EMPLOYER GROUP APPLICATION

network health

Employer Demographic Information

		Effective date:				
1.	Full legal name of employer: (full legal names usually have Inc., LLC or Corporation at the end of the name)	Legal name:				
2.	Do you have a “doing business as” (DBA) name you want Network Health to use on member material? If so, what is your DBA name?	DBA name:				
3.	Physical Address:	Street				
		City		State		
		Zip		County		
4.	If subsidiaries/affiliates are included in the plan Network Health will be administering, do you want separate bills sent to each?	☐ Yes ☐ No				
5.	List subsidiaries or affiliates to be covered by the plan, if any, including their address. (Attach sheet if additional space is needed.)	a. _____ b. _____ c. _____				
6.	Employer Tax ID Number (as assigned by IRS):					
7.	Mailing Address: ☐ Check if same as corporate address	Street or P.O. Box				
		City		State		
		Zip		County		
8.	Administrative Contact:	Name				
		Title				
		Phone				
		Fax				
		Email				

9.	Type of Ownership:	☐ Corporation	
		☐ Partnership	☐ Proprietorship
		☐ Labor Union	☐ Government Entity
		☐ Church Plan (not a school or day care staff)	☐ Other
10.	Nature of Business:	# Years in business: _____	
11.	Name of Workers' Compensation Carrier: _____	S.I.C. # _____	
12.	Are any owners/officers/partners not legally required to be covered by workers' compensation, and need on-the-job medical coverage with Network Health Plan (NHP) or Network Health Insurance Corporation (NHIC)?	☐ Yes ☐ No	
	(If yes, list names)	a. _____ b. _____ c. _____ d. _____	
13.	Will this coverage replace your current group health coverage?	☐ Yes ☐ No	
	If yes, list your current health insurance carrier:	_____	
14.	Will your employees have access to another medical plan due to their employment with you?	☐ Yes ☐ No	
	If yes, name of carrier(s):	a. _____ b. _____	
15.	COBRA – are any present or former employees or their dependents, including eligible owners, currently on or eligible to elect COBRA/State Continuation? ☐ Yes ☐ No If Yes, complete the following: **Name** _____ **COBRA/State Cont. Start Date** _____ **Qualifying Event / Date (e.g., termination, divorce, etc.)** _____ _____ _____ _____ If you have a current COBRA administrator, please provide name: _____		

16.	Employer contribution** (Percent or Flat Rate)	**Percent**		**Flat Rate**	
		Single	_____%	Single	$_____
		Family	_____%	Family	$_____
		EE & Child(ren)	_____%	EE & Child(ren)	$_____
		EE / Spouse	_____%	EE / Spouse	$_____
	***** NHP and NHIC have a minimum employer contribution requirement of 50 percent of the single premium of the lowest cost plan offer.***				

Eligibility Information

All employees working a minimum of 30 hours per week are eligible. If requested in writing and approved by NHP/NHIC, employees working less than 30 but not less than 20 hours per week may be eligible.

1.	**Are you a small or large group?** Groups with 51 or more Full Time Equivalents (FTEs) are large groups. For more information visit https://www.irs.gov/affordable-care-act/individuals-and-families/aca-information-for-employers-counting-full-time-and-full-time-equivalent-employees	☐ Small Group ☐ Large Group
2.	Hourly requirement (cannot be greater than 30): _____	
3.	Total number of current employees: _____	
4.	Total number of eligible employees: _____	
5.	Total number of eligible employees enrolling: _____	
6.	Number of eligible employees waiving due to other coverage: _____	

Participation Information

Small Groups must maintain NHP/NHIC's employee participation requirements for all lines of coverage. Failure to maintain the participation requirement will terminate your coverage under the terms of the policy. Other termination provisions are stated in the policy. Small groups that do not meet NHP/NHIC's participation or minimum employer contribution may only enroll November 15 through December 15.

For groups of 2 to 50 employees, the following are NHP/NHIC's participation requirements.

Number of Eligible Employees	Number that Must Enroll
2-4	2
5-6	3
7	4
8-9	5
10	6
11-50	70%

Those waiving coverage under this policy, due to other creditable coverage, are not considered eligible employees.

Employee Waiting Period

Employees must apply within 31 days of becoming eligible, or they must wait until open enrollment.

1.	Check employee waiting period and effective date of coverage if it applies to all classes. If waiting period varies by class, please indicate below.	**First of Month After** ☐ Date of Hire ☐ 30-day waiting period ☐ 60-day waiting period	**OR**	**Immediately After** ☐ None ☐ 30-day waiting period ☐ 60-day waiting period ☐ 90-day waiting period

Do you want to separate employees based on location or benefit provisions? If yes, please list.
(example: hourly/salary, immediately/60 day waiting period)

Class	Name	Waiting Period

2.	Do you want new employees currently in their waiting period to be eligible as of the group's plan effective date?	☐ Yes ☐ No
3.	Rehire Provision ACA Small Groups: All rehires will be treated as new employees if rehired more than 30 days after termination. Large groups will be set-up as "Waive **waiting period** if rehired within 91 days" to be compliant with the ACA Employer Shared Responsibility requirements. *(i.e., coverage will resume upon rehire if within 91 days)*	
4.	Employee ceases to be eligible:	☐ Immediately ☐ End of month
	ACA Small Groups: employee termination will be at the end of the month. For all groups: Dependent coverage will terminate at the end of the month of his/her 26th birthday.	

5.	Plan(s) selected (maximum of four plans for Small Groups):		
		Medical Plan	**Pharmacy Benefit (Large Group only)**
	a.		
	b.		
	c.		
	d.		
	Wellness Options		☐ Wellness*Ways* (includes WellBeats) ☐ WellBeats Only ☐ No wellness
	Does Employer offer a health reimbursement account (HRA)?		☐ Yes ☐ No
	Is the vendor:		☐ Employee Benefits Corporation (EBC) ☐ Diversified Benefit Services (DBS)
	If you have an HRA with EBC or DBS, do you want us to send claim info to them through our electronic feed?		☐ Yes ☐ No
	If Yes, indicate which plans you have the HRA apply to.		
	Please note that the Certificate of Coverage does not include information regarding any contribution the employer makes toward an HRA or HSA. The employer is responsible for providing their eligible employees with information regarding their HRA or HSA plan, including any contribution the employer may make to it.		

Large Group Questions (Only employers with 51+ employees)

1.	Plan or calendar-year deductible:	☐ Plan Year ☐ Calendar Year
2.	If large group (51 or more eligible employees) offers medical benefits to retired employees up to age 65, state attained age and years of service for retiree class eligibility. Benefits will be effective for retirees if approved.	Age
		Years of Service
		Employer contribution
3.	Do you want to offer coverage to Legally Domiciled members (Domestic Partners and their dependents)?	☐ Yes ☐ No
	Is this contract part of a union negotiated agreement?	☐ Yes ☐ No
5.	If yes, please provide a copy of the union contract.	Expiration date: _____ / _____ / _____
6.	Do you offer open enrollment at renewal? ☐ Yes ☐ No (Open Enrollment required for ACA Small Groups) If yes, to be effective, the employee must complete and sign the enrollment application within 31 days of the group's renewal date	
7.	Do you have employees residing outside the Network Health service area that you want covered under this plan?	☐ Yes ☐ No If yes, how many? _____

8.	Please indicate any non-standard provisions discussed with and approved by Network Health:	
	NOTE: Late applications for large groups without open enrollment may be subject to a 90-day late enrollee waiting period.	
Payment Information–Payment of Initial Deposit		
	☐ Direct Bill (For groups with 51 or more employees a $25 service fee will be added to monthly bill)	☐ ACH (Separate signed authorization form required)
Payment Information–Monthly Recurring Payment		
	☐ Direct Bill (For groups with 51 or more employees a $25 service fee will be added to monthly bill)	☐ ACH (Separate signed authorization form required)
Paperless Billing Option **Please Note:** An invoice will be uploaded to the group portal on a monthly basis. An email notification will be sent out each month once the invoice is available to view.		
	Do you wish to employ paperless billing?	☐ Yes ☐ No
	If yes, what email address should bill be sent to?	

Terms and Conditions

Application Submission

The Group understands that providing incomplete, inaccurate or untimely information may delay, void, reduce or terminate an individual's coverage or the Group's coverage. The Group shall furnish to NHP/NHIC any information required for NHP/NHIC to administer the policy. NHP/NHIC reserves the right to contact any employee at the place of business to complete the enrollment process. The Group shall have records available for NHP/NHIC to inspect at any time insurance is in force, and to the earlier of three years after termination date or final adjustment and settlement of claims is made.

Please submit the following forms for application of coverage

1. Employer Group Application
2. Completed employee enrollment forms
3. Waiver forms with copy of other insurance ID cards when requested
4. A copy of the quoted rates
5. A copy of your current carrier's benefit design(s)
6. A completed ACH Authorization Form when requested
7. New Group Submission Checklist
8. A completed copy of the most recent filing of UCT State Quarterly Unemployment Compensation Report Form (non-experienced rated groups)
9. A copy of current billing if replacing coverage (non-experience rated groups)

UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP COVERAGE WITHOUT PRIOR WRITTEN NOTICE OF APPROVAL BY NHP OR NHIC.

Coverage is not in effect unless and until the Group receives written notification from NHP/NHIC.

Application Terms
The Group understands and agrees that neither the Group nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract or waive any of NHP's or NHIC's other rights or requirements. No agent or field representative of NHP or NHIC has the authority to modify any terms or conditions of applications, policies or contracts.

Authority of Agent
No agent or field representative of the insurance company has the authority to waive any of NHP's or NHIC's other rights or requirements, pass on insurability or waive a complete answer to any questions, nor bind the insurance company by making any promises or representations, written or verbal. The undersigned agrees that any such attempt by the agent is void and is not effective.

Payment and Enrollment Submission

The Group's first month's premium must be submitted with the Employer Group Application. All premiums must be paid with the Group's business check written out to NHP and/or by electronic transfer when an electronic fund transfer business account is established. A monthly $25 fee will be charged to all large employer groups who pay their premiums via check. Also, a $25 service fee will be applied to non-sufficient funds when allowed by state law. **The Group agrees to collect any employee contribution toward premium.**

EMPLOYER GROUP CERTIFICATION

The undersigned, as authorized representative of the Employer Group applying for insurance coverage ("Group"), certifies reading the entire completed application and that the information provided is accurate and complete. The Group agrees to provide the documentation requested by NHP/NHIC, which establishes all eligibility and participation requirements of the policy are met. The Group also certifies business records maintained by the Group can substantiate the information provided here.

Furthermore, the Group certifies the insurance agent has explained the coverage, limitations, and exclusions, other details of coverage of the insurance applied for, and the rules and regulations of NHP or NHIC. This document will form part of any policy issued upon NHP/NHIC's acceptance of the Group's application for coverage. The Group accepts and agrees to the provisions contained in this Employer Group Application.

Employer representative (Must be authorized to purchase coverage for this firm)	Signature	
	Print Name	
	Date	
	Title	
Writing Agent *Signature certifies that I met with the Employer submitting this application and fully explained its contents.*	Signature	
	Print Name	
	Date	
	Title	
	Agency	