

GHI

GHI HMO

SMALL EMPLOYER GROUP



Group Application

SECTION I GROUP INFORMATION

Company Name _____ Date _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone No. () _____ Fax No. () _____

Company Officer's Name _____ E-Mail Address _____

Title _____

Group Contact _____ Title _____ Telephone No. () _____

E-Mail Address _____

Address Same as above

Additional Office Locations

SECTION II BILLING

Premium invoices should be sent to: _____ Telephone No. _____ E-Mail Address _____
()

Address _____

Contact Person (if different than above) _____ Telephone No. _____ E-Mail Address _____
()

SECTION III GROUP ADMINISTRATION

- Please check all applicable class(es) of employees eligible for the GHI or GHI HMO coverage for which you are applying (note that classes must be based upon conditions pertaining to employment):
 Non-Management Union Part Time Other
 If you checked "Other" above, please identify the other class(es): _____
NOTE: Employees must work at least 20 hours per week in order to be eligible for GHI or GHI HMO coverage. Retirees are not eligible for coverage under GHI small group programs.
- Please specify the total number of eligible employees, exclusive of dependents and spouses, by class(es):
 Management: [] Non-Management: [] Union: [] Part-time (less than 20 hours per week: []
 Other (please specify for each class(es): _____ []
- For GHI HMO and HMO/POS skip to question 4. If your Group is an association, chamber of commerce or fund comprised of one or more employees or labor unions, please identify the total number of member groups by the following group size(s):
 [] Total number of member groups with 50 or fewer eligible employees.
 [] Total number of member groups with 51 and above eligible employees.
- Please specify the current number of COBRA Participants: _____
- Indicate number of enrolles eligible for the GHI and/or GHI HMO by coverage type:
 ____ Individual ____ Employee/Spouse ____ Employee/Child(ren) ____ Family
- Pre-Existing Condition Limitation: THERE WILL BE AN ELEVEN-MONTH WAITING PERIOD FOR BENEFITS FOR ANY CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE SIX-MONTH PERIOD ENDING ON A MEMBER'S ENROLLMENT DATE. THIS WAITING PERIOD WILL BE REDUCED TO THE EXTENT THAT A MEMBER IS ENTITLED BY LAW TO A CREDIT FOR PRIOR CONTINUOUS CREDITABLE COVERAGE. THE CERTIFICATE OF INSURANCE OR CERTIFICATE OF COVERAGE WILL CONTAIN MORE INFORMATION ABOUT THE PRE-EXISTING CONDITION WAITING PERIOD AND THE TYPES OF COVERAGE THAT QUALIFY AS PRIOR CONTINUOUS CREDITABLE COVERAGE.

SECTION VIA ENROLLMENT POLICIES CLASS: _____

EMPLOYER CONTRIBUTION

Please specify the percent or amount that your group will contribute towards GHI and/or GHI HMO program premiums for your employees and their dependents.

Employee: _____ % or \$ _____

Family: _____ % or \$ _____

Other

NEW HIRE ELIGIBILITY POLICY

Please specify the date on which a new employee will be eligible for coverage under the GHI or GHI HMO program.

Date of Hire

First of the month following date of hire

Plus: 30 Days 60 Days

90 Days Other (*please specify*)

Waived for Rehire? Yes No

If rehired within _____ days of rehire.

For additional classes, please continue on a separate piece of paper.

SECTION VII

For employer groups comprised of one or more employees, please check your current employer status below to ensure proper coordination of benefits for your Medicare Eligible Active Employees (*you must check one of the boxes below*):

- Employed fewer than twenty (20) full time or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).
- Employed twenty (20) or more full or part time employees for twenty (20) or more calendar weeks for each working day in each of twenty (20) or more calendar weeks in the current calendar year (or the preceding calendar year).

NOTE: All employers that are treated as a single employer under Internal Revenue Code Section 52 must be treated as a single employer for purpose of the Medicare secondary payer rules. According to Internal Revenue Code Section 52, all employees of all corporations that are members of the same controlled group of corporations must be treated as employed by a single employer. This means that if a parent company owns at least fifty percent (50%) of a subsidiary, then the number of employees of the parent and the subsidiary must be combined for purposes of determining the 20-employee threshold. Similarly, brother-sister corporations may be combined in some cases if the parent corporation owns at least fifty percent (50%) of the brother-sister corporations.

- Please check here if your group is a large group health plan. A large group health plan is a plan of, or contributed to by, an employer or employee organization to provide health benefits that cover the employees of at least one (1) employer that normally employed at least one hundred (100) employees on a typical business day during the preceding calendar year.

SECTION VIII

By signing this Application, I agree to be bound by all terms, including but not limited to the terms relating to payment of premiums, of the Group Contract issued by GHI or GHI HMO pursuant to this Application in the event that GHI or GHI HMO approves this application and issues the Group Contract. I understand and agree that the Group Contract issued by GHI or GHI HMO pursuant to this Application will be the GHI or GHI HMO Group Contract currently available that most closely resembles the coverage requested. I further understand and agree that the premium rate to be charged by GHI or GHI HMO for my coverage will be GHI or GHI HMO's prevailing premium rate(s) for my Group Contract, notwithstanding any premium rates that may have been quoted or otherwise represented to me. By signing this Application, I also certify under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business. I hereby authorize any person or other entity to release to GHI any information requested by GHI or GHI HMO in connection with the processing of this application.

This application is subject to review and approval by GHI and/or GHI HMO's underwriters. GHI and/or GHI HMO's acceptance and negotiation of your first premium payment does not guarantee that

your application will be approved. In the event that your application is rejected, GHI and/or GHI HMO will refund the first premium payment to you.

I understand that any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Name

Signature

Title

Date

SECTION IX

To be completed by GHI General Agent or Selling Agent

Company Name _____ Date _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone No. () _____ Fax No. () _____

Group Contact _____ E-Mail Address _____

Desired Effective Date _____ Effective Date Changed Since Original Application? Yes No

Master Agency _____ MA No. _____ Override _____

GHI Group No: _____ Marketing Rep: _____

(For GHI internal use only.)

General Agency <input type="checkbox"/> To be Credentialed	
GA No. _____	Override: _____
Contact _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

Selling Agent <input type="checkbox"/> To be Credentialed	
SA No. _____	Commission: _____
Name/Agency Name _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

Selling Agent <input type="checkbox"/> To be Credentialed	
SA No. _____	Commission: _____
Name/Agency Name _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

Selling Agent <input type="checkbox"/> To be Credentialed	
SA No. _____	Commission: _____
Name/Agency Name _____	
Address _____	
Telephone No. _____	E-Mail _____
Fax _____	

Split Commission _____%

- | | | |
|--|------------------------------|-----------------------------|
| Deposit Check Attached | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Proof of Employment | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Last Paid Premium Invoice from Current Carrier | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| COBRA Letters of election | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |
| Proof of Medicare eligibility, Part A and B | <input type="checkbox"/> Yes | <input type="checkbox"/> NO |

Amount: \$ _____

GA Authorized Signature _____

Date _____



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