WASHINGTON FIRE COMMISSIONERS ASSOCIATION
HEALTH CARE PROGRAM
2026 - Employer Application and Eligibility/Contribution Form

PLEASE CHECK APPROPRIATE BOX:

☐ Renewal January 1 ☐ New Organization
☐ Add Additional Line of Coverage ☐ Change in Program ☐ Organization Name Change
☐ Eligibility Change ☐ Address Change ☐ Other _____

I. ORGANIZATION INFORMATION **Employer Tax ID Number:** _____

Fire Service Organization _____ **TPSC Case #** _____

County _____

Street Address _____ City _____ State _____ Zip _____

P.O. Box _____ City _____ State _____ Zip _____

Organization Contact Name _____ Title _____ Phone _____

Email _____ Fax _____ Chief _____

II. MEDICAL BENEFIT SECTION

Medical administered by TPSC, PO Box 1894, Tacoma, WA 98401-1894

Vision administered by Vision Service Plan, 333 Quality Drive, Rancho Cordova, CA 95670.

Vision is included in all self-funded medical plans

MEDICAL/VISION ◯ Yes ◯ No ***If "Yes":*** check all the medical plans you wish to have available to eligible people in your organization

☐ Traditional Plan (LEOFF I ONLY)

Combo Plans· Active LEOFF I Dependent(s) only:

☐ Combo PP0-100 Plan ☐ Combo *PPO-Plus Plan
☐ Combo PP0-300 Plan ☐ Combo PPO-750 Plan
☐ Combo HD Plan

☐ PP0-100 Plan ☐ *PPO·Plus Plan
☐ PP0-300 Plan ☐ HD Plan
☐ PP0-750 Plan

Insured Medical/Vision Options: offered and underwritten by:

☐ Kaiser Foundation Health Plan of Washington
2715 Naches Ave. SW
Renton, WA 98057

☐ Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St. Suite 100. Portland. OR
97232·5398

* Enrollment in the PPO Plus Plan is only available to organizations that were enrolled in the PPO Plus Plan before 1/1/2021

III. DENTAL BENEFIT SECTION Dental administered by: Delta Dental of Washington, 9706 4th Ave NE, Seattle, WA 98115

DENTAL ◯ Yes ◯ No **If "Yes", choose only one** (1) of the following Dental plans for all eligible people in your organization:

◯ PPO INCENTIVE PLAN With Orthodontia ◯ PPO BASIC PLAN With Orthodontia
◯ PPO INCENTIVE PLAN Without Orthodontia ◯ PPO BASIC PLAN Without Orthodontia

IV. LIFE AND AD&D BENEFIT SECTION - Available if organization enrolls in Medical and/or Dental

Plan offered and underwritten by: Standard Insurance Company, 1100 SW 6th Ave, Portland, OR 97204

1. **CORE LIFE AND AD&D PLAN:** $2,000 per employee -automatic for employees and commissioners enrolled in the Traditional, PP0-100, PP0-300, PPO-750 *PPO-Plus, HD. or Combo medical plans
2. **BASIC LIFE / AD&D FOR EMPLOYEES AND COMMISSIONERS** ◯ Yes ◯ No
   ◯ $5,000 ◯ $10,000 ◯ $25,000 ◯ $50,000 ◯ $75,000 ◯ $100,000
3. **BASIC LIFE / AD&D FOR VOLUNTEERS** (paid by employer) ◯ Yes ◯ No
   If "Yes", Choose Volunteer amount: ◯ $5,000 ◯ $10,000 ◯ $25,000 ◯ $50,000

Fire Organization: _____

V. ELIGIBILITY

1. Total number of employees on your payroll: _____
   (*Include full time, union, part-time, temporary people, LEOFF I employees. Do not include volunteers, retirees, or commissioners)*
2. Number TO BE COVERED: _____

2.a. Total number of LEOFF I employees in above figure: _____

2.b. Total number of LEOFF II employees in above figure: _____

2.c. Total number of PERS employees in the above figure: _____

2.d. Total number of LEOFF I Retirees to be covered: _____

2.e. Total number of Non-LEOFF I Retirees to be covered: _____

2.f. Total number of Commissioners to be covered: _____

2.g. Total number of Former Commissioners to be covered: _____

3. TOTAL NUMBER OF ELIGIBLE ENROLLEES TO BE COVERED:
   (2a + 2b + 2c + 2d + 2e + 2f + 2g) _____

VI. DOMESTIC PARTNER ELIGIBILITY SECTION

WASHINGTON STATE REGISTERED DOMESTIC PARTNERS ARE TREATED THE SAME AS A SPOUSE

In addition, Organizations can choose to cover other domestic partners (as described on the WFCA Affidavit of Domestic Partnership)

Do you want to add Domestic Partner Coverage, in addition to State Registered Domestic Partners? ◯ Yes ◯ No

If "Yes", choose one of the following:

◯ Same-sex only*

◯ Opposite-sex only*

◯ Both Same-sex and Opposite-sex

**The Washington State Human Rights Commission may consider same-gender only or opposite-gender only selections to be discriminatory.*

***Washington State Domestic Partner Registry is only applicable when at least one partner is age 62 or older*

VII. 2026 ELIGIBILITY & EMPLOYER CONTRIBUTION LEVELS

Notes for completing this form:

1. Fire Service Organization's contributions for an employee's coverage under Medical and Dental must be noted below (either as a dollar amount or as a percentage of premium). Organization contributions can be any amount (including $0)*; *however, all eligible employees must be enrolled* (i.e. the employee cannot waive coverage).

   IMPORTANT: The Organization's contribution for an employee's coverage under either the Kaiser Foundation Health Plan of Washington medical plan or the Kaiser Foundation Health Plan of the Northwest medical plan must be at least 50% and contributions must be non-discriminatory.

2. Organization contributions for dependents' coverage under Medical and Dental must be noted below (either as a dollar amount or as a percentage of premium). Organization contributions can be any amount (including $0).

3. Organization contributions for an employee's coverage under Basic Life must be 100% of the premium.

All Employees	**Eligibility**	**Employer Contribution** (Employee / Dependent) **Medical**		**Dental**	
☐ Full-time employees**	_____ Minimum hours per week* (Maximum of 30 hours / week (Fire service organization can choose hourly requirements ranging from 20 to 30 hours per week))	_____	_____	_____	_____
☐ Qualified Volunteers‡ (Qualified volunteers must complete the volunteer affidavit)					
☐ Employer contributes towards the premium		_____	_____	N/A	
☐ Self-Pay Basis		_____	_____	N/A	
☐ Part-time employees	From _____ to _____ Hours per week				
☐ Employer contributes towards the premium**		_____	_____	N/A	
☐ Self-Pay Basis‡		_____	_____	N/A	

*The Affordable Care Act (ACA) defines full-time employment for purposes of health care coverage as working an average of 30 hours or more per week. Should fire service organizations wish to provide health care coverage to an employee working less than 30 hours per week, the employee must work no less than 20 hours per week to be eligible for WFCA health care coverage.

**For employees covered under either Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of the Northwest, the organization contribution must be at least 50%.

‡Volunteers and Part-time employees on a self-pay basis are only eligible for the PPO-300, PPO-750 and HD Plans.

Fire Organization: _____

APPLICATION AGREEMENT

To Become a Participating Member of the Washington Fire Commissioners Association Employee Benefit Program:

The undersigned applicant hereby applies for membership in the Washington Fire Commissioners Association Employee Benefit Program and hereby adopts such Program in accordance with the terms, conditions, and representations set forth herein and in the insurance or service contracts. The WFCA health care committee has oversight of the account (the IRSRA) established for purposes of this Program. Trusteed Plans Service Corporation, herein called "Administrator" is hereby requested to approve this application for participation and to request the insurer or service providers to effect desired coverage, subject to group underwriting rules of the insurer, and subject to any required underwriting for employees, including dependents under individual applications for insurance or service which may be submitted by or on behalf of the applicant, its owners, officers and employees, including their dependents.

Applicant hereby represents, covenants, warrants, and agrees as follows:

1) Applicant is a member in good standing of the Washington Fire Commissioners Association. Applicant agrees that at such a time as the preceding statement is no longer true, participation in the program shall automatically terminate without notice, as shall all insurance or other coverage provided through the plans of the Program for the Applicant, its employees and its employees' dependents.

2) Any rights of the Applicant, its employees, or employee's dependents, and the beneficiaries of any of them or any person claiming by or through such person to any insurance, self-funded benefits, or service benefits shall be subject to the terms and conditions, including any future modification thereof, of the standard operating procedures of the Administrator, the self-funded plan document, and of any insurance policy or service contract issued by an insurer or service provider.

3) Any organization enrolling in the Washington Fire Commissioners Association self-funded medical plan accepts that the program is subject to audit by the Office of the State Auditor and review by the Department of Enterprise Services Risk Management Division.

4) Applicant adopts the Washington Fire Commissioners Association Program and appoints Trusteed Plans Service Corporation of Tacoma, WA as Administrator. The Administrator shall have total and exclusive administrative control over the Program. The Administrator may directly bill and collect premiums, self-funded plan rates, contributions, and fees from members. The Administrator shall provide administrative, accounting, and other services as required for the Program. The Administrator is appointed the agent of the Washington Fire Commissioners Association and shall be held harmless by it for any Liability arising out of the performance of its duties, except liability arising out of its own negligence or willful misconduct. It is understood that all computer hardware and software, programs, are the exclusive property of Trusteed Plans. The data and other records are the sole and exclusive property of The Washington Fire Commissioners Association.

5) No coverage shall be in force until the inter-local agreement, this membership application and the individual applications for coverage have been approved, notice of the effective date of each individual's coverage has been furnished to them by the Administrator in writing, and the full premium, self-funded plan rates, and administrative fees has been received by the Administrator or Insurer.

6) Washington Fire Commissioners Association, in its sole discretion, for what it deems the overall benefit of the Program and a majority of the participating members, may accept, deny, and terminate membership in the Program.

7) Applicant will at its own expense provide any and all information and documentation that may be required for the purposes of providing information to comply with an insurer's underwriting rules or the terms of any contract.

8) Applicant will distribute to eligible individuals and/or participants all applicable plan materials and documents as required by Washington Fire Commissioners Association or the Administrator.

9) If dependent children are covered, they are covered through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan.

10) Applicant agrees that it will submit an individual application for each person as he/she becomes eligible as a member of a covered classification, and the amount of coverage once in force on an insured or covered individual will not change until written application for the change has been made and approved by the insurer or the Administrator and the proper premium has been paid to the Administrator.

Fire Organization: _____

11) To control premium costs to applicant, applicant agrees to immediately submit the appropriate notice to the Administrator as soon as the Applicant is aware that a person is no longer eligible under any of the benefit plans.

12) Applicant shall pay all premiums, self-funded plan rates, contributions, and administrative fees billed to it by the Administrator or its agent on or before the due date. Applicant understands that its failure, or the failure on the part of any member firm, to make proper payments on or before the due date could jeopardize the plan for all covered individuals as there would not be sufficient funds to submit the premium to the insurer. Consequently, Applicant understands that coverage will cease retroactively on the due date for all individuals of the Applicant and their dependents if payment is not in the hands of the Administrator or its representatives **ON OR BEFORE THE TENTH OF THE MONTH IN WHICH IT IS DUE**. In order to eliminate any possibility of lapse of coverage due to inadvertent failure to make timely payment, the Administrator will accept two monthly payments initially and bill one month in advance in the future upon your checking "Yes" below.

    ☐ Yes, we desire to make two monthly payments initially and be billed one month in advance in the future. (If you choose this option, your organization would make a two month initial premium payment. This will ensure that your plan eligibility is always up-to-date and will reduce on-line eligibility delays for your employees, since eligibility is based on payment.)

    ☐ No, we do not desire to make two monthly payments initially.

13) Applicant certifies that it has established policies and procedures to secure protected health information (PHI), in accordance with the HIPAA privacy and security rules, codified at 45 C.R.F. Parts 160- 164 as it pertains to the Washington Fire Commissioners Association plan.

14) Applicant certifies that it has taken affirmative action by resolution or by ordinance of the local board to adopt the required interlocal agreement in accordance with RCW 48.62.031(2) and RCW 39.34.

15) Upon offering a HSA, HRA, FSA or any other method of contribution, Applicant agrees to sign and adhere to the Association's Certificate of Compliance requirements consistent with Internal Revenue Rules and Regulations found in IRS Publication 969 and WFCA Polices.

16) Applicant acknowledges that it is a crime to knowingly provide false, incomplete, or misleading information to the WFCA for the purposes of defrauding the Healthcare Program. Penalties include imprisonment, fines, and denial of employee health and welfare benefits.

17) 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 ON BEHALF OF DISTRICT _____ **DATE** _____

PRINT NAME AND TITLE _____

EMAIL COMPLETED and SIGNED FORM to:
WFCA@trusteedplans.com