



# EMPLOYER GROUP APPLICATION

(Becomes part of the Group Agreement)

COMPANY NAME		GROUP NUMBER (Office Use)			
STREET ADDRESS (No P.O. Boxes)		DIVISION NAME AND NUMBER (Office Use)			
CITY	STATE	ZIP	REQUESTED EFFECTIVE DATE		
BILLING/MAILING ADDRESS		COUNTY	FEDERAL EMPLOYER I.D. NUMBER		
CITY	STATE	ZIP	TYPE OF INDUSTRY		
CHIEF EXECUTIVE OFFICER OR PROPRIETOR		PHONE NUMBER	EXT.	FAX NUMBER	
BENEFITS ADMINISTRATOR/CONTACT PERSON		TITLE	PHONE	EXT.	
E-MAIL AND WEBSITE ADDRESS		PRIMARY LANGUAGE SPOKEN			
DOES THE APPLICANT OFFER OTHER COVERAGE: <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE LIST THE CARRIERS AND TYPE OF COVERAGE OFFERED AND PREMIUM FOR EACH OPTION					
1.		3.			
2.		4.			
PREVIOUS CARRIER(S)		FOR HOW LONG: _____ YEARS			
1.		2.			
Are all employees eligible for this plan covered by Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO      Years in business: _____ If NO, please explain: _____					
<b>Is the company governed by ERISA?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>TYPE OF ORGANIZATION:</b> (CHECK ALL APPLICABLE)					
<input type="checkbox"/> Non-Profit		<input type="checkbox"/> Sole Proprietorship		<input type="checkbox"/> Union	
<input type="checkbox"/> Corporation		<input type="checkbox"/> Political Subdivision		<input type="checkbox"/> Partnership	
				<input type="checkbox"/> Municipality	
				<input type="checkbox"/> Trust Fund	
				<input type="checkbox"/> Association	
				<input type="checkbox"/> Other _____	
Eligible employees shall be active, full-time employees who work at least _____ hours per week.					
Are all eligible employees subject to withholding as appears on a W-2 form? <input type="checkbox"/> YES <input type="checkbox"/> NO. If NO, please explain: _____					
Are retired beneficiaries included? <input type="checkbox"/> YES <input type="checkbox"/> NO					
1. Total number of employees.		_____		<u>CAL-COBRA</u>	
2. Number of part-time, seasonal and temporary employees.		_____		Note: To be completed by employers with 2 or more employees.	
3. Number of eligible employees (subtract line 2 from line 1)		_____			
4. Number of employees declining (complete waiver) or covered elsewhere		_____		Are you subject to the CAL-COBRA Act? <input type="checkbox"/> YES <input type="checkbox"/> NO	
5. Total employees enrolling in WHA (subtract line 4 from line 3)		_____		Number of employees enrolled on COBRA _____ (Attach listing)	
<b>BENEFITS</b>					
<b>Type of Plan</b>			<b>Prescription Rider</b>		<b>Eligible Employees</b>
<input type="checkbox"/> 111	<input type="checkbox"/> 411	<input type="checkbox"/> 10-20	<input type="checkbox"/> R	<input type="checkbox"/> O	<input type="checkbox"/> L
<input type="checkbox"/> 211	<input type="checkbox"/> 420	<input type="checkbox"/> 15-30	Copoly _____		
<input type="checkbox"/> 311	<input type="checkbox"/> 520	<input type="checkbox"/> 70			
<input type="checkbox"/> Medicare Supplement			<b>Vision Rider</b>		<input type="checkbox"/> Sole Proprietor
<input type="checkbox"/> Custom (Attach Benefit Description) _____			<input type="checkbox"/> Eyewear _____		<input type="checkbox"/> 2 - 50
<input type="checkbox"/> OTHER _____			<input type="checkbox"/> Full-Service _____		<input type="checkbox"/> 51+
<input type="checkbox"/> OTHER _____			<input type="checkbox"/> OTHER _____		<input type="checkbox"/> Association
					<input type="checkbox"/> Sponsor
<b>(Office Use) RATES</b>					
	<b>MEDICAL</b>	<b>EMPLOYEE</b>	<b>EE + SP/1</b>	<b>EE + CH(REN)</b>	<b>EE + SP + CH(REN)</b>
TIERS	_____	_____	_____	_____	_____
<input type="checkbox"/> 2	_____	_____	_____	_____	_____
<input type="checkbox"/> 3	_____	_____	_____	_____	_____
<input type="checkbox"/> 4	_____	_____	_____	_____	_____
<input type="checkbox"/> COMP	_____	_____	_____	_____	_____
<input type="checkbox"/> Age-Rated (attach list)	_____	_____	_____	_____	_____
	MEDICARE _____	_____	_____	_____	_____
EFFECTIVE DATE _____	RENEWAL DATE: _____	OPEN ENROLLMENT: _____	TO: _____		
RAF: _____	PMPM Target: _____	PMPM Actual: _____			

# Enrollment / Payment Provisions

GROUP NAME	GROUP NUMBER (Office Use)
DIVISION	DIVISION NUMBER (Office Use)
<b>SELECTED ELIGIBILITY REQUIREMENTS:</b> A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship. Any other eligibility arrangements require prior authorization.	
<b>CATEGORIES OF ELIGIBILITY</b> <input type="checkbox"/> <b>Actively-at-work Employees</b> scheduled to work at least _____ hours per week. <ul style="list-style-type: none"> <li>• Employees are eligible to continue group coverage for _____ month(s) while on an Employer-<b>approved temporary personal leave of absence</b> (maximum is 6 months - please submit copy of written policy)</li> <li>• Employees are eligible to continue group coverage for _____ month(s) while on an Employer-<b>approved temporary medical leave of absence</b> (maximum is 6 months - please submit copy of written policy)</li> </ul> <input type="checkbox"/> <b>COBRA Beneficiaries.</b> <input type="checkbox"/> <b>Retired Beneficiaries.</b> <input type="checkbox"/> <b>Other Types of Subscribers</b> (subject to approval by WHA): attached description. <input type="checkbox"/> <b>Domestic Partners</b> (subject to approval by WHA): attach Declaration of Domestic Partner Form. <input type="checkbox"/> <b>Dependents</b> (spouse, children under 19 or up to age 24 if full-time students or IRS dependent). <input type="checkbox"/> <b>Other types of Dependents</b> (subject to approval): attach a description of any unique Employer dependent prerequisites which differ from standard requirements.	
<b>COMMENCEMENT OF COVERAGE</b> <input type="checkbox"/> 1 <sup>st</sup> month following Date of Hire. <input type="checkbox"/> 1 <sup>st</sup> month following _____ days from Date of Hire. <input type="checkbox"/> Other (attach description).	
<b>TERMINATION OF ELIGIBILITY PROVISION:</b> <input type="checkbox"/> All terminations are effective the last day of the month in which Employee ceases to be eligible under group eligibility provisions.	
<b>EMPLOYER CONTRIBUTION &amp; PARTICIPATION REQUIREMENTS</b> <input type="checkbox"/> <b>Employee Only</b> \$ _____ or _____ % of Rate. <input type="checkbox"/> <b>Dependents</b> \$ _____ or _____ % of Rate.  Minimum Participation Requirements: _____ employees must enroll during initial enrollment period and must be maintained thereafter by the group.	
<b>BROKER INFORMATION</b> <input type="checkbox"/> New Broker                      Agent: _____                      Phone: _____ <input type="checkbox"/> Existing Broker                    Company Name: _____                      Agent # (Office Use)                      Fax: _____  Address (City, State, Zip) _____                      E-mail: _____  Commission: <input type="checkbox"/> Standard <input type="checkbox"/> Split <input type="checkbox"/> Other: _____                      IRS Number _____  Approval: _____                      License Number: _____	
<b>COMMENTS:</b>     	

# Employer Statement and Group Underwriting Statement

GROUP NAME	GROUP NUMBER (Office Use)
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**TO BE ANSWERED BY EMPLOYERS WITH 15 TO 50 EMPLOYEES (without prior group coverage). TO BE ANSWERED BY ALL EMPLOYERS WITH 51 OR MORE EMPLOYEES.**

*Include information about all eligible employees, dependents, COBRA participants, and retirees:*

1. Has the company ever been canceled or denied group health coverage?  YES  NO If yes, please explain: \_\_\_\_\_
2. During the past 12 months, has any employee or dependent incurred medical expenses in excess of \$10,000?  YES  NO  
(If yes, include written details and current health status) If yes, how many \_\_\_\_\_. If yes, are any multiple births expected? \_\_\_\_\_
3. Are there any chronic conditions (diabetes, cancer, heart, kidney problems, etc.) affecting any eligible employee or dependent?  YES  NO If yes, give details: \_\_\_\_\_
4. Are there any medical conditions that may result in a claim over \$10,000 or hospitalization in the next year?  YES  NO If yes, give details: \_\_\_\_\_
5. Has an employee or dependent been declined for group life or medical insurance under your present or prior plan?  YES  NO
6. Is any person currently receiving continuation of benefits pursuant to the COBRA Act of 1985  YES  NO (if yes, list names and effective dates).

We wish to enroll our organization as an employer account with Western Health Advantage. We understand the eligibility rules applicable to enrollment and understand prepayment fee requirements. Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

**PREPAYMENT REQUIREMENTS:** Monthly prepayment fees are due and payable in full on the first day of each calendar month for which services are provided. Delinquent prepayment fees shall be subject to late charges. If payment is not received from the employer, coverage for enrollees will be terminated on the last day of the month for which prepayment fees were received. Any other payment arrangements require prior approval.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the group agreement and shall become a part thereof. WHA reserves the right to terminate group coverage or the coverage for any individual member of the contract holder or individual member has made any material misrepresentation.

**EMPLOYER STATEMENT**

I certify that all the information contained in this application is correct to the best of my knowledge and all participation requirements have been met.  
I certify that all the coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been explained and understood.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

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

\_\_\_\_\_  
Authorized Employer Signature

**AGENT STATEMENT**

I certify that all the information contained in this application is correct to the best of my knowledge.  
I certify that the applicant is a bona-fide business establishment.  
I certify all participation requirements have been met.  
I certify that all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer.  
I recommend that such coverage be offered and know of no reason why coverage should be declined.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Print Agent Name

\_\_\_\_\_  
Authorized Agent Signature

**WHA APPROVAL**

\_\_\_\_\_  
Sales Administrator

\_\_\_\_\_  
Date

\_\_\_\_\_  
Account Executive

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chief Administrative Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Finance Department

\_\_\_\_\_  
Date

## NEW BUSINESS CHECKLIST GROUP PLANS

Completed and signed material should be submitted as follows:

- Employer Group Application (to be completed by Employer)
- Enrollment forms \_\_\_\_\_ # of forms.
- Copy of Rate Quote.
- If no prior health coverage exists, then health statements are required for groups with 1 to 14 employees. For groups of **15 or more** employees, the Group Underwriting Statement must be included. (Valid for 45 days from date of approval.)
- Waiver forms must be completed for eligible employees who refuse coverage for themselves OR their dependents.
- Medicare-eligible employees: Employers who are subject to the Federal Medicare Secondary Payer laws (generally groups of **20 or more** employees on payroll), the selected WHA plan is primary to Medicare for ACTIVE employees age 65 or older (and spouses age 65 or older of active employees). Please note: Groups with **fewer than 20** employees, may have an employee who requests that Medicare be primary. He/she must submit a copy of their Medicare card and a letter requesting that Medicare be primary. To be eligible they must be enrolled in both Parts A & B. Medicare Supplement or a Medicare Choice Plan are available from WHA.
- Partnership: Schedule K tax filing for each Partner; If partnership is new and has not yet filed taxes, copy of Partnership Agreement and a Federal Tax ID number form is required.
- Self-employed: must be a fulltime business engaged in producing adequate income. A Schedule C showing annual earned income of \$40,000 must be submitted. Sole Proprietor and Partnership Statement must also be submitted.
- Groups of 2 or more: a copy of prior carrier's list billing.
- DE6 required for groups of **2 or more** enrolling.
- A deposit in the amount of one month's premium.

**Return Materials to: Western Health Advantage  
Sales Department  
1331 Garden Highway, Suite 100  
Sacramento, CA 95833  
(916) 563-3198 Phone  
(916) 568-1338 Fax  
www.westernhealth.com**