluntary plans).
- b) The employee must be employed on a permanent, full-time basis defined as 20 hours or more per week.
- c) The employee must be performing the usual duties of his/her occupation at a place of business designated by the employer.
- d) The employee must be compensated in the form of wages or salary for services presently being performed.

9) **Preparation and Distribution of Various Plan Documents: Summary Plan Descriptions and Plan Booklets.** We understand that employees participating in the Trust are entitled to certain information under federal law, and that the Trust does not maintain addresses for all employees.

a) Preparation. The Trust (and/or the Trust insurance carriers) will prepare the Summary Plan Description, Summary Annual Report, HIPAA notices and other descriptive material for WHIT benefit plans.

b) Distribution. Thus, we accept the responsibility to promptly distribute to our employees the "Summary Plan Description" that the Trust sends to us, and the benefit booklets/certificates that the insurance carriers send to us for distribution.

c) IRS Form 5500. The Trust accepts the responsibility to prepare the annual IRS Form 5500 for the benefit plans listed in Section 3 hereof, and timely file it with the IRS.

10) **Effective Date.** This Agreement shall become effective on the date signed below, and shall remain in effect unless terminated by either party in accordance with the terms of this agreement. The Employer or Trust may terminate this Agreement effective the first of any month, provided written notice is given at least 10 days in advance to the other party. The Trust may also terminate coverage effective the first of any month for the Employer's failure to remit contributions when due. **Written notice of termination must be received by the other party at least 10 days prior to the first day of the month in which coverage is to be terminated, or contributions will be due for that month.**

EMPLOYER NAME

PRINT NAME & TITLE
OF CHIEF HUMAN RESOURCES OFFICER

DATE

AUTHORIZED SIGNATURE

Approved and accepted by Western Healthcare Insurance Trust.

TRUSTEE or ADMINISTRATIVE AGENT

1/22/09 edition