# Cascade Employers Health Insurance Trust
# Participating Employer Election Form

## Group Information

| | | |
|---|---|---|
| Name of Group | | Group Number |
| Nature of Business | | Requested Effective Date of Coverage |
| Name and Email of Group Benefits Administrative Contact | | |
| Name and Email of Billing Contact | | |
| Billing Address | | |
| City | State | Zip |
| Physical Address | | |
| City | State | Zip |
| Phone Number | Fax Number | |
| Signature of Group Representative | | Date |
| Group Representative (Print Name) | | Title |

## Product Selections

**Dental Plan Options**

| ☐ LMD Plan 1: | ☐ LMD Plan 2: | ☐ LMD Plan 3: | ☐ LMD Plan 4: (MAC Plan) |
|---|---|---|---|
| PPO 1000 (DED 50/150) 100/80/50 | PPO 1500 (DED 50/150) 100/80/50 | PPO 2000 (DED 50/150) 100/80/50 | PPO 1000 (DED 50/150) 100/80/50 |

**Orthodontia Benefit Rider** ☐ Plan 1 - $1,000 ☐ Plan 2 - $1,500 ☐ Plan 3 - $2,000

**Add TMJ Rider** ☐ No ☐ Yes

**Basic Life and AD&D:** ☐ Plan A 10K ☐ Plan B 20K ☐ Plan C 30K ☐ Plan D 50K

**Short Term Disability:** ☐ (8/8/26)

**Will Owners be covered for STD?** ☐ Yes ☐ No

If yes; Owners contribution to that coverage will be 100% of the premium and 100% participation will be required.

## Employee Eligibility Requirements

**Eligible Classes:** Active work means the Employee is working at least the minimum number of hours stated below for the Employer on a regular and active basis, is receiving regular earnings from the Employer, and is employed at the Employer's usual place of business or at a location to which the Employer's business requires the Employee to travel.

**Select one of the following for Class 1:**

☐All full-time active Employees ☐Management ☐Non-Management ☐Salaried ☐Hourly ☐Other_____

**Select one of the following for Class 2 (if applicable):**

☐All full-time active Employees ☐Management ☐Non-Management ☐Salaried ☐Hourly ☐Other _____

**Minimum Hours Requirement for ALL Classes ( 17.5 - 40 ):**

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**New Employee Waiting Period:** New full-time employees are eligible for coverage the first of the month following:
**Select one of the following for Class 1:**

☐ Date of hire ☐ 30 Days ☐ 60 Days

Do you wish to waive the new employee waiting period for existing employees at initial enrollment? ☐ Yes ☐ No

**Select one of the following for Class 2 (if applicable):**

☐ Date of hire ☐ 30 Days ☐ 60 Days

Do you wish to waive the new employee waiting period for existing employees at initial enrollment? ☐ Yes ☐ No

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**Credit Service**: Employees transferring from part-time to full-time status, the new employee waiting period should apply:

☐ Retroactive to the original date of hire **OR** ☐ Beginning on the date transferred to full-time status

## Participation Requirements and Contribution

**Participation:** Total number of Eligible Employees _____ Number to be insured _____

**The Plan(s) selected will cover:** ☐ Employees Only ☐ Employees and Dependents

**Employer Contribution (Percentage employer will pay)**

**Dental:** Employee _____% Dependents _____%

**Basic Life and AD&D:** _____ %

**Short Term Disability:** _____ %

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### Prior Carrier Information

**Current Carrier Information:** _____

**Phone#:**_____

**Start date:** _____ **End date:** _____

**Is this plan a total replacement of any existing group plans?** ☐ Yes ☐ No

**Did the prior coverage include:**

**a) Major Coverage?** ☐ Yes ☐ No **b) Orthodontia** ☐ Yes ☐ No

### Administrative Information

**Rehire Period:** Applies only to employees covered under the plan at the time of termination from employment. Employees subject to the rehire provision must be enrolled the first of the month following the date of rehire. Application must be received within 15 days of this effective date. Employees rehired after the designated rehire period will be subject to the company's new employee waiting period established above.

**Would you like to offer the standard Rehire Period of 6 months?**: ☐ Yes ☐ No

All State Certified/Registered Domestic Partners are eligible for coverage. Would you also like to include Non-State Certified/Registered Domestic Partners as eligible for coverage?

☐ Same Sex Domestic Partners Only ☐ Both Same and Opposite Sex Domestic Partners ☐ No

This organization/group is enrolling under the policies issued to the Cascade Employers Health Insurance Trust (CEHIT). The CEHIT provides predetermined plan design and rate options to its membership. Each CEHIT group will determine their own eligibility guidelines. Please complete all of the information on this form and return to the New Business Team at the address shown below. You may also send the complete and signed form by fax or email it as an attachment.

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