USHL
US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

Employer Group Application

Small Employer Group - Insured (WI)

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_____

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:

Eligible Employees (All Locations)	Participation Requirements (Less Waivers for Creditable Coverage)
Up to 4	2
5 or 6	3
7	4
8 or 9	5
10	6
11 to 50	70%

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. No dependent contribution is 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.	
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)	
☐ Other Rider_____	
C. Network Options (check if requested – subject to Underwriter approval)	
Primary Network: ☐ Trilogy ☐ 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

Employer Special Requests

Special requests are subject to written approval from USHL._____

_____

_____

Premium Deposit

Premium Deposit:_____

Termination of Insurance

The employer may terminate insurance on the first day of any month during the contract period by giving written notice by the 10th day of the requested termination month. The employer may also non-renew insurance by giving written notice at least 31 days before the current renewing contract period or by the 10th day of the renewing month.

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 25% 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.

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:_____