MercyCare Health Plans™

MercyCare Insurance Company
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EMPLOYER GROUP APPLICATION

For coverage consideration by MercyCare Insurance Company and/or MercyCare HMO, Inc.

UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR NOTICE OF APPROVAL BY THE UNDERWRITING DEPARTMENT.

YOU, the Employer (Policyholder), intend to establish and sponsor an Employee Benefit Plan, which will be governed by the Employee Retirement Security Act of 1974 (ERISA).

YOU understand and agree that the Policyholder is not an insurer with respect to paying claims for benefits under this Policy.

For YOU to remain eligible under this Policy, the following participation requirements must be maintained for all coverage. Failure to maintain participation requirements may result in termination of YOUR coverage under the Policy. Other termination provisions are stated in the Policy.

YOU must meet the following participation requirements:

a. For groups with more than 10 employees, 70% participation of employees eligible for medical insurance benefits.
b. For groups with less than 11 employees:

Eligible Employees	Participating Employees
2 to 4	2
5 to 6	3
7	4
8 to 9	5
10	6

The following employees do not count as eligible employees for determining minimum participation requirements:

(a) Employees with continuous coverage under YOUR prior health insurance policy; or
(b) Employees with qualifying coverage (unless the group has 10 or less eligible employees and the qualifying coverage is another plan you sponsor).

Qualifying coverage means a group health plan; health insurance; Medicare; Medicaid; a medical care program of the armed forces of the United States, the federal Indian health service, or an American Indian tribal organization; a state health benefits risk pool; a health insurance program for federal government employees and their dependents; a public health plan as defined by the federal department of health and human services; and the health coverage plan for Peace Corps volunteers.

Creditable coverage does not include the limited or special purpose coverage excluded by law, such as accident-only, disability income, workers compensation, auto medical payment, credit-only, dental or vision benefits offered separately, specified illness, hospital or other fixed indemnity, and Medicare supplement.

YOU are required to contribute at least 50% of single coverage and 25% of all other coverage.

Print in black/blue ink

SECTION A – GENERAL EMPLOYER INFORMATION

1. Exact legal name of Employer (Policyholder): _____
2. Name of D/B/A (doing business as): _____
3. County: _____ Federal Tax ID # _____
4. Street Address: _____ City: _____ State: _____ Zip Code: _____
5. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
6. Phone Number: ( ) _____ Fax Number: ( ) _____
7. Website: _____
8. Is this group associated or affiliated with any other group insured by us? NO ☐ YES ☐

   If Yes, List name (s) and how affiliated: _____
9. Is this coverage part of a union negotiated agreement? NO ☐ YES ☐ Date of Expiration: _____
10. Nature of Business: _____ SIC Code: _____
11. How long has this legal entity been doing business? _____
12. Employer Administrative Contact Person: _____ Title: _____
13. Contact email address: _____
14. Employer Corporate Contact Person: _____ Title: _____

SECTION B – PLAN INFORMATION

1. Active employees who work on a permanent basis and with a normal workweek of 30 or more hours are eligible. Persons who work on a temporary, seasonal (temporary) or substitute basis are not eligible for coverage.

   Number of eligible employees: _____ Total number of employees on payroll: _____
2. If your hourly requirement varies from 30 hours or more per week and you have 15 or more employees selecting medical coverage, you may reduce the hourly requirement to not less than 25 hours per week. Indicate hourly requirement: _____
3. Do you currently have any former employees who have elected and are covered under COBRA – Consolidated Omnibus Budget Reconciliation Act/State Continuation? NO ☐ YES ☐ If Yes, indicate names of individuals and their expiration dates: _____
4. Do you currently have a Workers' Compensation Policy? NO ☐ YES ☐ If Yes, please provide name of carrier and the expiration date of the policy: _____
5. Do you wish to have 24 hour coverage for owners or partners not covered by Workers' Compensation? NO ☐ YES ☐
   If Yes, please provide name(s): _____
6. Is this a replacement of your current group coverage? NO ☐ YES ☐
   If YES, you must furnish the following information:

   a) Name of current group carrier: _____ b.) Include your most recent billing statement.

   If NO, have you requested medical coverage in the last 12-months? NO ☐ YES ☐

   If YES, from whom? _____
7. Percentage (%) of premium contributed by Employer: (you are required to contribute at least 50% of single coverage and 25% of all other coverage.)

   Single _____% Employee/Spouse _____% Employee/Child(ren) _____% Family _____%

8. Probationary Period for new employees: ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ 90th day* ☐ Other_____

   Effective Date for new employees:
   ☐ First day of the month following the probationary period. *Not an option if selecting 90th day
   ☐ First day following the probationary period. *Not an option if selecting 90th day
   ☐ Date of Hire

9. Termination Date for Terminated Employees:
   ☐ Last day of the month of termination date
   ☐ Date of termination

10. Do all classes of employees serve the same probationary period? ☐ Yes ☐ No

    If "no", please list each class and their probationary period requirements:_____

11. Is the probationary period the same for employees in the following situations?

    Changing from Part-time to Full-time:

    ☐ Yes ☐ No If "no" please explain eligibility guidelines _____

    Return from leave of absence:

    ☐ Yes ☐ No If "no" please explain eligibility guidelines_____

    Return from layoff:

    ☐ Yes ☐ No If "no" please explain eligibility guidelines_____

    Rehire:

    ☐ Yes ☐ No If "no" please explain eligibility guidelines _____

12. Are you requesting domestic partner coverage? (Large group only): ☐ Yes ☐ No

13. Requested effective date: _____ Please note: Coverage will only be effective upon written notification from MercyCare Health Plans.

14. Is there a current HRA or HSA plan in place? ☐ Yes ☐ No If "yes" please provide a copy of this plan.

15. Do you require a claims feed to a third party vendor? ☐ Yes ☐ No If "yes", please provide name of vendor and contact information_____.

SECTION C – BENEFITS

MERCYCARE HMO	MERCYCARE EPO
☐ Full Pay with $_____ Copay ☐ CO-90 with $_____ Deductible ☐ CO-80 with $_____ Deductible ☐ CO-70 with $_____ Deductible ☐ CO-60 with $_____ Deductible ☐ H.S.A. with $_____ Deductible	☐ Full Pay with $_____ Copay ☐ CO-90 with $_____ Deductible ☐ CO-80 with $_____ Deductible ☐ CO-70 with $_____ Deductible ☐ CO-60 with $_____ Deductible ☐ H.S.A. with $_____ Deductible
☐ 4 Tier $10/$25/$50/50% ☐ 4 Tier $20/$40/$75/50% ☐ 4 Tier $20/$50/$100/50% ☐ Other	☐ Full Pay with $_____ Copay ☐ dual choice ☐ CO – 90/70 with $_____ Deductible ☐ dual choice ☐ CO – 80/60 with $_____ Deductible ☐ dual choice ☐ CO – 70/50 with $_____ Deductible ☐ dual choice ☐ CO – 60/40 with $_____ Deductible ☐ dual choice ☐ H.S.A. with $_____ Deductible ☐ dual choice
OTHER PLAN OPTION (specify):	

SECTION D – EMPLOYER AGREEMENT

You, the employer (Policyholder), understand and agree that the first month's estimated premium (for groups of less than 51 lives), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application BEFORE action is take on the application. Insurance coverage is not in effect unless and until you receive written notification from us.

UNDER NO CIRCUMSTANCES SHOULD YOU CANCEL YOUR PRESENT GROUP INSURANCE COVERAGE WITHOUT PRIOR NOTICE OF APPROVAL BY MERCYCARE HEALTH PLANS.

Dated On: _____ By: _____

(Month, Date, Year) (Employer signature)

Dated At: _____ _____

(City and state) (Title)

SECTION E – AGENT/AGENCY INFORMATION

(To be completed by agent only. Please print.)

AGENT OF RECORD (Agent/Agency to receive commissions)

Social Security/Tax ID Number: _____

Agency: _____

Agent completing application: _____

Phone: _____ Fax: _____

Street: _____ Mailing: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

You, the agent, certify that you have met with the Employer submitting this application and that you have fully explained its contents. You have discussed coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions.

DATE: _____ **AGENT'S NAME:** _____

(*Please print)*

AGENT'S SIGNATURE _____