Employer Group Application

Western Health Advantage

within reach,
beyond expectation

Employer Group Application

Becomes part of the Group Agreement

Western Health Advantage

Company Name	Group Number (Office Use)	
Street Address (Physical Address Only)	Subgroup/Class (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	Years in Business	
Benefits Administrator/Title	Phone	Fax
E-mail and Website Address	Other Language Considerations	

Does the Employer Offer Other Coverage: ❑ Yes ❑ No
If Yes, Please List the Carriers and Type of Coverage Offered and Premium for Each Option

1.	3.
2.	4.
Previous Carrier(s) 1.	2.

Are all employees eligible for this plan covered by Worker's Compensation? ❑ Yes ❑ No

If NO, please explain:______________________________

Are your benefits subject to ERISA regulation? ❑ Yes ❑ No

TYPE OF ORGANIZATION ❑ Sole Proprietorship ❑ Corporation ❑ Partnership Other______________

ELIGIBLE EMPLOYEES

1. Total number of employees ______________
2. Number of part-time, seasonal and temporary employees ______________
3. Number of eligible employees (subtract line 2 from line 1) ______________
4. Number of employees declining (complete waiver) or covered elsewhere ______________
5. Total employees enrolling in WHA (subtract line 4 from line 3) ______________

ELIGIBLE EMPLOYEES

❑ Sole Proprietor
❑ 2 – 19
❑ 20 – 50
❑ 51+

CONTINUATION COVERAGE

Employer is responsible for contacting current carrier to obtain name(s) and address(es) of current COBRA participants.

Please indicate number of current COBRA participants ____________ (attach list)

Is employer required to offer: ❑ Cal-COBRA ❑ Federal COBRA

BENEFITS

HMO Medical Plans

❑ Premier 10
❑ Premier 15
❑ Premier 20
❑ Premier 40
❑ Advantage 15-30
❑ Advantage 420
❑ Advantage 70
❑ Advantage 40
❑ Western 4010
❑ Western 2025
❑ Western 4025
❑ Western 2800 (HSA compatible)

❑ Medicare Supplement (available to groups under 20 eligible employees)

❑ Other ______________________________

Prescription Rider

❑ Rx A ❑ Rx E ❑ Rx H ❑ Rx W

Multiple Plans

(available to groups with 3 or more employees enrolled)

	Medical	Rx
Plan 2	________	________
Plan 3	________	________

❑ **Infertility Rider**

(available to groups over 20 eligible employees)

Vision Rider (minimum 2 employees enrolled)

❑ Eyewear Only ❑ $0 Copay
❑ Full-Service ❑ $10 Copay

❑ **Healthyroads Coaching Program**

(minimum 2 employees enrolled)

RATES (OFFICE USE)	PLAN	EMPLOYEE	EE + SP/I	EE + CH(REN)	EE + SP + CH(REN)
TIERS ❑ 2	________	________	________	________	________
❑ 3	________	________	________	________	________
❑ 4	________	________	________	________	________
❑ COMP	________	________	________	________	________
❑ Age-Rated (attach rates)	Medicare Supplement	________	________		

EFFECTIVE/RENEWAL DATE______________ **RAF**______________ **OPEN ENROLLMENT**______________ **TO**______________

Enrollment / Payment Provisions

Western Health Advantage

GROUP NAME **GROUP NUMBER (Office Use)**

ELIGIBILITY REQUIREMENTS

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.

Eligible employees shall be active, full-time employees who work at least ________ hours per week (minimum of 20 hours)

CATEGORIES OF ELIGIBILITY

❑ **Dependents** (spouse, CA registered domestic partner, children under 19 or up to age 24 if full-time student)
❑ **Domestic Partners** (non-registered domestic partner coverage, subject to approval, attach notarized Declaration of Domestic Partner Form with enrollment form)
❑ **Retired Beneficiaries** (subject to approval)

COMMENCEMENT OF COVERAGE

❑ 1st month following Date of Hire
❑ 1st month following _________ month(s) from Date of Hire
❑ Other (attach description)

Note: All terminations are effective the last day of the month in which Employee ceases to be eligible under group eligibility provisions.

EMPLOYER CONTRIBUTION & PARTICIPATION REQUIREMENTS (employer must contribute a minimum of 50% of employee only premium)

❑ **Employee Only** $ ____________________ **or** ____________________ % of Rate
❑ **Dependents** $ ____________________ **or** ____________________ % of Rate

BROKER INFORMATION

❑ Existing Broker
❑ New Broker
(must complete Agent Commission Agreement)

Broker Name: ________________________ Phone: ________________________

Agency: ________________________ Fax: ________________________

Broker Number: ________________________ E-mail: ________________________

Commission: ❑ Standard Scale ❑ Flat ____% ❑ Other: ________________ License Number: ________________

COMMENTS

EMPLOYER STATEMENT

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 Service Agreement and shall become a part thereof. WHA reserves the right to terminate group coverage or the coverage for any individual member if the Employer or individual member has made any material misrepresentation.

Signature Date

Print Name Title

BROKER STATEMENT

I certify that: All the information contained in this application is correct to the best of my knowledge; the applicant is a bona fide business establishment; participation requirements have been met; 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.

Broker Signature Date

WHA APPROVAL

Sales Approval Date Account Executive Date

Published: March 2008

Employer New Business Checklist

The following documentation should be complete and submitted to WHA by the 5th of the month:

- ❏ Employer Group Application (to be completed by Employer)
- ❏ Enrollment forms _______ # of forms
- ❏ Copy of Rate Quote
- ❏ Employers with 51 or more employees or Employers with no prior health coverage must complete *WHA Group Underwriting Questionnaire*
- ❏ Waiver forms for eligible employees who decline group health coverage for themselves *or* their dependents
- ❏ Sole Proprietor/Self Employed: Must be a full-time business engaged in producing adequate income (amount specified by WHA). A Schedule C showing annual gross income and the *WHA Sole Proprietor and Partnership Statement* is required.
- ❏ Employer groups of 2 or more: A copy of DE6 required
- ❏ A deposit in the amount of one month's premium

Return Materials to:

Western Health Advantage
2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.3198 local
916.568.1338 fax

westernhealth.com

Western Health Advantage

within reach, beyond expectation