

# Group Election Form

## Enrolling a Group with American Specialty Health

The following checklist should provide you with all the information necessary to enroll a new group with American Specialty Health. If you have any questions, please contact your local Regional Account Executive. Please pay special attention to the timelines listed below. **If these deadlines are not met, the effective date will be moved to the following month.**

### The following is needed by the 5<sup>th</sup> of the month PRIOR to the effective date

#### Group Election Form (attached)

- The employer & broker signatures are required.
- Please make sure that every section is filled out in its entirety.
- Please indicate whether it is Net Of Commissions.
- Please indicate if Subgroups are necessary
  - Attach a list of each subgroup name (please note that the subgroup name is what will be printed on their separate invoices and the ID cards). Also include the billing contact's name, billing address and contact info for each subgroup.

#### Producer Agreement (Broker's Requirement – for first ASHP group sold)

- Sign pages 1, 8, and 15 as indicated on the cover page.
- Fill out W-9 completely and sign.

#### Current license and E&O Insurance (unless direct group)

- Your Regional Account Executive can verify that current information is on file.
- If not, fax copies to (619)237-3859.

#### Fully Electronic Enrollment

- This is a continuous electronic upload of enrollment data. All additions/deletion will be sent over regularly (as determined by the group) via a FULL eligibility file on an FTP site.
- Identify the IT contact for the group, and provide your Regional Account Executive with the IT contacts name, phone #, and e-mail address.
- Our IT will contact the groups IT contact to set up an FTP site. Once the FTP site is set up we can begin receiving test files (should be started a month prior to effective date).
- The file must be in the correct form to load membership accurately.

### The following is needed by the 15<sup>th</sup> of the month PRIOR to the effective date

#### Binder Check

- For the estimated first month's premium
- Make out to *American Specialty Health Plans*

#### Employee Enrollment

- You can elect to enroll electronically (full electronic file due by the 15<sup>th</sup>), by manual enrollment forms, or with a one time census:

##### **Manual Employee Enrollment Forms**

- Each member needs to fill out the ASH Enrollment Form
- Please ensure accuracy of ALL enrolled.

##### **One-Time Census Enrollment**

- This will be a one-time upload of enrollment data. All additions/deletions will be manual (paper) format after the initial upload
- Please use "One\_Time\_Census\_Prfd\_Layout.xls" found on ASHBenefits.com.
- The file must be in the correct format in order to load membership accurately.
- Once completed, submit to your Regional Account Executive, (password-protected from being opened) via e-mail.

**Please ensure ASH receives this form at least 25 days before your requested effective date.**

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## EMPLOYER INFORMATION

Full legal name of company	Principal contact	Title		Phone
E-mail address	Routine billing contact	Title		Phone
Street address	City	State	ZIP	Employer Tax ID Number
Billing address (if different from street address)	City	State	ZIP	

## ELECTION

**Group Rider Plan Election (select one – note that there is no voluntary program for complementary health care benefits)**

- Chiropractic  
 Acupuncture  
 Chiropractic and Acupuncture

### Elections

Copay Per Visit

\$ \_\_\_\_\_

Maximum Visits Per Year

\_\_\_\_\_

### Monthly Rates

\$ \_\_\_\_\_ Employee only

\$ \_\_\_\_\_ Employee & spouse

\$ \_\_\_\_\_ Employee & child(ren)

\$ \_\_\_\_\_ Employee & family

### Plan Information

\_\_\_\_\_ Effective Date of Plan

\_\_\_\_\_ Employees under this plan (must match medical plan)

### Employer Contribution Levels

\_\_\_\_\_ % Employee

\_\_\_\_\_ % Dependent

## EMPLOYEE PROVISIONS FOR GROUP RIDERS (must match medical plan)

**New Hire Waiting Period (select one):**

- First of month following \_\_\_\_\_ months from date of hire  
 Date of hire  
 Other: \_\_\_\_\_

Open Enrollment Period \_\_\_\_\_

**Coverage Ceases On (select one):**

- Last day of month following termination date  
 Date of employee termination

**Eligibility:**

Must work at least \_\_\_\_\_ hours / week

### Employee Enrollment (Select One)

- One Time Census  
  Electronic Enrollment  
  Manual Enrollment Forms  
 Subgroups Needed  
 Yes (Please attach list of Subgroups)  
 No

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## DEPENDENT ELIGIBILITY FOR GROUP RIDERS

Dependent coverage ceases on dependent's \_\_\_\_\_<sup>h</sup> birthday (default is 19<sup>th</sup> birthday).  
 Overage dependent coverage ceases on (determined by full time student and/or IRS dependent status)  23<sup>rd</sup> Birthday  24<sup>th</sup> Birthday  25<sup>th</sup> Birthday  Other \_\_\_\_\_

## MEDICAL PLAN(S)

Medical Plan Carrier(s)	Employees Enrolled	Open Enrollment is in the Month of

## AGENT INFORMATION

Writing agent signature:	Writing agent name (print):
Writing agent firm:	Phone:
Writing agent address (where commission is sent):	E-mail:
City:                      State:                      ZIP:	General agent name:
Pay commissions to: <input type="checkbox"/> Agency <input type="checkbox"/> Individual <input type="checkbox"/> Net of Commission	

## EMPLOYER ACKNOWLEDGEMENT & PREMIUM DEPOSIT

We tender herewith the amount of \$\_\_\_\_\_ in consideration of approval of this application and, in the event of such approval, promise to pay ASHP any balance necessary to constitute the full initial payment for the group benefits described herein. All checks must be written against funds or accounts belonging to the group. Checks from a broker's account will not be accepted and will be returned to the broker.

**Please make payments payable to American Specialty Health Plans.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Send member packet to:  
 Employer  Broker

Name & Title: \_\_\_\_\_

## FOR ASHP USE ONLY:

Firm ID \_\_\_\_\_ Broker ID \_\_\_\_\_  
 RAE \_\_\_\_\_ Plan Code \_\_\_\_\_

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