



EMPLOYER GROUP APPLICATION

1. Name of Firm _____
Legal Name Phone Number Fax Number
2. Business Address _____
Street City State Zip
3. Billing Address _____
Street City State Zip
4. Contact Name _____
Billing Contact Name E-mail Address Direct Phone Number
5. Type of Organization: Sole proprietorship Partnership Corporation Other Year Started _____
6. Address of Subsidiaries / Affiliates: _____
7. Nature of Business _____
SIC Code
8. Have any employees that have not been actively at work for more than five (5) consecutive days during the last 60 days due to sickness or injury (including on the job accidents)? If yes, please attach explanation. Yes No
9. A. Are any employees currently absent due to illness or injury receiving disability benefits? If yes, please attach explanation.
 Yes No
- B. Have any employees or dependents incurred medical expenses in excess of \$5,000 during the last 12 months? If yes, please attach explanation. Yes No
- C. Are you aware of any employee/dependent with a life threatening illness or injury (i.e. cancer, heart disease, diabetes, AIDS, etc..)?
 Yes No
If yes, provide details here: _____
- D. Are any former employees on COBRA benefit extension? Yes No
If yes, list names and end of eligibility periods: _____
- E. Number of full time employees (including owner) working 30 hours or more weekly: _____
Number of employees enrolling in medical: _____
- F. Eligibility and Termination Periods: **(Select One)**
A) _____ Eligible employees will be effective on the first day of the month following a waiting period of: 30 days
 60 days 90 days 120 days 150 days 180 days, and coverage will expire on termination date of employment.
B) _____ Eligible employees will be effective on the day following a waiting period of: 30 days 60 days 90 days
 120 days 150 days 180 days, and coverage will expire on termination date of employment.
- G. The waiting period will apply to: Future employees Present and Future employees
10. Are all individuals covered by Workers' compensation? Yes No Name of carrier: _____
If no, give names of persons not covered: _____

Health Plan Option Elected for Employees

Health Plan:

Prescription Drug \$8/ \$20 / \$45 or 20%

Yes No

* You must have 10 or more members to choose more than one plan.

11. COBRA ADMINISTRATION: (additional PEPM charge applies) Yes No Coordination, notification and premium collection for your COBRA employees. COBRA premiums will be 102% of current COBRA medical premiums. Must have 20 or more employees insured under the Evergreen Health Plan for EHP to administer COBRA for your group.

12. SECTION 125 PREMIUM ONLY PLAN: Yes No

13. The insurance being applied for _____ replaces, _____ is in addition to the following group or wholesale insurance.

Name of Insurer _____ Paid to Date _____

14. Does your current health plan include retirees? Yes No

15. Amount submitted with application \$ _____ Requested effective date _____

ATTACH A COPY OF THE FOLLOWING DOCUMENTS

- | | |
|---|--|
| <input type="checkbox"/> Complete enrollment forms, including waivers | <input type="checkbox"/> Copy of proposal submitted to client with sold rates |
| <input type="checkbox"/> First months premium check (no personal checks accepted) | <input type="checkbox"/> Copy of employer's current business license |
| <input type="checkbox"/> Copy of last bill from prior insurance carrier | <input type="checkbox"/> Copy of Workers compensation coverage |
| <input type="checkbox"/> Employer's most recent wage & tax report | <input type="checkbox"/> Certificate of Creditable Coverage from prior carrier |

PARTICIPATION AGREEMENT

Pursuant to the rights granted by said AGREEMENT, the subscribing Employer named below by its signature to this AGREEMENT, does hereby agree to be a group under Evergreen Medical Group. I hereby apply for the above referenced coverage and agree, that Evergreen Medical Group, L.L.C., d /b / a Evergreen Health Plan, Inc., subject to the terms and conditions of the policies applied for will take affect as of effective date requested. Provided that this application is approved by Evergreen Medical Group, L.L.C. and provided that the employees are to contribute to the cost of the insurance. Insurance shall not become effective unless 75% of net eligible employees or the minimum required by the company have enrolled and will be maintained. If this application is not approved, no insurance shall become effective and any advance payment will be returned.

SUBSCRIBING EMPLOYER

EVERGREEN HEALTH PLAN, INC

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Federal ID#: _____

Federal ID# 58-2244760

Signed this _____ of _____, 20__

Signed this _____ of _____, 20__

TO BE COMPLETED BY AGENT

Agent Name _____ Agent Signature _____

Mailing Address: _____ Phone: _____

Insurance License #: _____

Social Security or ID #: _____