WESTERN HEALTHCARE INSURANCE TRUST

2023 RENEWAL AGREEMENT (NO PLAN CHANGES)

Annual Renewal Effective Date: 01/01/2023 Vimly Account Number (INTERNAL USE):

EMPLOYER INFORMATION

Field				
Legal Name of Business				
Doing Business As (DBA)				
Business Physical Address		City:	State:	Zip:
Mailing PO Box		City:	State:	Zip:
Federal Tax ID Number		State of Legal Domicile		
Type of Legal Entity		Tax Exempt: ☐ YES ☐ NO	Governmental Entity: ☐ YES ☐ NO	

Does your group cover Non-Registered Domestic Partners? ☐ YES ☐ NO

We allow the following Domestic Partnerships. ☐ Same Sex ☐ Opposite Sex ☐ Both

Group Benefits Administrator (This contact will be the primary contact for benefit updates and administration)

Name & Title	Phone:	Email:

Group Billing Administrator (This contact will be the primary contact for billing updates)

Name & Title	Phone:	Email:

Insurance Producer (as applicable)

Does your organization use an insurance producer for WHIT plans? ☐ YES (if YES, complete the following) ☐ NO

Agency Name:	Producer Name:	Phone:	
Agency Address:	City:	State:	Zip:
PRODUCER SIGNATURE:		DATE:	

COBRA

An employer is subject to Cobra during the current calendar year if the company employed 20 or more employees on 50% of its typical business days in the preceding calendar year.

Subject to COBRA? ☐ YES ☐ NO

Does your group currently have any COBRA participants? ☐ YES (if YES, how many) ______ ☐ NO

If your organization uses an outside COBRA administrator, please complete the following:

Agency Name:

How should COBRA premiums be billed: ☐ Employer Bill ☐ TPA Direct

Contact Name:	Phone:	Email:	
Agency Address:	City:	State:	Zip:

SIMON

Will the group process enrollment via the WHIT/Vimly Benefit Solutions Web Enrollment System? ☐ YES ☐ NO

If YES, for access to the online enrollment system and billing services, indicate the individual(s) whom should be authorized. An email invitation will be sent out to the designated individual(s) to register for Web Enrollment System functionality. *
IMPORTANT: Email addresses are mandatory for Web Enrollment System access.

Name & Title	Phone:	Email:
Name & Title	Phone:	Email:

VERIFY

☐ **Please check this box to acknowledge that the group will be renewing with no changes for the 2023 plan year.** *If you will be changing plans or eligibility requirements in 2023, please fill out the 2023 MPA Form.*

Western Healthcare Insurance Trust (WHIT) Subscription Agreement

1) Subscribe to Trust. As a participating employer of the Western Healthcare Insurance Trust, ___________________________ (hereafter, "Employer" or "we"), subscribes to the Western Healthcare Insurance Trust Agreement and acknowledges receipt of the Trust Agreement governing the Western Healthcare Insurance Trust, restated effective May 1, 2015, (Dr. 12/2/14) and subsequent amendments.

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 above.

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 is allowed to charge the participating employer for liquidated damages, interest, attorney fees, audit fees and other associated costs; and the employer will be liable for such charges.

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 6(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 8 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, the benefit booklets/certificates that the insurance carriers send to us for distribution, and any other notices that we receive from the Trust or insurance carriers for distribution to employees.
c) IRS Form 5500. The Trust accepts the responsibility to prepare the annual IRS Form 5500 for the benefit plans listed in Section III hereof, and timely file it with the IRS.

10) Effective Date and Termination. 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 by an employer must be received by the Trust at least 10 days prior to the first day of the month for which coverage is to be terminated, or contributions for coverage will be due for that month.**

The below signed applicant acknowledges 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.

Authorized Signature: ____ Date: _______________

Title: ____