

Employer Group Application

FOR LARGE GROUP [101+ EMPLOYEES]



westernhealth
ADVANTAGE

SUBMIT COMPLETED FORMS TO:

Mail to: Western Health Advantage
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.1338
Email to: whasales@westernhealth.com
Call: 916.563.2206, 888.442.2206 toll-free or 711 for TTY

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 Large Group
- Enrollment/Change Form for each enrollee (if setting up EDI file transfer, contact WHA Sales to initiate the process)
- HealthEquity HSA Authorization Form, if applicable
- Copy of rate quote
- Declination of Coverage Form for each eligible employee who declines group health coverage for themselves and/or their dependents (employer may retain on file)
- A payment for the first month's premium on company check stock or via e-check (complete form; auto-pay option is available once the group has been installed)

COMPANY INFORMATION

Company Name_____ Group #_____ (office use)

Federal Tax ID_____ Requested Effective Date_____

Business Address_____

City, State, Zip_____ County_____

Billing/Mailing Address_____

City, State, Zip_____

For multiple billing locations, please submit Group Structure Form.

Type of Industry_____ Website_____

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

Are your benefits subject to ERISA regulation? Yes No

Employer Form 5500: Plan Name_____ Plan Number (3 digit code)_____

GROUP ACCOUNT CONTACTS

CEO or other Company Officer_____

BENEFITS ADMINISTRATOR

Name_____

Phone_____

Title_____

Email_____

BILLING CONTACT (if different from Benefits Administrator)

Name_____

Phone_____

Title_____

Email_____

FEDERAL COBRA ADMINISTRATOR

TPA_____

Phone_____

Contact Name_____

Email_____

COBRA billing statement to be sent to:

- Group Administrator
- COBRA Administrator
(complete Group Structure Form)

MEDICAL CARRIER(S) OFFERED

Does the employer offer other coverage? Yes No

If yes, list the carriers and type of coverage offered:

Carrier _____ HMO PPO

Carrier _____ HMO PPO

WHA will be sole carrier

PREVIOUS MEDICAL CARRIER(S)

Did the employer offer coverage previously? Yes No

If yes, list the previous carriers and type of coverage offered:

Carrier _____ HMO PPO

Carrier _____ HMO PPO

MEDICAL AND PRESCRIPTION PLANS

Choose medical and pharmacy plan options: only one HSA-compatible high-deductible plan (HDHP) can be offered within the same eligibility class

TRADITIONAL PLANS

Select a medical plan and write in selected prescription plan:

Rx **Classic** (\$10/30/50/100)

Rx **Plus** (\$15/30/50/100 ded)

Rx **Base** (\$15/50/75/250)

Premier 0/10/0 HMO Prime + Rx_____

Premier 0/15/0 HMO Prime + Rx_____

Premier 0/20/0 HMO Prime + Rx_____

Premier 0/40/0 HMO Prime + Rx_____

Advantage 0/15/250 HMO Prime + Rx_____

Advantage 0/20/250A HMO Prime + Rx_____

Advantage 0/25/500A HMO Prime + Rx_____

Advantage 0/20/500 HMO Prime + Rx_____

Advantage 0/20/30% HMO Prime + Rx_____

Advantage 0/40/30% HMO Prime + Rx_____

DEDUCTIBLE PLANS

Select a medical plan and write in selected prescription plan:

Rx **Classic** (\$10/30/50/100)

Rx **Plus** (\$15/30/50/100 ded)

Rx **Base** (\$15/50/75/250)

Western 1000/20/20% HMO Prime + Rx_____

Western 1000/40/500 HMO Prime + Rx_____

Western 2500/20/500 HMO Prime + Rx_____

Western 2500/40/500 HMO Prime + Rx_____

Western 2500/0/30% HMO Prime + Rx_____

Western 1500/20/20% HMO Prime + Rx_____

Western 2500/20/20% HMO Prime + Rx_____

Western 3000/30%/30% HMO Prime + Rx_____

Western 4500/50/40% HMO Prime + Rx_____

HSA-COMPATIBLE HIGH-DEDUCTIBLE PLANS (HDHP)

Select a medical plan – prescription benefits are included

Western 1800/0/0 HDHP HMO Prime

Western 2800/0/0 HDHP HMO Prime

Western 2800/40/500 HDHP HMO Prime

Western 3000/30/30% HDHP HMO Prime

Western 4000/40%/40% HDHP HMO Prime

Western 5500/0/0 HDHP HMO Prime

HealthEquity HSA — a complimentary health savings account (HSA) as an added benefit to an HDHP with WHA

OPTIONAL BENEFIT PLANS

Available with all medical plans; check box next to elected plan(s)

Wellness Coaching Healthy Lifestyle Program, includes:
Real Appeal Weight Loss
Quit for Life
Maven Family Support

Hearing Aid Plans Choice (\$1,000 allowance)
 Select (\$699 or \$999 copayment)

Vision Plans 12/12/24 \$0
 12/24/24 \$20

Enrollment / Payment Provisions

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 Declination 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/CalCOBRA participants _____ (attach list)

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 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 (expanded eligibility class for non-registered domestic partner: attach 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

BROKER INFORMATION

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

Broker name: _____ Phone: _____

Agency: _____ Email: _____

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

Account manager or service team contact: _____

Commission: Flat _____ % Other _____

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 (office use)

Group Approval: _____ Date: _____

Sales Team Assignment: _____ Date: _____