Administrative Services Provided Through

EDHP™ EMPLOYER DRIVEN HEALTH PLANS

E.D.I.S. EMPLOYER DRIVEN INSURANCE SERVICES

EMPLOYER APPLICATION FORM
(For Level-Funded Products)
EMPLOYER INFORMATION

Full Legal Business Name of Employer/Plan Sponsor:			
Street Address:	City:	State:	Zip:
Mailing Address (if different):	City:	State:	Zip:
Phone:	Fax:		County:
Name of person for service of legal process:			
Name of group contact for billing and administration:		Email Address:	
Nature of Business:	Date Business Started:	SIC Code:	Fed. Tax I.D:

Names/Addresses of subsidiaries/affiliates to be included: _____

_____

_____

Is this group a government agency or church group? ☐ Yes ☐ No	Is the PLAN subject to collective bargaining? ☐ Yes ☐ No	If yes, union name: Exp. Date:
List prior insurance carrier(s) or TPA(s) during previous two (2) years:		
Employer contribution percentage is _____%. NOTE: The employer is required to contribute a minimum of 50% of the employee only cost of the lowest cost plan offered.		
Current group health plan: ☐ fully insured ☐ self-funded	Name of workers' compensation carrier:	

Are you subject to COBRA? (You are subject to COBRA if you or your controlled group, as defined in 26 U.S.C. 1563, employed at least 20 full or part-time employees on at least 50% of the typical business days during the previous calendar year. You must include employees residing outside the U.S.). ☐ Yes ☐ No

Is anyone in your group currently under COBRA, state continuation plan, or within their election period? ☐ Yes ☐ No

If yes, please list below (Note: Any COBRA applications received after approval of this application may result in a rate adjustment or declination).

Employee/Dependent Name	Termination Date of Original Coverage	Qualifying Event
_____	_____	_____
_____	_____	_____
_____	_____	_____

__MEDICAL PLAN CHOICES__: (Please include signed and dated proposal for each medical plan being offered to your employees.)

Signed and Dated Proposals Included? ☐ Yes

ANCILLARY PLAN OPTIONS:

Freedom Dental™

Fully Insured Freedom Dental™ Plan Selection: ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 Network: PPO or EPO (select one)

Network Vendor: First Dental Health (Default) or Other: _____

☐ Pre-Paid DHMO / Western Dental®

☐ 100% Self-Funded Dental (must complete the Employer Elect Application)

Eagle Vision™

☐ 100% Self-Funded Vision Plan

EMPLOYEE INFORMATION

Total number of full-time active employees:	Total number of eligible employees:
* Minimum hours (per week) required for eligibility:_____ (* Minimum of 30 hours per week, 48 weeks per year, which may be reduced to 20 hours per week by request.)	* Total number of enrolling employees:_____ * Minimum participation requirement is 75% of all eligible employees (but not less than 50% of all full-time employees.)

Employee probationary period / effective date: ☐ First of the month following 30 days ☐ First of the month following 60 days

☐ _____ [days] of employment following Date of Hire, not to exceed 90 days

Total Number of eligible employees currently in probationary period: _____

Employee termination date: ☒ End of month

Employee Classes: Class I _____ Class II _____ Class III _____ Class IV _____

Are you establishing a retiree class for medical? ☐ Yes ☐ No If yes, attained age _____ Years of Service _____	Any excluded classes of employees? ☐ Yes ☐ No If yes, give descriptions and reasons: _____
Does current health insurer/TPA extend coverage/benefits for disabilities after termination date? ☐ Yes ☐ No If yes, please provide copy of policy, employee certificate and/or SPD.	How many of your employees do not speak English? _____ Language(s) spoken _____

The Employer terminates employment after an employee has not worked for the Employer for _____ work days (e.g. 3, 5, 10 working days). If labor laws such as FMLA or any other terms, conditions or contract of employment require that the Employer continues to employ an employee for a longer period of time, the Employer will give written notice to the TPA when the Employer terminates employment for that employee.

EFFECTIVE DATE / DEPOSIT

*** Deposit must include first month's fixed costs, first month's maximum claims costs and plan set-up fees**

Requested effective date _____	Deposit with Application $ _____

IMPORTANT: Benefits are not effective until the undersigned receives written approval. No action is taken on the Application until after all required information is submitted. The deposit amount will be returned to the Applicant if the Application is declined.

APPLICANT AGREEMENT

The agent has explained the details of the coverage(s)/benefits and I, the undersigned, acknowledge reading the entire application, including Plan Services Agreement. Under the terms of my Plan Service Agreement with the TPA, I have agreed to provide funds for benefit payments monthly or more frequently as required by the banking arrangement, and agree the TPA is under no obligation to pay plan benefits if I have not provided adequate funds. I understand that I am financially responsible for all eligible claims incurred while my Plan is in effect. If your enrollment decreases, you will continue to be responsible for **80%** of the monthly Maximum medical claim liability determined for the first month of the plan year. This is referred to as the minimum aggregate attachment point.

IMPORTANT: If you do not remit funds as required after notification by the TPA, administration of your Plan will be terminated. The Employee Retirement Income Security Act (ERISA) places a fiduciary responsibility on the employer, as Plan Sponsor, to ensure the Plan is adequately funded. The TPA may notify all Plan Participants, at your expense, if your claims account is determined to be in jeopardy. The answers I have provided are true and complete. I understand that the terms and conditions herein bind the applicant and the TPA only when the applicant receives written approval**.**

Dated at _____ (City & State) Dated on _____(Month, Day, Year)

Full Legal Business Name _____

Signature **X** _____ (Must be signed by a person authorized to purchase benefits for this firm)

Print Signature and Title _____

AGENT / PRODUCER INFORMATION

General Agent Name: _____

Writing Agent #1 Name: _____	Social Security / Identification Number: _____	
Street:		
City:	State:	Zip:
Telephone Number:	Fax Number:	Production Split: _____%

Writing Agent #2 Name: _____	Social Security / Identification Number: _____	
Street:		
City:	State:	Zip:
Telephone Number:	Fax Number:	Production Split: _____%

I have notified the employer not to terminate present benefits until notified in writing of acceptance of this application.

Agent #1 Signature **X** _____ Date _____

Agent #2 Signature **X** _____ Date _____

SPECIAL REQUESTS / ADDITIONAL COMMMENTS / INSTRUCTIONS

*** Subject to written approval by TPA**

INTERNAL USE ONLY

Effective date _____ Approved by _____ Date _____

Comments: _____

Employer Measurement Method Confirmation

(for Determining Full-Time Status of Variable Hour/Seasonal Employees)

The Internal Revenue Services (IRS) regulations under the Affordable Care Act (ACA) consider a full-time employee as one who is employed, on average, at least 30 hours of service per week (or 130 hours in a calendar month). In regards to variable hour/part-time/seasonal employees, the IRS provides two methods for identifying which variable hour/part-time/seasonal employees are to be considered as full-time: the **monthly measurement method** and the **look-back measurement method**

For purposes of determining eligibility for coverage under the Plan, please provide the following information regarding the method used for variable hour/part-time/seasonal employees:

Employer Name	
Measurement Method Used	☐ Monthly ☐ Look-Back (see below)
If you selected the "Look-Back" measurement method, please complete the following:	
Standard Measurement Period (must be between 3-12 consecutive months)	☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months
Standard Measurement Period Start and End Dates (Please provide start and end dates for each measurement period based on duration of measurement period selected. (e.g. 12 months would only require completion of Period 1, where 3 months would require completion of Period 1-4)	Period 1: Start Date: _____ End Date: _____. Period 2: Start Date: _____ End Date: _____. Period 3: Start Date: _____ End Date: _____. Period 4: Start Date: _____ End Date: _____.
Initial Measurement Period Start Date	☐ Date of Hire ☐ First of the month following date of hire
Stability Period (must be at least the same as the standard Measurement Period, but in no event less than 6 months)	☐ 6 months ☐ 9 months ☐ 12 months
Administrative Period (Up to 90 days)	# of Days:

☐ **N/A - Our company does not have any variable hour/ part-time/ seasonal employees**

By signing below you are confirming the method and time frames used for determining full-time status of variable hour/ part-time/ seasonal employees for the purposes of coverage under the Plan. These time frames will be considered in effect until such time when a new form has been completed stating otherwise.

Please complete all of the information requested before signing this confirmation. Please initial any changes. This is an application only, coverage and issuance of an Administrative Agreement is subject to review and approval by E.D.I.S.

_____ _____

Employer Signature **Date**