EMPLOYER GROUP APPLICATION

FOR SMALL GROUP [1 TO 100 EMPLOYEES]

Effective 1.1.18

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 Small Group
- ❑ For Employers: a copy of the most recent Quarterly Contribution Return and Report of Wages (Continuation) (DE 9C) and a copy of the prior carrier premium statement may be submitted in lieu of the DE9C
- ❑ For Partnerships and LLCs: a copy of most recent Schedule K listing all partners
- ❑ Sole proprietors, owners or partners who are not listed on the DE 9C or payroll report will need to sign the WHA Sole Proprietor/Owner/Partner 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
- ❑ Copy of rate quote
- ❑ A payment for the first month's premium on company check stock (electronic payment options are available once the group has been installed)

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Western Health Advantage

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SMALL 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_____

OTHER MEDICAL COVERAGE

List additional medical carrier(s) to be offered:

Carrier_____ ❑ HMO ❑ PPO

Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

Carrier_____ ❑ HMO ❑ PPO

Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

PREVIOUS MEDICAL COVERAGE

List any medical carrier(s) previously offered:

Carrier_____ ❑ HMO ❑ PPO

Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

Carrier_____ ❑ HMO ❑ PPO

Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

OR ❑ No Prior Coverage

MEDICAL PLANS

Groups with one to two enrolled employees: Choose one plan

Groups with three or more enrolled employees: Choose up to three plans: one HSA-compatible high-deductible plan per metal tier

TRADITIONAL	GATEWAY SERIES	CAPITAL SERIES
	❑ Gateway 20 Platinum 90 HMO	❑ Capital 15 Platinum 90 HMO
	❑ Gateway 30 Platinum 90 HMO	❑ Capital 25 Gold 80 HMO
	❑ Gateway 70 Platinum 90 HMO	
DEDUCTIBLE	**GATEWAY SERIES**	**CAPITAL SERIES**
	❑ Gateway 4010 Gold 80 HMO	❑ Capital 2000 Silver 70 HMO
	❑ Gateway 4020 Gold 80 HMO	❑ Capital 6300 Bronze 60 HMO
	❑ Gateway 5020 Silver 70 HMO	
HSA-COMPATIBLE* HIGH-DEDUCTIBLE	**GATEWAY SERIES**	**CAPITAL SERIES**
	❑ Gateway 2000 Gold 80 HDHP HMO	❑ Capital 2000 Silver 70 HDHP HMO
	❑ Gateway 1500 Silver 70 HDHP HMO	❑ Capital 4800 Bronze 60 HDHP HMO
	❑ Gateway 5200 Bronze 60 HDHP HMO	
	❑ Gateway 6500 Bronze 60 HDHP HMO	

*Employees will receive a complimentary HealthEquity health savings account (HSA) as an added benefit if employer elects an HSA-compatible high-deductible plan. ❑ Employer declines the HealthEquity HSA (check only if declining)

OPTIONAL RIDER PLANS

❑ **INFERTILITY**	available to all groups with 20 or more eligible employees	
❑ **VISION**	available to all groups with 2 or more enrolled employees	
indicate plan choice:	**Eyewear Only (EO) Plans** ❑ EO $0 Copay	❑ EO $10 Copay
	Full Service (FS) Plans ❑ FS $0 Copay	❑ FS $10 Copay
❑ **ADULT DENTAL**	available to all groups	
indicate plan choice:	**PPO Plan** ❑ Delta Dental PPO℠	**DMHO Plan** ❑ DeltaCare® USA

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

TYPE OF ORGANIZATION

❑ Sole Proprietorship ❑ Corporation ❑ Partnership ❑ Limited Liability Company (LLC) ❑ Other_____

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)

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

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.

(office use) Region: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 8 ❑ OOA

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: ❑ Small group standard License #:_____

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

Sales Approval:_____ Date:_____

Sales Team Assignment:_____ Date:_____