EMPLOYER GROUP APPLICATION

(Becomes part of the Group Agreement)

COMPANY NAME	GROUP NUMBER (Office Use)
STREET ADDRESS (No P.O. Boxes)	DIVISION NUMBER (Office Use)
CITY STATE ZIP	REQUESTED EFFECTIVE DATE
BILLING/MAILING ADDRESS	COUNTY / FEDERAL EMPLOYER I.D. NUMBER
CITY STATE ZIP	TYPE OF INDUSTRY
CHIEF EXECUTIVE OFFICER OR PROPRIETOR	PHONE NUMBER EXT. / FAX NUMBER
BENEFITS ADMINISTRATOR/CONTACT PERSON	TITLE PHONE EXT.
DOES THE APPLICANT OFFER OTHER COVERAGE: ☐ YES ☐ NO	IF YES, PLEASE LIST THE CARRIERS AND TYPE OF COVERAGE OFFERED AND PREMIUM FOR EACH OPTION
1.	3.
2.	4.
PREVIOUS CARRIER(S) 1.	FOR HOW LONG: _____ YEARS 2.

Are all employees eligible for this plan covered by Worker's Compensation? ☐ YES ☐ NO Years in business: _____

If NO, please explain: _____

Company governed by ERISA? ☐ Yes ☐ No

TYPE OF ORGANIZATION: (CHECK ALL APPLICABLE)

☐ Non-Profit ☐ Sole Proprietorship ☐ Union ☐ Partnership ☐ Municipality
☐ Corporation ☐ Political Subdivision ☐ Trust Fund ☐ Association ☐ Other _____

Eligible employees shall be active, full-time employees who work at least _____ hours per week.

Are all eligible employees subject to withholding as appears on a W-2 form? ☐ YES ☐ NO. If NO, please explain: _____

Are retired beneficiaries included? ☐ YES ☐ NO

1. Total number of employees. _____
2. Number of part-time, seasonal and temporary employees. _____
3. Number of eligible employees (subtract line 2 from line 1) _____
4. Number of employees declining (complete waiver) or covered elsewhere _____
5. Total employees enrolling in WHA (subtract line 4 from line 3) _____

CAL-COBRA

Note: To be completed by employers with 2 or more employees.

Are you subject to the CAL-COBRA Act? ☐ YES ☐ NO

Number of employees enrolled on COBRA _____ (Attach listing)

BENEFITS

Type of Plan

☐ 111 ☐ 411
☐ 211 ☐ 420
☐ 311 ☐ 520
☐ Medicare Supplement
☐ Custom (Attach Benefit Description) _____
☐ OTHER _____
☐ OTHER _____

Prescription Rider

☐ R ☐ O ☐ P ☐ N Copay_____

Vision Rider

☐ Eyewear _____ ☐ Full-Service _____
☐ OTHER _____

Eligible Employees

☐ 1 – 2
☐ 2 – 50 (AB1672)
☐ 51 – 99
☐ 100 – 199
☐ 200 – 499
☐ 500+
☐ Association
☐ Sponsor

(Office Use) **RATES**	**MEDICAL**	**EMPLOYEE**	**EE + SP/1**	**EE + CH(REN)**	**EE + SP + CH(REN)**
TIERS					
☐ 2	_____	_____	_____	_____	_____
☐ 3					
☐ 4	_____	_____	_____	_____	_____
☐ COMP					
☐ Age-Rated (attach list)	_____	_____	_____	_____	_____
MEDICARE_____					

EFFECTIVE DATE _____ RENEWAL DATE: _____ OPEN ENROLLMENT: _____ TO: _____

RAF: PMPM Target: PMPM Actual:

Enrollment / Payment Provisions

GROUP NAME	GROUP NUMBER (Office Use)
DIVISION	DIVISION NUMBER (Office Use)

SELECTED ELIGIBILITY REQUIREMENTS: A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship. Any other eligibility arrangements require prior authorization.

CATEGORIES OF ELIGIBILITY

☐ **Actively-at-work Employees** scheduled to work at least _____ hours per week.

- Employees are eligible to continue group coverage for _____ month(s) while on an Employer-**approved temporary personal leave of absence** (maximum is 6 months - please submit copy of written policy)

- Employees are eligible to continue group coverage for _____ month(s) while on an Employer-**approved temporary medical leave of absence** (maximum is 6 months - please submit copy of written policy)

☐ **COBRA Beneficiaries.**

☐ **Retired Beneficiaries.**

☐ **Other Types of Subscribers** (subject to approval by WHA): attached description.

☐ **Domestic Partners** (subject to approval by WHA): attach Declaration of Domestic Partner Form.

☐ **Dependents** (spouse, children under 19 or up to age 24 if full-time students or IRS dependent).

☐ **Other types of Dependents** (subject to approval): attach a description of any unique Employer dependent prerequisites which differ from standard requirements.

COMMENCEMENT OF COVERAGE

☐ 1st month following Date of Hire.

☐ 1st month following _____ days from Date of Hire.

☐ Other (attach description).

TERMINATION OF ELIGIBILITY PROVISION:

☐ Last day of the month in which Employee ceases to be eligible under group eligibility provisions.

☐ Other (attach description).

EMPLOYER CONTRIBUTION & PARTICIPATION REQUIREMENTS

☐ **Employee Only $ _____ or _____ % of Rate.**

☐ **Dependents $ _____ or _____ % of Rate.**

Minimum Participation Requirements: _____ employees must enroll during initial enrollment period and must be maintained thereafter by the group.

BROKER INFORMATION

☐ New Broker

☐ Existing Broker

Agent: _____ Phone: _____

Company Name: _____ Fax: _____

Address (City, State, Zip) _____ IRS Number _____

Commission: ☐ Standard ☐ Split ☐ Other: _____ License Number: _____

Approval: _____

COMMENTS:

Employer Statement and Group Underwriting Statement

GROUP NAME	GROUP NUMBER (Office Use)

TO BE ANSWERED BY EMPLOYERS WITH 15 OR MORE EMPLOYEES (without prior group coverage)

Include information about all eligible employees, dependents, COBRA participants, and retirees:

1. Has the company ever been canceled or denied group health coverage? ☐ YES ☐ NO If yes, please explain: _____

2. During the past 12 months, has any employee or dependent incurred medical expenses in excess of $10,000? ☐ YES ☐ NO
   (If yes, include written details and current health status) If yes, how many _____. If yes, are any multiple births expected? _____

3. Are there any chronic conditions (diabetes, cancer, heart, kidney problems, etc.) affecting any eligible employee or dependent? ☐ YES ☐ NO If yes, give details:

4. Are there any medical conditions that may result in a claim over $10,000 or hospitalization in the next year? ☐ YES ☐ NO If yes, give details: _____

5. Has an employee or dependent been declined for group life or medical insurance under your present or prior plan? ☐ YES ☐ NO

6. Is any person currently receiving continuation of benefits pursuant to the COBRA Act of 1985 ☐ YES ☐ NO (if yes, list names and effective dates).

We wish to enroll our organization as an employer account with Western Health Advantage.
We understand the eligibility rules applicable to enrollment and understand prepayment fee requirements.
Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

PREPAYMENT REQUIREMENTS: Monthly prepayment fees are due and payable in full on the first day of each calendar month for which services are provided. Delinquent prepayment fees shall be subject to late charges. If payment is not received from the employer, coverage for enrollees will be terminated on the last day of the month for which prepayment fees were received. Any other payment arrangements require prior approval.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the group agreement and shall become a part thereof. WHA reserves the right to terminate group coverage or the coverage for any individual member of the contract holder or individual member has made any material misrepresentation.

EMPLOYER STATEMENT

I certify that all the information contained in this application is correct to the best of my knowledge and all participation requirements have been met.

I certify that all the coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been explained and understood.

Dated at _____ this _____ day of _____ , _____

_____ _____
Print Name and Title Authorized Employer Signature

AGENT STATEMENT

I certify that all the information contained in this application is correct to the best of my knowledge.

I certify that the applicant is a bona-fide business establishment.

I certify all participation requirements have been met.

I certify that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer.

I recommend that such coverage be offered and know of no reason why coverage should be declined.

Dated at _____ this _____ day of _____ , _____

_____ _____
Print Name and Title Authorized Agent Signature

WHA APPROVAL

_____ _____
Sales Coordinator Date Account Executive Date

_____ _____
Chief Sales & Marketing Officer Date Finance Department Date

NEW BUSINESS CHECKLIST
GROUP PLANS

Completed and signed material should be submitted as follows:

- ☐ Employer Group Application (to be completed by Employer)
- ☐ Enrollment forms _____ # of forms.
- ☐ Copy of Rate Quote.
- ☐ If no prior health coverage exists, then health statements are required for groups with 1 to 14 employees. For groups of **15 or more** employees, the Group Underwriting Statement must be included. (Valid for 45 days from date of approval.)
- ☐ Waiver forms must be completed for eligible employees who refuse coverage for themselves OR their dependents.
- ☐ Medicare-eligible employees: Employers who are subject to the Federal Medicare Secondary Payer laws (generally groups of **20 or more** employees on payroll), the selected WHA plan is primary to Medicare for ACTIVE employees age 65 or older (and spouses age 65 or older of active employees). Please note: Groups with **fewer then 20** employees, may have an employee who requests that Medicare be primary. He/she must submit a copy of their Medicare card and a letter requesting that Medicare be primary. To be eligible they must be enrolled in both Parts A & B. Medicare Supplement or a Medicare Choice Plan are available from WHA.
- ☐ Self-employed; must be a fulltime business engaged in producing adequate income. A copy of two current consecutive quarterly tax filings showing a minimum of $12,500 of gross earned income, or a Schedule C showing annual earned income of $25,000 must be submitted. Sole Proprietor and Partnership Statement must also be submitted.
- ☐ Groups of 2 or more: a copy of prior carrier's list billing.
- ☐ DE6 required for groups of **2 or more** enrolling and **all carve out** groups.
- ☐ A deposit in the amount of one month's premium.

Return Materials to: Western Health Advantage
Sales Department
1331 Garden Highway, Suite 100
Sacramento, CA 95833
(916) 563-3198 Phone
(916) 568-1338 Fax
www.westernhealth.com