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

Are retirees covered for medical? (Must have a min. of 20 covered lives) ☐ Yes ☐ No Number of retirees to be covered:_____

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. Retirees are subject to Retiree Class Rules.

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_____

Excess loss insurance policies and EPO/PPO insurance plans underwritten by US Health and Life Insurance Company.
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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_____

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