USHL
US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

Employer Group Application

Small Employer Group - Insured (MI)

Employer Information

Legal Name of Employer____

Legal Status: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Other____________________

Other Names of Group Policyholder____

Principal Address____

City__________________________ State________ County __________________________ Zip______________

Billing Address (if different from above)____

City__________________________ State________ County __________________________ Zip______________

Telephone Number________________ Fax Number____________________ Tax ID Number____________________

Nature of Business__________________________ Years in Business____________________ SIC Code__________

Chief Executive__________________ Insurance Contact Person___________ E-mail Address____________________

Are you including affiliates or subsidiaries? ☐ Yes ☐ No If yes, please give names and addresses below.

____

Effective Date

Requested effective date____

Workers' Compensation Information

Name of Workers' Compensation Carrier______________________________ Policy Number____________________

Do you request on the job health coverage for employees not eligible for and not covered by Workers' Compensation? ☐ Yes ☐ No

If yes, please complete Workers' Compensation Rider application. (Subject to Underwriter approval – additional premium may be required)

COBRA Information

Is the Employer legally required to provide COBRA Continuation Coverage? ☐ Yes ☐ No

If yes, please give names of persons currently on COBRA or within COBRA election period (attach supplemental list if necessary, initialed by signatory).

Name	Social Security Number	Qualifying Event-Describe	Effective Date of Coverage
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Employer Data

Employer Minimum Participation and Contribution Requirements:

US Health and Life (USHL) requires the following:

- an employer with 2-5 eligible employees to enroll 100% of all eligible employees
- an employer with 6 or more eligible employees to enroll:
  - 100% of all eligible employees if employer pays 100% of the premiums; or
  - 75% of all eligible employees if the employer does not pay 100% of the premiums.

Regardless of the number of employees, if Life/AD&D coverage is elected, USHL requires 100% of the eligible employees (including eligible population waiving health coverage) to enroll for life insurance. The Employer shall furnish to USHL any information required for USHL to administer the Policy. The Employer shall have records available for USHL to inspect at any time while insurance is in force, and for up to the earlier of the three years after termination date or when final adjustment and settlement of claims is made. Retirees are subject to Retiree Class Rules. A copy of your current quarterly wage detail report is required. USHL reserves the right to waive or change any of the above requirements at any time.

USHL New Business Requirements: Each eligible employee whether enrolling or waiving MUST COMPLETE the Employee Enrollment Form. This requirement applies to all enrollees or waivers at initial enrollment and for all subsequent new hires and late entrants. Insurance for any person who submits an Employee Enrollment Form is not effective until date specified by USHL. USHL reserves the right to waive or change premium amounts. The Employer is deemed to act as agent for the employee with respect to certifying the employee eligibility in an approved class of employees, and with respect to paying to USHL any contributions the employee makes for premium payment.

What percentage or dollar amount of your employee's insurance premium do you intend to pay? (Required)
Employer must contribute no less than 50% of the total cost of insurance for the employee and dependents, and no less than 75% of the total cost of insurance for the employee only.

Employee_______% or $ Employee and Spouse_______% or $ Employee and Child________% or $ Family________% or $

I have read and understand the above requirements. Employer Initials _______________ (Required)

Employer Worksheet

A. Total number of employees	_______________	(Total A)
B. Employees on payroll roster (as submitted with this application)	_______________	(Total B)
C. Individuals NOT eligible for coverage, but listed on Wage and Detail Report.	_______________	(Total C)
1. Terminated	_______________	
2. In waiting period	_______________	
3. Part-time	_______________	
4. Other non-covered class(es)	_______________	
5. Other (describe):____	_______________	
D. Individuals eligible for coverage, but NOT listed on Wage and Detail Report.	_______________	(Total D)
1. Owners and Officers	_______________	
2. On disability or leave	_______________	
3. Retiree(s)	_______________	
4. COBRA(s)	_______________	
5. Other (describe):____	_______________	
E. Eligible employee population = (B) – (C) + (D)	_______________	(Total E)
F. Eligible employee population who are waiving coverage (signed waivers are required for each)	_______________	(Total F)
Due to:	_______________	
1. Spousal coverage	_______________	
2. Medicare eligible	_______________	
3. Canadian Provincial Health Care	_______________	
G. Eligible employee population who are waiving coverage (signed waivers are required for each)	_______________	(Total G)
Due to:	_______________	
1. Other employer provided coverage (NON HMO)	_______________	
2. Employer provided HMO coverage	_______________	
3. Unwilling to make employee contribution to premium	_______________	
4. Other (describe):____	_______________	
H. Total enrollment by eligible employees = (E) – [(F) + (G)]	_______________	(Total H)
I. Applications submitted (including waivers): MUST equal (E)	_______________	(Total I)
J. Participation percentage = (H) divided by [(I) – (F)] *See rules above.*	_______________	% (Percentage)

Other Important Employee Information

Are retirees covered for medical? ☐ Yes ☐ No Number of retirees to be covered:________________________________

(Must have a minimum of 20 covered lives under medical in order to qualify for retiree coverage)

Employee waiting period: ☐None ☐30 Days ☐60 Days ☐Other (0-60)____

Number of employees applying for coverage who live outside the primary network service area:________________________________

Coverage will be effective on the first day of the month following completion of the waiting period designated above. For late enrollees, coverage will be effective on the first day of the month after approval by USHL. Retirees are subject to Retiree Class Rules.

Coverage Requests

1. Employee Life and Accidental Death and Dismemberment (If Life/AD&D coverage is elected, USHL requires 100% participation including waivers)

Step One: Choose method of life insurance amount determination between A. Salary Multiple OR B. Flat Dollar Amount

A. Salary Multiple ☐ Yes ☐ No (Check "Yes" if you would like Life Insurance to be determined by a multiple of salary)

Multiplier_____________________

B. Flat Dollar Amount ☐ Yes ☐No (Check "Yes" if you would like Life Insurance to be determined by a flat dollar amount)

Dollar Amount_________________

Step Two: Choose Dependent Life Amounts if electing to offer dependent life coverage

C. Dependent Life ☐ Yes ☐ No (Check "Yes: if you choose to offer dependent life coverage)

☐ $5,000 Spouse, $2,500 Child ☐ $10,000 Spouse, $5,000 Child

Guaranteed Issue Amounts: Amounts in excess of the guaranteed issue are subject to evidence of insurability. Guaranteed issue amount varies based on group size.

Less Than 10 lives:	$50,000 per person
11 to 25 lives:	$100,000 per person
26 to 100 lives:	$150,000 per person
101 or more lives:	$200,000 per person

Note: Amounts of group life insurance must be a uniform percentage of salary or a flat amount for each employee.

All Groups: The amount of life insurance for each employee who is 65 years of age or older, but less than age 70 will be 65% of the amount for employees under age 65. At age 70, the amount of life insurance will be 65% of the amount at age 65. At 75, the amount of life insurance will be 65% of the amount at age 70.

2. Medical Plans ☐Yes ☐ No

Please check the plans desired.

A. Metal Plans

☐ USHL Platinum Deductible and Coinsurance	☐ USHL Silver Deductible and Coinsurance
☐ USHL Platinum Copay	☐ USHL Silver Copay
☐ USHL Gold Deductible and Coinsurance	☐ USHL Silver HDHP
☐ USHL Gold Copay	☐ USHL Bronze Deductible and Coinsurance
☐ USHL Gold HDHP	☐ USHL Bronze HDHP

B. Optional Riders (check if requested – subject to Underwriter approval – additional premium and application may be required)

☐ Motor Vehicle Accident Rider ☐Workers' Compensation Rider ☐Other Rider__________________________________

C. Network Options (check if requested – subject to Underwriter approval)

Primary Network: ☐ Cofinity ☐HAP ☐Central Care ☐Other____

Secondary Network (describe):____

Questionnaire for High Deductible Health Plans (HDHP Plans)

Question	Response
Would you like USHL to offer your employees an HSA (Health Savings Account) with their plan?	☐ Yes ☐ No
We already have an HSA plan in place that we will use with our HDHP.	☐ Yes ☐ No
We plan to offer an HRA (Health Reimbursement Arrangement) to our employees with our HDHP.	☐ Yes ☐ No
Who will be your HRA plan administrator?	☐ ABS ☐ Other
If other, name of administrator_____________________________	
We plan to offer the HDHP as a stand alone without an HSA or HRA.	☐ Yes ☐ No

4. Dental Coverage ☐ Yes ☐ No

A. Coinsurance Percentages by Service

Plan	*I. Preventive*	*II. Basic*	*III. Major*	*IV. Endo/Perio*
☐ One	100%	80%	80%	50%
☐ Two	100%	80%	60%	50%
☐ Three	80%	50%	50%	50%
☐ Four	50%	50%	50%	50%

B. Deductible* / **C. Annual Maximum Benefit**

Individual $	*Family $*	*Annual Maximum Benefit*
☐ $0	☐ $0	☐ $750
☐ $50	☐ $100	☐ $1000
☐ $100	☐ $200	☐ $1500

**Waived for Preventive*

D. Orthodontic Coverage (Only covers children under 19. Requires Dental Coverage) ☐ Yes ☐ No

E. Orthodontic Lifetime Maximum Benefit (Only covers children under 19. Requires Orthodontic Coverage)(V)

☐ $1000

☐ $1250

☐ $1500

(V) *May also be referred to as Class V of dental services*

Employer Special Requests

Special requests are subject to written approval from USHL.____

____

____

Premium Deposit

Premium Deposit:____

Termination of Insurance

Employer may cancel all insurance by written notice received at least 31 days before the requested cancellation date.

USHL may cancel insurance for any of the following reasons, including but not limited to:

- Nonpayment of premium
- Fraud or intentional misrepresentation of a material fact
- Violation of certain mandatory employee contribution or participation requirements (see page 2 for more details)
- Termination of all coverage
- Movement outside of a network service area by all enrollees
- Cessation of a membership in an association
- Any other reason as stated in policy of insurance

USHL will give employer a minimum of 31 days advance written notice prior to termination date. Cancellation does not prejudice a valid claim existing on termination date. Employer is solely responsible to notify insured persons of termination, and to return to employees their portion of any contribution toward premium made for a period after their termination date.

Employer Agreement

The undersigned Employer acknowledges reading the entire completed application and that the insurance agent has explained the coverages, limitations and exclusions, other details of coverage of the insurance applied for, and the underwriting rules and regulations of USHL.

The undersigned Employer understands and agrees:

1. To be bound by all terms, provisions, conditions and limitations of the Policy(ies) as they may be amended;
2. To make required monthly payments in advance to cover the cost of the insurance. If the premiums are not paid by the Employer within 31 days of the date due, Employer will have ended the insurance coverage;
3. That this fully completed and signed Employer Group Application, as well as any supplements attached to it, will be attached to and made a part of the policy(ies);
4. That the Employer's insurance agent has a separate compensation agreement with USHL that may include bonus and incentive payments.
5. That insurance is not in effect until the Employer receives written approval from the administrator or from USHL.
6. That no action is taken on the Employer Group Insurance Application until after all required information in the application, and required information for enrolling employees and their dependents, is submitted.
7. That no person other than an officer of USHL has authority to bind or alter coverage, and that any such attempt by the agent is void and is not effective.
8. For Life and Dental Only: To the Trustees of the Select Health Plans Group Insurance Trust: the Employer, whose representative has signed below, requests to participate in the Select Health Plans Group Insurance Trust and Group Insurance Policy(ies) which is (are) issued to the Trust by USHL and agrees to assume all obligations of a Participating Employer.

Legal Business Name:____

Signature:____

(Authorized representative able to legally bind the Employer)

Typed/Printed Signature:____

Title:____

Dated on (Month/Day/Year):______________________ Dated at (City/State):______________________

Agent:______________________________________ Date:______________________

Typed/Printed Signature:____