

# Employer Group Application

FOR LARGE GROUP [101+ EMPLOYEES]



## SUBMIT COMPLETED FORMS TO:

Mail to: Western Health Advantage  
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833  
Fax to: 916.568.1338  
Email to: whasales@westernhealth.com  
Call: 916.563.2206, 888.442.2206 toll-free or 711 for TTY

## 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
- Enrollment/Change Form for each enrollee (if setting up EDI file transfer, contact WHA Sales to initiate the process)
- HealthEquity HSA Authorization Form, if applicable
- Copy of rate quote
- Declination of Coverage Form for each eligible employee who declines group health coverage for themselves and/or their dependents (employer may retain on file)
- A payment for the first month's premium on company check stock or via e-check (complete form; auto-pay option is available once the group has been installed)

## COMPANY INFORMATION

Company Name \_\_\_\_\_ Group # \_\_\_\_\_ (office use)  
Federal Tax ID \_\_\_\_\_ Requested Effective Date \_\_\_\_\_  
Business Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ County \_\_\_\_\_  
Billing/Mailing Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_

*For multiple billing locations, please submit Group Structure Form.*

Type of Industry \_\_\_\_\_ Website \_\_\_\_\_

Are all employees eligible for this plan covered by Worker's Compensation?  Yes  No – Explain \_\_\_\_\_

Are your benefits subject to ERISA regulation?  Yes  No

Employer Form 5500: Plan Name \_\_\_\_\_ Plan Number (3 digit code) \_\_\_\_\_

## GROUP ACCOUNT CONTACTS

CEO or other Company Officer \_\_\_\_\_

### BENEFITS ADMINISTRATOR

Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Title \_\_\_\_\_  
Email \_\_\_\_\_

### FEDERAL COBRA ADMINISTRATOR

TPA \_\_\_\_\_  
Phone \_\_\_\_\_  
Contact Name \_\_\_\_\_  
Email \_\_\_\_\_

### BILLING CONTACT *(if different from Benefits Administrator)*

Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Title \_\_\_\_\_  
Email \_\_\_\_\_

COBRA billing statement to be sent to:

- Group Administrator
- COBRA Administrator  
*(complete Group Structure Form)*

**MEDICAL CARRIER(S) OFFERED**

Does the employer offer other coverage?  Yes  No

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

Carrier \_\_\_\_\_  HMO  PPO

Carrier \_\_\_\_\_  HMO  PPO

WHA will be sole carrier

**PREVIOUS MEDICAL CARRIER(S)**

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 medical and pharmacy plan options: 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 **Classic** (\$10/30/50/100)

Rx **Plus** (\$15/30/50/100 ded)

Rx **Base** (\$15/50/75/250)

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 0/20/250A HMO Prime + Rx \_\_\_\_\_

Advantage 0/15/250 HMO Prime + Rx \_\_\_\_\_

Advantage 0/25/500A HMO Prime + Rx \_\_\_\_\_

Advantage 0/20/500 HMO Prime + Rx \_\_\_\_\_

Advantage 0/20/30% HMO Prime + Rx \_\_\_\_\_

Advantage 0/40/30% HMO Prime + Rx \_\_\_\_\_

**DEDUCTIBLE PLANS**

Select a medical plan and write in selected prescription plan:

Rx **Classic** (\$10/30/50/100)

Rx **Plus** (\$15/30/50/100 ded)

Rx **Base** (\$15/50/75/250)

Western 1000/20/20% HMO Prime + Rx \_\_\_\_\_

Western 1000/40/500 HMO Prime + Rx \_\_\_\_\_

Western 2500/20/500 HMO Prime + Rx \_\_\_\_\_

Western 2500/40/500 HMO Prime + Rx \_\_\_\_\_

Western 2500/0/30% HMO Prime + Rx \_\_\_\_\_

Western 4500/50/40% HMO Prime + Rx \_\_\_\_\_

**HSA-COMPATIBLE HIGH-DEDUCTIBLE PLANS (HDHP)**

Select a medical plan – prescription benefits are included

Western 1800/0/0 HDHP HMO Prime

Western 2800/0/0 HDHP HMO Prime

Western 2800/40/500 HDHP HMO Prime

Western 3200/30/30% HDHP HMO Prime

Western 4000/40%/40% HDHP HMO Prime

Western 5500/0/0 HDHP HMO Prime

HealthEquity HSA — a complimentary health savings account (HSA) as an added benefit to an HDHP with WHA

**OPTIONAL RIDER PLANS**

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

**Wellness Coaching**  Healthy Lifestyle Program, includes:  
Real Appeal Weight Loss  
Quit for Life  
Maven Family Support

**Hearing Aid Plans**  Choice (\$1,000 allowance)  
 Select (\$699 or \$999 copayment)

Employer declines Family Diversity & Pregnancy Support program offered with commercial medical plans

# Enrollment / Payment Provisions

## 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/CalCOBRA 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 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 (expanded eligibility class for non-registered domestic partner: attach 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

## BROKER INFORMATION

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

Broker name: \_\_\_\_\_ Phone: \_\_\_\_\_

Agency: \_\_\_\_\_ Email: \_\_\_\_\_

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

Account manager or service team contact: \_\_\_\_\_

Commission:  Flat \_\_\_\_\_ %  Other \_\_\_\_\_

## COMMENTS

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## 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)

Group Approval: \_\_\_\_\_ Date: \_\_\_\_\_

Sales Team Assignment: \_\_\_\_\_ Date: \_\_\_\_\_