USHL SafeGuard
US Health and Life

Group Setup Form

Employer Information

Legal Name of Employer_____

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

Other Name(s) of Employer_____

Principal Address_____

City_____ State_____ County _____ Zip_____

Billing Address (if different from above)_____

City_____ State_____ County _____ Zip_____

Telephone Number_____ Fax Number_____ Years in Business_____

Tax ID Number_____ Nature of Business_____ SIC Code_____

Chief Executive_____

Insurance Contact Person_____ E-mail Address_____

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

_____

Are you an Applicable Large Employer (ALE)? ☐ Yes ☐ No

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

Other Important Employee Information

Employee waiting period: ☐ None ☐ 30 Days ☐ 60 Days

Number of employees applying for coverage who live outside the state in which company is located:_____

Coverage will be effective on the first day of the month following completion of the waiting period designated above.

Workers Compensation

Would you like the 24-Hour Work-Related Coverage Option? ☐ Yes ☐ No (On-the-job health coverage is only available for employees not eligible for or not covered by Workers' Compensation.)

Name of current Workers' Compensation Carrier_____

Policy Number_____

USHL SafeGuard
US Health and Life

Appointment of Authorized Representative

The following named individual(s) is/are authorized to act on behalf of the Plan Sponsor:

Primary Name (Please Print)_____

Position/Title_____

Signature_____

Secondary Name_____

Position/Title_____

Signature_____

Privacy Officer(s) Assignment

Authorized Privacy Officer(s)

Name (Please Print)_____

Name (Please Print)_____

Name (Please Print)_____

Name (Please Print)_____

USHL shall be entitled to rely on the above-named individual(s) for instructions.

Employer Name_____

Plan Sponsor (or authorized representative)_____

Date_____