

EMPLOYER GROUP APPLICATION

FOR SMALL GROUP [1 TO 100 EMPLOYEES]

Effective 4.1.19

EMPLOYER NEW BUSINESS CHECKLIST

All documentation must be submitted to WHA by the 5th of the month (or following business day) in order to guarantee that month's effective date.

- Employer Group Application for Small Group
- For Employers: a copy of the most recent Quarterly Contribution Return and Report of Wages (Continuation) (DE 9C); a copy of the prior carrier premium statement may be submitted in lieu of the DE9C
- Owners who are not listed on the DE 9C or payroll report will need to sign the WHA Owner Statement
- Enrollment/Change Form for each enrollee
- HealthEquity HSA Authorization Form, if applicable
- Declination of Coverage Form for each eligible employee who declines group health coverage for themselves and/or their dependents
- Copy of rate quote
- A payment for the first month's premium on company check stock or via e-check (electronic funds transfer option is available once the group has been installed)

Western
Health
Advantage



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SMALL GROUP EMPLOYER APPLICATION

Becomes part of the Group Agreement

Company Name _____ **Group #** _____ (office use)
 Business Address _____ Subgroup/Class (office use) _____
 City, State, Zip _____ Requested Effective Date _____
 Company Website _____ Federal Employer ID # _____
 Billing/Mailing Address _____ County _____
 City, State, Zip _____ Years in Business _____
 CEO or Proprietor _____ Type of Industry _____
 Benefits Administrator _____ Title _____
 Phone _____ Fax _____
 Email Address _____

OTHER MEDICAL COVERAGE

List additional medical carrier(s) to be offered:

Carrier _____ HMO PPO
 Plans offered: Platinum Gold Silver Bronze

Carrier _____ HMO PPO
 Plans offered: Platinum Gold Silver Bronze

PREVIOUS MEDICAL COVERAGE

List any medical carrier(s) previously offered:

Carrier _____ HMO PPO
 Plans offered: Platinum Gold Silver Bronze

Carrier _____ HMO PPO
 Plans offered: Platinum Gold Silver Bronze

OR No Prior Coverage

MEDICAL PLANS

Groups with one to two enrolled employees: Choose one plan

Groups with three or more enrolled employees: Choose up to three plans: one HSA-compatible high-deductible plan per metal tier

TRADITIONAL	GATEWAY SERIES	CAPITAL SERIES
	<input type="checkbox"/> Gateway 20 Platinum 90 HMO	<input type="checkbox"/> Capital 15 Platinum 90 HMO
	<input type="checkbox"/> Gateway 30 Platinum 90 HMO	<input type="checkbox"/> Capital 30 Gold 80 HMO
	<input type="checkbox"/> Gateway 70 Platinum 90 HMO	
DEDUCTIBLE	GATEWAY SERIES	CAPITAL SERIES
	<input type="checkbox"/> Gateway 4010 Gold 80 HMO	<input type="checkbox"/> Capital 2000 Silver 70 HMO
	<input type="checkbox"/> Gateway 4020 Gold 80 HMO	<input type="checkbox"/> Capital 6300 Bronze 60 HMO
	<input type="checkbox"/> Gateway 5020 Silver 70 HMO	
HSA-COMPATIBLE* HIGH-DEDUCTIBLE	GATEWAY SERIES	CAPITAL SERIES
	<input type="checkbox"/> Gateway 2000 Gold 80 HDHP HMO	<input type="checkbox"/> Capital 2500 Silver 70 HDHP HMO
	<input type="checkbox"/> Gateway 1500 Silver 70 HDHP HMO	
	<input type="checkbox"/> Gateway 6500 Bronze 60 HDHP HMO	

*Employees will receive a complimentary HealthEquity health savings account (HSA) as an added benefit if employer elects an HSA-compatible high-deductible plan. Employer declines the HealthEquity HSA (check only if declining)

OPTIONAL RIDER PLANS

INFERTILITY available to all groups with 20 or more eligible employees

VISION available to all groups with 2 or more enrolled employees
 indicate plan choice: **Eyewear Only (EO) Plans** EO \$0 Copay EO \$10 Copay
Full Service (FS) Plans FS \$0 Copay FS \$10 Copay

ADULT DENTAL available to all groups
 indicate plan choice: **PPO Plan** Delta Dental PPOSM **DHMO Plan** DeltaCare[®] USA

ENROLLMENT / PAYMENT PROVISIONS

Company Name _____ Group # _____ (office use)

Are all employees eligible for this plan covered by Worker's Compensation? Yes No – Explain _____

Are your benefits subject to ERISA regulation? Yes No

EMPLOYEE COUNTS

_____ Total number of full-time and full-time equivalent employees*

_____ Number of eligible employees

_____ Number of employees enrolling in WHA (employees declining all group coverage should complete Declaration of Coverage form)

*Employee counts must be determined by the employer consistent with California Health & Safety Code Section 1357.500 et seq., 45 CFR 155.20, and all other applicable statutes and regulations.

CONTINUATION COVERAGE

Employer is responsible for contacting current carrier to obtain name(s) and address(es) of current COBRA participants.

Please indicate number of current COBRA participants _____ (attach list)

Is employer required to offer: Cal-COBRA Federal COBRA

ELIGIBILITY REQUIREMENTS

A bona fide employee/employer relationship must be maintained; that is, the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona fide employer/employee relationship.

Eligible employees shall be active, full-time employees who work at least:

20 hours or more per week 30 hours or more per week Other _____

CATEGORIES OF ELIGIBILITY

Dependents (spouse, CA registered domestic partner, child(ren) up to age 26)

Domestic Partners (non-registered domestic partner: attach notarized Declaration of Domestic Partner Form with enrollment form)

Retired Beneficiaries (subject to approval, attach retiree policy)

COMMENCEMENT OF COVERAGE

1st month following Date of Hire

1st month following 30 days from Date of Hire

1st of the month following 60 days from Date of Hire

Other (attach description)

Note: All terminations are effective the last day of the month in which employee ceases to be eligible under group eligibility provisions.

EMPLOYER CONTRIBUTION

Employee Only \$ _____ or _____% of Rate

Dependents \$ _____ or _____% of Rate

Note: Employer must contribute a minimum of 50% of the employee's premium of the lowest cost plan offered by WHA. Any other contribution arrangements are subject to WHA underwriting approval.

ENROLLMENT / PAYMENT PROVISIONS

Company Name _____ Group # _____ (office use)

BROKER INFORMATION

- Existing Broker
- New Broker (must complete Agent Agreement)

Broker name: _____ Phone: _____

Agency: _____ Fax: _____

WHA Broker #: _____ Use broker-specific ID number if producer is to be listed on account

Email: _____

General Agent: _____ WHA Agency Number for General Agent: _____

COMMENTS

PREPAYMENT REQUIREMENTS

Monthly prepayment fees are due and payable in full on the first day of each calendar month for which services are provided. If payment is not received from the employer, coverage for enrollees will be terminated on the last day of the month for which prepayment fees were received. Any other payment arrangements require prior approval.

EMPLOYER STATEMENT

We wish to enroll our organization as an employer group with Western Health Advantage. We understand the eligibility rules, employee counting rules and prepayment fee requirements. Employer contribution and employee participation requirements have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Service Agreement and shall become a part thereof. WHA reserves the right to terminate group coverage or the coverage for any individual member if the employer or individual member has made any material misrepresentation.

Signature: _____ Date: _____

Print Name: _____ Title: _____

BROKER STATEMENT

I certify that: all the information contained in this application is correct to the best of my knowledge; the applicant is a bona fide business establishment; participation requirements have been met; and all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

Broker Signature: _____ Date: _____

WHA APPROVAL

Sales Approval: _____ Date: _____

Sales Team Assignment: _____ Date: _____