

# Employer Group Application

## Large Employer Group - Insured (MI)

<b>Employer Information</b>			
Legal Name of Employer _____			
Legal Status: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please give names and addresses below.			
<b>Effective Date</b>			
Requested effective date _____			
<b>Workers' Compensation Information</b>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete Workers' Compensation Rider application. (Subject to Underwriter approval – additional premium may be required)			
<b>COBRA Information</b>			
Is the Employer legally required to provide COBRA Continuation Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
<b>Current Insurance Information</b>			
Do you currently provide health insurance coverage for your employees? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete this section.			
Carrier Name	Effective Date	Termination Date	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

**Employer Data**

**Employer Minimum Participation and Contribution Requirements:**

US Health and Life (USHL) requires an employer 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.

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 Underwriting 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)] <i>See rules above.</i>	_____	% (Percentage)

Other Important Employee Information	
Are retirees covered for medical? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 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	
<b>1. Employee Life and Accidental Death and Dismemberment</b> (If Life/AD&D coverage is elected, requires 100% participation including waivers.) <i>Minimum of \$15,000 per employee is required.</i>	
<b>Step One:</b> Choose method of life insurance amount determination between A. Salary Multiple OR B. Flat Dollar Amount	
A. Salary Multiple <input type="checkbox"/> Yes <input type="checkbox"/> No	(Check "Yes" if you would like Life Insurance to be determined by a multiple of salary)
Multiplier _____	
B. Flat Dollar Amount <input type="checkbox"/> Yes <input type="checkbox"/> No	(Check "Yes" if you would like Life Insurance to be determined by a flat dollar amount)
Dollar Amount _____	
<b>Step Two:</b> Choose Dependent Life Amounts if electing to offer dependent life coverage	
C. Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No	(Check "Yes: if you choose to offer dependent life coverage)
<input type="checkbox"/> \$5,000 Spouse, \$2,500 Child <input type="checkbox"/> \$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 plan(s) desired.

(\*Caution: If you do not provide Prescription Drug coverage with these Medical Plans, your Medical Plan will not meet Minimum Value requirements as defined in the Affordable Care Act.)

A. Traditional Plans	HDHP Plans
<input type="checkbox"/> Pinnacle 500	<input type="checkbox"/> Pinnacle HDHP 1500
<input type="checkbox"/> Pinnacle 1000	<input type="checkbox"/> Pinnacle HDHP 2500
<input type="checkbox"/> Pinnacle 2000*	<input type="checkbox"/> Peak HDHP 1500
<input type="checkbox"/> Pinnacle 3500*	<input type="checkbox"/> Peak HDHP 2500
<input type="checkbox"/> Summit 500	<input type="checkbox"/> Peak HDHP 4000
<input type="checkbox"/> Summit 1000	<input type="checkbox"/> Peak HDHP 5000
<input type="checkbox"/> Summit 2000*	
<input type="checkbox"/> Summit 3500*	
<input type="checkbox"/> Peak 500	
<input type="checkbox"/> Peak 1000	
<input type="checkbox"/> Peak 2000*	
<input type="checkbox"/> Peak 3500*	

**Questionnaire for  
High Deductible Health Plans (HDHP Plans)**

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

**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): \_\_\_\_\_

**3. Prescription Drug Coverage**  Yes  No Skip this section if you chose a High Deductible Health Plan.

(Please see Caution under 2. Medical Plans.)

Prescription Plans

Plan	Pharmacy	Home Delivery
<input type="checkbox"/> One	\$10/\$20/\$40/20%	\$20/\$40/\$80/20%
<input type="checkbox"/> Two	\$10/\$25/\$50/20%	\$20/\$50/\$100/20%
<input type="checkbox"/> Three	\$10/\$40/\$70/20%	\$20/\$80/\$140/20%
<input type="checkbox"/> Four	\$15/\$30/\$50/20%	\$30/\$60/\$100/20%
<input type="checkbox"/> Five	\$20/\$40/\$60/20%	\$40/\$80/\$120/20%
<input type="checkbox"/> Six	\$25/\$50/\$75/30%	\$50/\$100/\$150/30%

**4. Dental Coverage**  Yes  No

**A. Coinsurance Percentages by Service**

<i>Plan</i>	<i>I. Preventive</i>	<i>II. Basic</i>	<i>III. Major</i>	<i>IV. Endo/Perio</i>
<input type="checkbox"/> One	100%	80%	80%	50%
<input type="checkbox"/> Two	100%	80%	60%	50%
<input type="checkbox"/> Three	80%	50%	50%	50%
<input type="checkbox"/> Four	50%	50%	50%	50%

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

<i>Individual \$</i>	<i>Family \$</i>	<i>Annual Maximum Benefit</i>
<input type="checkbox"/> \$0	<input type="checkbox"/> \$0	<input type="checkbox"/> \$750
<input type="checkbox"/> \$50	<input type="checkbox"/> \$100	<input type="checkbox"/> \$1000
<input type="checkbox"/> \$100	<input type="checkbox"/> \$200	<input type="checkbox"/> \$1500

*\*Waived for Preventive*

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

**E. Orthodontic Lifetime Maximum Benefit** (Only covers children under age 19. Requires Dental 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
- Reduction in workforce of more than 20% of covered employees
- Bankruptcy of employer
- 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: \_\_\_\_\_