# EMPLOYER GROUP APPLICATION

## FOR LARGE GROUP [101+ EMPLOYEES]

Effective 1.1.20

## EMPLOYER NEW BUSINESS CHECKLIST

**All documentation must be submitted to WHA by the 5th of the month (or following business day) in order to guarantee that month's effective date.**

- ❑ Employer Group Application for Large Group
- ❑ A copy of the most recent Quarterly Contribution Return and Report of Wages (Continuation) (DE 9C); a copy of the prior carrier premium statement may be submitted in lieu of the DE9C
- ❑ Owners who are not listed on the DE 9C or payroll report will need to sign the WHA Owner Statement
- ❑ Enrollment/Change Form for each enrollee
- ❑ HealthEquity HSA Authorization Form, if applicable
- ❑ Declination of Coverage Form for each eligible employee who declines group health coverage for themselves and/or their dependents (employer may retain on file)
- ❑ Copy of rate quote
- ❑ A payment for the first month's premium on company check stock or via e-check (electronic funds transfer option is available once the group has been installed)

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# LARGE GROUP EMPLOYER APPLICATION

Becomes part of the Group Agreement

**Company Name**_____ **Group #**_____(office use)

Business Address_____ Subgroup/Class (office use)_____

City, State, Zip_____ Requested Effective Date_____

Company Website_____ Federal Employer ID #_____

Billing/Mailing Address_____ County_____

City, State, Zip_____ Years in Business_____

CEO or Proprietor_____ Type of Industry_____

Benefits Administrator_____ Title_____

Phone_____ Fax_____

Email Address_____

### CURRENT MEDICAL CARRIER(S)

Does the employer offer other coverage? ❑ Yes ❑ No

If yes, list the carriers and type of coverage offered:

**Carrier**_____ ❑ HMO ❑ PPO

**Carrier**_____ ❑ HMO ❑ PPO

### PREVIOUS MEDICAL COVERAGE

Did the employer offer coverage previously? ❑ Yes ❑ No

If yes, list the previous carriers and type of coverage offered:

**Carrier**_____ ❑ HMO ❑ PPO

**Carrier**_____ ❑ HMO ❑ PPO

## MEDICAL AND PRESCRIPTION PLANS

Choose up to three plans: only one HSA-compatible high-deductible plan (HDHP) can be offered within the same eligibility class

### TRADITIONAL PLANS

Select a medical plan and write in selected prescription plan:

| | | Rx 10/30/50<br>Rx 10/40/60<br>Rx 10/30/50 Deductible |
|---|---|---|
| ❑ Premier 0/10/0 HMO Prime | + Rx | _____ |
| ❑ Premier 0/15/0 HMO Prime | + Rx | _____ |
| ❑ Premier 0/20/0 HMO Prime | + Rx | _____ |
| ❑ Premier 0/40/0 HMO Prime | + Rx | _____ |
| ❑ Advantage 0/15/250 HMO Prime | + Rx | _____ |
| ❑ Advantage 0/40/30% HMO Prime | + Rx | _____ |
| ❑ Advantage 0/20/500 HMO Prime | + Rx | _____ |
| ❑ Advantage 0/20/30% HMO Prime | + Rx | _____ |

### DEDUCTIBLE PLANS

Select a medical plan – prescription benefits are included

❑ Western 1000/40/500 HMO Prime + Rx 10/30/50 Deductible

❑ Western 2500/20/500 HMO Prime + Rx 10/30/50 Deductible

❑ Western 2500/40/500 HMO Prime + Rx 10/30/50 Deductible

❑ Western 4500/50/40% HMO Prime + Rx 15/50/75

### MEDICARE COORDINATED PLAN

Available to employer groups who offer retiree benefits

❑ Premier MC 0/10/0 HMO Prime + Rx 10/30/50

### HSA-COMPATIBLE HIGH-DEDUCTIBLE PLANS (HDHPS)*

Select a medical plan – prescription benefits are included

❑ Western 1800/0/0 HDHP HMO Prime [Rx embedded]

❑ Western 2800/0/0 HDHP HMO Prime [Rx embedded]

❑ Western 2800/40/500 HDHP HMO Prime [Rx embedded]

❑ Western 3000/30/30% HDHP HMO Prime [Rx embedded]

❑ Western 4000/40%/40% HDHP HMO Prime [Rx embedded]

❑ Western 5500/0/0 HDHP HMO Prime [Rx embedded]

*Employees will receive a complimentary HealthEquity health savings account (HSA) as an added benefit to employer-elected HSA-compatible HDHP unless declined (check box below).

❑ **Employer Declines** HealthEquity HSA benefit

## OPTIONAL RIDER PLANS

Available with all medical plans; check box next to rider plan(s)

**Infertility Benefits**
❑ Infertility A

**Vision Benefits**
❑ Eyewear Only $0 Copay
❑ Full Service $0 Copay
❑ Eyewear Only $10 Copay
❑ Full Service $10 Copay

**Wellness Coaching**
❑ Real Appeal
❑ Quit For Life
❑ Complete Coaching (both programs)

# ENROLLMENT / PAYMENT PROVISIONS

**Company Name**_____ **Group #**_____(office use)

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

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

## EMPLOYEE COUNTS

_____ Total number of full-time and full-time equivalent employees*

_____ Number of eligible employees

_____ Number of employees enrolling in WHA
(employees declining all group coverage should complete Declination of Coverage form)

*Employee counts must be determined by the employer consistent with California Health & Safety Code Section 1357.500 et seq., 45 CFR 155.20, and all other applicable statutes and regulations.

## 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)

## ELIGIBILITY REQUIREMENTS

A bona fide employee/employer relationship must 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:

❑ 20 hours or more per week ❑ 30 hours or more per week ❑ Other_____

## CATEGORIES OF ELIGIBILITY

❑ Dependents (spouse, CA registered domestic partner, child(ren) up to age 26)

❑ Domestic Partners (non-registered domestic partner: attach notarized Declaration of Domestic Partner Form with enrollment form)

❑ Retired Beneficiaries (subject to approval, attach retiree policy)

## COMMENCEMENT OF COVERAGE

❑ 1st month following Date of Hire

❑ 1st month following 30 days from Date of Hire

❑ 1st of the month following 60 days 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

❑ Employee Only $_____ or _____% of Rate

❑ Dependents $_____ or _____% of Rate

**Note:** Employer must contribute a minimum of 50% of the employee's premium of the lowest cost plan offered by WHA. Any other contribution arrangements are subject to WHA underwriting approval.

# ENROLLMENT / PAYMENT PROVISIONS

**Company Name**_____ **Group #**_____(office use)

## BROKER INFORMATION

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

Broker name:_____ Phone:_____

Agency:_____ Fax:_____

WHA Broker #:_____ Use broker-specific ID number if producer is to be listed on account

Email:_____

Commission: ❑ Flat _____% ❑ Other _____

## COMMENTS

_____

_____

_____

## PREPAYMENT REQUIREMENTS

Monthly prepayment fees are due and payable in full on the first day of each calendar month for which services are provided. 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.

## EMPLOYER STATEMENT

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

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; and 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 (office use)

Sales Approval:_____ Date:_____

Sales Team Assignment:_____ Date:_____