



APPLICATION FOR GROUP POLICY (Please check one):

HMO PLAN

POINT OF SERVICE PLAN

ADVANTAGE CHOICE PLAN

EMPLOYER DATA

Full Legal Business Name\*: \_\_\_\_\_ Employer Tax I.D. #: \_\_\_\_\_
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
Mailing Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
Phone #: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_
Nature of Business: \_\_\_\_\_ SIC Code: \_\_\_\_\_
Administrative Contact Person: \_\_\_\_\_ Executive Contact Person: \_\_\_\_\_
\* Employer name to be printed on ID cards, if different from Full Legal Business Name: \_\_\_\_\_

Is the Plan subject to collective bargaining?  Yes  No

Classes of employees to be covered: (i.e. Hourly, Salary, Bargaining, Non-Bargaining, Management, Non-Management, etc.) If all classes of employees are to be rated together, all classes of employees are offered the same benefit packages, and no special reporting by class is required, please note by placing "ALL" in Class 1.

Class 1 \_\_\_\_\_ Union (If Applicable) \_\_\_\_\_
Class 2 \_\_\_\_\_ Union (If Applicable) \_\_\_\_\_

List prior insurance carriers or Third Party Administrators (TPAs) during previous three years:

Current Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_
Prior Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_
Prior Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_

SMALL EMPLOYERS

Certain state and federal laws may apply if you are an employer which has had an average of 50 or fewer employees over the past year ("Small Employer"). Companies that are affiliated or that are eligible to file a combined tax return are considered one employer for purpose of answering the following question.

Did your organization average between 2 and 50 employees for the previous year?  Yes  No

EMPLOYEE DATA

MINIMUM PARTICIPATION REQUIREMENTS:

ADVANTAGE requires at least 75% of all eligible employees to participate in an Employer sponsored healthcare program. Employees working a minimum of 30 hours per week are eligible for coverage. Temporary, substitute, or seasonal employees are not eligible for coverage.

Number of full-time (30 or more hours per week) active employees \_\_\_\_\_
Number of part-time employees \_\_\_\_\_
Total number of employees \_\_\_\_\_
Are any past employees or their eligible dependents currently participating under COBRA continuation?  Yes  No

COBRA Administrator \_\_\_\_\_

Table with 3 columns: Employee / Dependent Name, Date of Qualifying Event, End Date of COBRA Eligibility

Are any employees currently on workers compensation or other disability program?  Yes  No
Employee Name \_\_\_\_\_ Date of Disability \_\_\_\_\_ Date Due Back To Work \_\_\_\_\_

WAITING PERIOD FOR NEW HIRES: (Coverage will not be effective until the first day of the month following the waiting period, unless noted otherwise.)

0 Days  30 Days  60 Days  Other \_\_\_\_\_

DEPENDENT/STUDENT STATUS:  End of calendar month in which he/she turns 19 or if a full-time student, end of calendar month in which he/she turns 25; end of calendar month in which he/she marries.  Other: specify \_\_\_\_\_

RESPONSIBLE PARTY FOR OBTAINING STUDENT STATUS DOCUMENTATION: :  ADVANTAGE  The Group

HIPAA CERTIFICATES OF CREDITABLE COVERAGE TO BE SENT BY:  ADVANTAGE  The Group

TERMINATION POLICY:  Coverage terms as of the date of the termination  Coverage terms as of the last day of the month following the termination

TO BE COMPLETED BY EMPLOYERS WITH 25 OR MORE ELIGIBLE EMPLOYEES NOT SUBMITTING INDIVIDUAL HEALTH STATEMENTS:

To the best of your knowledge and belief, has any eligible employee or his or her eligible dependents incurred a claim in excess of \$5,000 in the last 36 months?  Yes  No If yes, provide details (Diagnosis, Prognosis, and Incurred Dollars):

Details: \_\_\_\_\_

To the best of your knowledge and belief, has any eligible employee or his or her eligible dependents been treated by a physician for:

High Blood Pressure, Stroke, or Heart Disease  Diabetes  AIDS / ARC or Human Immunodeficiency Virus
 Cancer, Leukemia, Melanoma, or Tumor  Congenital Disease / Defect  Emphysema, Chronic Asthma

Details: \_\_\_\_\_

**EMPLOYER CONTRIBUTION REQUIREMENTS:**

ADVANTAGE requires Employers to contribute to the Enrollment Fees at a minimum an amount equal to of 50% of the Subscriber (Employee) Enrollment Fee for each category of enrollment (i.e., Single Subscriber, Subscriber & Spouse, Subscriber & Children, or Subscriber, Spouse & Child(ren)).

Proposed Employer contributions to Enrollment Fees:

Single Subscriber \_\_\_\_\_ %      Subscriber & Spouse \_\_\_\_\_ %  
Subscriber & Child(ren) \_\_\_\_\_ %      Subscriber, Spouse, & Child(ren) \_\_\_\_\_ %

**RECORD KEEPING REQUIREMENTS:**

The Employer shall furnish ADVANTAGE any information required for ADVANTAGE to administer the Plan. The Employer shall have records available for ADVANTAGE to inspect at any time while the health benefit plan is in force, and until the earlier of three years after termination date or final adjustment and settlement of claims made.

**EMPLOYER SPECIAL REQUESTS (Special requests are subject to written approval by ADVANTAGE)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EFFECTIVE DATE**

Applications may be submitted with a requested Effective Date and Renewal Date. The Effective Date will be determined by ADVANTAGE's underwriting department. Do not cancel your present coverage. Coverage is not in effect until you receive written confirmation from ADVANTAGE. ADVANTAGE must also agree to the Renewal Date.

Requested Effective Date: \_\_\_\_\_ Requested Renewal Date: \_\_\_\_\_

(ADVANTAGE must agree to the Effective Date and the Renewal Date).

**PAYMENT OF ENROLLMENT FEES: CASH WITH APPLICATION**

The Employer's first month's Enrollment Fees must be submitted with this Application for Group Policy. All Enrollment Fees must be paid with the Employer's business check and will be due on the 1<sup>st</sup> day of the month. \*See attached Summary of Benefits and Rates

\*ADVANTAGE Plan Selected: \_\_\_\_\_ \* Pharmacy Copay \_\_\_\_\_ \* Vision benefits Copay \_\_\_\_\_ \* Dental Plan included? \_\_\_\_\_

\* Family Planning included? \_\_\_\_\_ \* Chiro Copay \_\_\_\_\_ **Total Enrollment Fee Deposit: \$ \_\_\_\_\_**

**EMPLOYER AGREEMENT**

The undersigned acknowledges reading the entire completed Application for Group Policy, and that the broker has explained the coverages, limitations, and exclusions, other details of the coverage applied for, as well as the underwriting rules and regulations of ADVANTAGE. **Coverage is not in effect until the undersigned receives written approval from ADVANTAGE.** Final approval or disapproval is not taken on the Application for Group Policy until after all required information in the application, and required information for enrolling employees and their dependents, is submitted. No one other than ADVANTAGE has the authority to bind or alter coverage, and the undersigned agrees that any such attempt by the agent is void and is not effective. The deposit amount will be returned to the applicant if the application is declined.

Dated At: \_\_\_\_\_  
(City & State)

Dated On: \_\_\_\_\_  
(Month, Day, Year)

Legal Business Name: \_\_\_\_\_

Signatures: **X** \_\_\_\_\_  
(Must be signed by a person authorized to purchase HMO or POS coverage for this firm).

Print Name and Title: \_\_\_\_\_

**BROKER INFORMATION (IF APPLICABLE)**

Broker Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone #: ( ) \_\_\_\_\_ FAX#: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_ License #: \_\_\_\_\_

Comments: \_\_\_\_\_

Commission: \_\_\_\_\_

I hereby certify that all information contained in the application has been explained to the Employer and that the answers are correct to the best of my knowledge. I am not aware of anything unfavorable about the Employer or any person proposed for coverage except as noted herein. I have complied with the underwriting rules and regulations and have explained to the Employer the coverages, limitations, and exclusions and other details of the coverage applied for. I have notified the Employer not to terminate present coverage until notified in writing by ADVANTAGE of acceptance of this application. Any exceptions are detailed herein or on an attached sheet.

Broker's Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_ Broker's Name (Print): \_\_\_\_\_

**CASE SUBMISSION**

Please submit the following forms for consideration of coverage: • Application for Group Policy • First month's Enrollment Fees

• A copy of current benefits • A copy of current billing if replacing coverage • A most recent copy of Wage & Tax Report

• A copy of the quoted rates • Employee Enrollment forms, including Health Statements (If applicable)

**HOME OFFICE USE ONLY**

Group Effective Date: \_\_\_\_\_ Approved By: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_