USHL
US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

Employer Group Application

Small Employer Group - Insured (OH)

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_____

NOTICE: The policy is <u>not</u> Workers' Compensation insurance. The employer does not become a subscriber to the Workers' Compensation system by purchasing the policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the Workers' Compensation laws. The employer must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

The policy does <u>not</u> cover any injury or sickness which arises out of or in the course of employment or activities for wages or profit whether such employment or activity is with the policyholder or another entity.

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 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)

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

Primary Network: ☐Emerald ☐Cigna ☐MMO ☐Other_____

Secondary Network (describe):_____

Questionnaire for High Deductible Health Plans (HDHP Plans)

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

3. 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 age 19. Requires Dental Coverage) ☐Yes ☐No

E. Orthodontic Lifetime Maximum Benefit (Only covers children under age 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 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 employer-sponsored 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.

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:_____

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.