



**Landmark Healthplan of California, Inc.**  
 2629 Townsgate Road, Suite 235  
 Westlake Village, CA 91361  
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## Group Application – Voluntary Plans

PLEASE PRINT

Coverage Effective Date \_\_\_\_\_

### EMPLOYER INFORMATION

Group Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### Eligibility and Service Contact:

Name \_\_\_\_\_

Title \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

**Billing Contact:** ☐ Check if same as Eligibility and Service Contact

Name \_\_\_\_\_

Title \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

E-mail \_\_\_\_\_

#### Billing Address – If different from street address:

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Multi-Employer Groups (Please provide a copy of trust agreement and/or bylaws)

☐ Association ☐ PEO ☐ Trust ☐ Other (Please Specify) \_\_\_\_\_

### NATURE OF BUSINESS

Description \_\_\_\_\_

### BENEFIT PLAN

#### Plan 1: Group Voluntary

- ☐ Chiropractic Plan  
 \$25 Copayment

#### Office Visits:

- ☐ 10 Visits per plan year  
☐ 15 Visits per plan year  
☐ 20 Visits per plan year

Employer may offer more than one plan, but each plan offered must have a minimum of two employees enrolled.

#### Plan 2: Group Voluntary

- ☐ Acupuncture Plan  
 \$35 Copayment

#### Office Visits:

- ☐ 10 Visits per plan year  
☐ 15 Visits per plan year  
☐ 20 Visits per plan year

Employer may offer more than one plan, but each plan offered must have a minimum of two employees enrolled.

### RATES

#### Plan 1:

Employee Only: \$ \_\_\_\_\_

Employee + One: \$ \_\_\_\_\_

Employee + Family: \$ \_\_\_\_\_

#### Plan 2:

Employee Only: \$ \_\_\_\_\_

Employee + One: \$ \_\_\_\_\_

Employee + Family: \$ \_\_\_\_\_

<b>ENROLLMENT SUMMARY</b> <i>(Enrolled members must have a major medical plan in place to be eligible)</i>		
Total # of employees	Total # of employees eligible for medical benefits	Employees to be enrolled in Landmark Healthplan
<b>CURRENT MEDICAL CARRIER(S)</b> <i>(Enrolled members must have a major medical plan in place to be eligible)</i>		
Carrier(s)	# Employees enrolled	Will Landmark coverage be provided to these employees? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>NEW EMPLOYEE WAITING PERIOD</b>		
<b>Options – select one:</b> <input type="checkbox"/> 1 <sup>st</sup> of the month following _____ days/months <i>(circle one)</i> from the date of hire <input type="checkbox"/> Date of hire <input type="checkbox"/> Other <i>(please be specific)</i> _____		
<b>TERMINATED EMPLOYEE COVERAGE</b>		
<b>Options – select one:</b> <input type="checkbox"/> Covered through the last day in the month of termination <input type="checkbox"/> Date of termination <input type="checkbox"/> Other <i>(please be specific)</i> _____		
<b>COBRA</b>		
How many COBRA participants are enrolling? _____ Your Group is: (circle one) Federal COBRA Cal-COBRA COBRA enrollment applications need to be identified as such by writing "COBRA" in large letters in the top portion of the application. Please indicate COBRA eligibility date and duration for the employee and all dependents.		
<b>DEPENDENT ELIGIBILITY</b>		
Per the provisions of the Patient Protection and Affordable Care Act of 2010, children of eligible subscribers are eligible until the age of twenty-six.		
<b>PREMIUM PAYMENT</b>		
Employer agrees to pay premiums to Landmark Healthplan when invoiced.		
<b>BROKER INFORMATION</b>		
Broker Name _____ Agency Name _____ Commissions to be paid to <input type="checkbox"/> Individual <input type="checkbox"/> Agency    Tax ID # _____ Phone _____ Fax _____ E-mail _____ Street _____ Landmark Broker ID: _____ City _____ State _____ Zip _____ Dept. of Insurance License # _____ Landmark Healthplan Sales Rep _____ General Agent (if applicable) _____		
<b>PAYMENT FOR FIRST MONTH'S COVERAGE</b> <i>(Please make checks payable to Landmark Healthplan)</i>		
The Group herewith tenders the amount of \$ _____ <i>(Premium and rate quotes are subject to change until Group and Landmark Healthplan execute a Group Agreement.)</i> and, in consideration of approval of this application and in the event of such approval, promises to pay Landmark Healthplan, as appropriate, any balance necessary to constitute the full initial payment for the group benefits herein identified. <b>By executing this application, Group hereby accepts and agrees to all of the terms and conditions contained in the Group Agreement which is incorporated herein by this reference.</b>  Signature of Responsible Party _____  Print Name and Title _____		