Group Application

The following form should be filled out completely and accurately. Please type or print neatly using black ink.

GROUP INFORMATION

Group Name: *(Note: Enter the legal name of the group, including any punctuation and abbreviations.)*

Street Address: City: State: Zip Code:

Mailing Address: City: State: Zip Code:

Telephone Number: ( ) – Fax Number: ( ) – Website Address:

Type of entity: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Association
☐ Government ☐ Non-Profit ☐ Other

Description of Business: Standard Industry Code (SIC): Years in Business:

Tax Identification Number (TIN):

Location of corporate/parent headquarters: ☐ Same as above ☐ Other

Are other divisions, subsidiaries or affiliates covered under this plan? ☐ No ☐ Yes
If yes, please list below:

Name	*Location*	*Relationship*

Primary Contact Person: Title:

Telephone Number: ( ) – Fax Number: ( ) – Email Address:

EMPLOYEE INFORMATION

Are there any employees located in other states or countries? ☐ No ☐ Yes
(If yes, list employees by state and country on census)

Are any foreign nationals covered under this plan? ☐ No ☐ Yes
(If yes, list employees by state and country on census)

Does this company participate in workers' compensation, PERA or PERS program? ☐ No ☐ Yes

Description of eligible employees: ☐ All full-time employees ☐ Other _____
Are any employees excluded from eligibility? ☐ No ☐ Yes, If yes, describe: _____

Note: Employees must work a minimum of 30 hours per week in order to be eligible for coverage. The waiting period for all employees is 30 days, with coverage to be effective the first of the month following completion of the waiting period.

Total number of full-time employees: _____

Total number of part-time employees: _____

Total number of eligible employees: _____

Total number of employees enrolling in this plan: _____
(Minimum participation is 75% of eligible employees.)

Total number of COBRA eligible members enrolling: _____
(Prior carrier COBRA election forms must be submitted.)

Total number of employees waiving coverage: _____

Total number of employees in the waiting period: _____

Employer Contributions: *(Note: Minimum employer contribution is 75% of the employee cost.)*

Line of Coverage			*Medical/Rx*
For employee coverage	☐ %	☐ $	_____
For dependent coverage	☐ %	☐ $	_____

COVERAGE HISTORY

Number of carriers in the past five (5) years: _____
Provide explanation if more than three (3) carriers:

_____

Has the group ever been denied or cancelled by another group carrier? ☐ No ☐ Yes
If yes, please explain.

_____

RISK INFORMATION

Number of…

_____ Employees or dependents in this group who are pregnant (Indicate date due below)

_____ Employees or dependents in this group who are disabled

_____ Employees or dependents in this group who have been hospitalized during the past twenty-four (24) months

_____ Employees or dependents in this group who are anticipating surgery

_____ Employees or dependents in this group who incurred $5,000 or more in claims during the past twenty-four (24) months

_____ Employees or dependents in this group who have knowledge of or, during the past twenty-four (24) months, received treatment for disease, disorder or ailment of: blood, immune system, cancer, diabetes, heart, kidney, skeletal system, respiratory system, psychological, alcohol or drug abuse.

Provide details to questions above in the area below. For past claims, provide diagnosis, prognosis, course of treatment (if applicable) and the approximate claim amount for all individuals. Please use another sheet if necessary.

_____

_____

_____

_____

_____

_____

PLAN INFORMATION

Requested effective date of plan: ___/___/___ Requested anniversary date of plan: ___/___/___

Initial open enrollment period: ___/___/___ to ___/___/___

Standard open enrollment period: ☐ 31 days prior to anniversary date ☐ Other _____

Plan Selection(s):

☐ Medical ☐ $500 Deductible Plan ☐ $1,000 Deductible Plan ☐ $5,000 Deductible Plan
☐ $750 Deductible Plan ☐ $2,000 Deductible Plan

☐ Rx ☐ $10-$20-$50 Copay Plan ☐ $15-$25-$60 Copay Plan ☐ $20-$35-$75 Copay Plan

☐ Life/AD&D ☐ Flat amount $_____ per employee ☐ Salary based _____ times annual salary

☐ Dependent Life ☐ Low *($5k - $2.5k - $1k)* ☐ High *($10k - $5k - $2.5k)*

Does this plan replace other coverage? ☐ No ☐ Yes

If yes, list coverage(s) and carrier name(s):

Coverage(s)	*Carrier*

EMPLOYER DECLARATION AND REQUEST FOR PARTICIPATION

I, the undersigned, understand and agree to the following…

1) This application is for the health care coverage offered by AgBenefits. It will form a part of any agreement issued in reliance upon it.
2) Acceptance of this group for coverage and the final rates are based upon the information contained herein and the census of actual enrollees. Any material misrepresentation, whether intentional or unintentional, will permit AgBenefits to terminate such coverage and to pursue all other legal remedies available.
3) By signing this application, I hereby adopt the Trust Agreement of AgBenefits (the Trust) and I hereby agree to be bound by all the terms, provisions, conditions and limitations of the Trust, including any amendments thereto. A copy of the Trust Agreement will be provided to me upon written request. Further, I hereby accept the Contract Administrator as designated by the Trust.
4) Any existing coverage presently being provided to employees should not be canceled until written approval of this application has been received.
5) Only those employees who meet the eligibility requirements (including the Statement of Health, if required) are to be included. It is my responsibility to offer coverage to all eligible employees and their eligible family members. I will provide to AgBenefits an enrollment form or a waiver of coverage form signed by each employee within 30 days of his/her hire date and collect any employee contribution(s) toward any payment/premium due. My group must maintain minimum participation and contribution levels for the coverage to continue under this agreement.
6) Contributions will include costs of benefits, administration and expenses of the Trust and any additional assessment determined by the Trustees as necessary to maintain the financial integrity of the Trust or its benefit plan(s), as provided in the Trust agreement.
7) A one-month deposit is being submitted with this application, to be held without obligation, until this application is approved. If the application is approved, the deposit will be applied to the first month's premium/fees under this agreement. If coverage does not become effective, the deposit will be refunded.
8) The obligation to participate in the Trust is on a plan year basis. If I withdraw from participating in the Trust or if my participation is terminated for failure to pay the required contribution for participation, the Trust will have no further obligation or liability to me or my covered participants for plan benefits or any claim on the Trust funds as of the date of withdrawal or termination. If claims have been incurred by my covered participants prior to that date, I will be solely liable for those claims and the Trust will have no liability for such claims, either to me, my covered participants or any third party claimant.
9) Premium credit for retro-active termination of plan members is limited to 30-days.
10) Plan year renewals will be delivered to the group 45 days before renewal date, if decision is not received by the Contract Administrator by the 15th of the month prior to renewal, the plan will auto-renew with quoted renewal rates.
11) My representative has explained the coverages, limitations, exclusions and other details of the coverage for which I applied.

Name: Title: Company:

Signature: Date:

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