



Landmark Healthplan of California, Inc.

2629 Townsgate Rd., Suite 235, Westlake Village, CA 91361

P: 800-298-4875 | F: 916-307-5250 | E: Sales@LHP-CA.com

Group Application

PLEASE PRINT or TYPE

Effective Date: / /

Employer/Group Contact Information	
Group Name: <input type="text"/>	Primary Billing Contact: <input type="checkbox"/> Same as Eligibility & Service Contact
Address: <input type="text"/>	Name: <input type="text"/>
City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/>	Title: <input type="text"/>
Eligibility & Service Contact:	Phone: <input type="text"/> Fax: <input type="text"/>
Name: <input type="text"/>	E-mail: <input type="text"/>
Title: <input type="text"/>	Secondary Billing Contact: (Optional)
Phone: <input type="text"/> Fax: <input type="text"/>	Name: <input type="text"/>
E-mail: <input type="text"/>	Phone: <input type="text"/> Fax: <input type="text"/>
Billing Address: (Complete if different from Company Address)	E-mail: <input type="text"/>
Address: <input type="text"/>	Billing Distribution: (Select Only One)
City: <input type="text"/> State: <input type="text"/> Zip: <input type="text"/>	<input type="checkbox"/> E-mail Invoice (Free) <input type="checkbox"/> Mail Paper Invoice (\$2/mo.)
Nature of Business	Employer Group Organization
Discription: <input type="text"/>	<input type="checkbox"/> Single Employer <input type="checkbox"/> Multi-Employer Association
Standard Industrial Classification (SIC) Code: <input type="text"/>	<input type="checkbox"/> Labor/Trust Group <input type="checkbox"/> P.E.O.
Benefit Plans and Rates	
Plan 1	Plan 2
Plan Design: Visit Copay: \$ <input type="text"/> Annual Visits: <input type="text"/>	Plan Design: Visit Copay: \$ <input type="text"/> Annual Visits: <input type="text"/>
Benefit Type: <input type="checkbox"/> Chiropractic Only <input type="checkbox"/> Acupuncture Only (Check One) <input type="checkbox"/> Combined - Chiropractic and Acupuncture	Benefit Type: <input type="checkbox"/> Chiropractic Only <input type="checkbox"/> Acupuncture Only (Check One) <input type="checkbox"/> Combined - Chiropractic and Acupuncture
Herbal Rider: (Available on plans w/ Acupuncture Benefits) <input type="checkbox"/> \$5 copay per bottle/\$500 Annual Maximum	Herbal Rider: (Available on plans w/ Acupuncture Benefits) <input type="checkbox"/> \$5 copay per bottle/\$500 Annual Maximum
<input type="checkbox"/> MultiPlan Access for CA/OOS Employees (Members' primary residence is in California but member travels outside of California for work or to attend out-of-state school or member lives OOS.)	<input type="checkbox"/> MultiPlan Access for CA/OOS Employees (Members' primary residence is in California but member travels outside of California for work or to attend out-of-state school or member lives OOS.)
<input type="checkbox"/> California Fully-Insured Monthly Rate Tiers: EE Only: \$ <input type="text"/> EE+Child(ren): \$ <input type="text"/> EE+One: \$ <input type="text"/> EE+Family: \$ <input type="text"/>	<input type="checkbox"/> California Fully-Insured Monthly Rate Tiers: EE Only: \$ <input type="text"/> EE+Child(ren): \$ <input type="text"/> EE+One: \$ <input type="text"/> EE+Family: \$ <input type="text"/>
Self-funded ASO Monthly Fees: <input type="checkbox"/> ASO-OOS Plan - \$3.56 PEPM (Employees Outside of CA) <input type="checkbox"/> ASO-CA Plan - \$3.03 PEPM (CA Employees) <input type="checkbox"/> ASO-Nationwide - \$ <input type="text"/> PEPM (Enrolled Blended Rate)	Self-funded ASO Monthly Fees: <input type="checkbox"/> ASO-OOS Plan - \$3.56 PEPM (Employees Outside of CA) <input type="checkbox"/> ASO-CA Plan - \$3.03 PEPM (CA Employees) <input type="checkbox"/> ASO-Nationwide - \$ <input type="text"/> PEPM (Enrolled Blended Rate)

Employer Contribution

% Employee Premium % Dependent Premium (Minimum 50% Employee Contribution Required for Fully-Insured Plan)

Dependent Eligibility

Children are eligible up to their 26th birthdate. Children will be automatically terminated on the last day of the month in which they turn 26.
Disabled dependents will be eligible/continue eligibility upon the annual return of a completed Landmark Healthplan Disabled Over-Age Dependent form.

Enrollment Summary by Medical Carrier

Medical Plan Carrier(s) - If enrolling in a fully-insured Landmark plan, all employees and their dependents on the group-sponsored medical plan must enroll.		Total # Employees	# Enrolling in Landmark	Carve-out (Yes/No)
1)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TOTALS:		<input type="text"/>	<input type="text"/>	

New Employee Waiting Period

- ☐ Retro-active to the First of the Month of the Hire Date
☐ First of the Month Following Date of Hire
☐ First of the Month following Days from Date of Hire

Termination of Coverage

- ☐ Covered through the Last Day in the Month of Termination
☐ Other

COBRA Information

COBRA Status: ☐ Federal COBRA ☐ Cal-COBRA Current number of employees on COBRA enrolling in Landmark?

Broker Information

Broker Name: Agency Name:
 Commission to be paid to: ☐ Individual Agent or ☐ Agency/Brokerage Firm at Tax ID #:
 D.O.I. Health License #: Landmark Broker ID: Landmark Rep:
 Phone: Fax: E-mail:
 Address:
 City: State: Zip: -
 General Agent (if applicable):

Authorization and Monthly Premium/Fee Payments

The Group herewith tenders the amount of \$ (Premium and rate quotes are subject to change until Group and Landmark Healthplan execute a Group Agreement.) and, in consideration of approval of this application and in the event of such approval, promises to pay Landmark Healthplan of California, as appropriate, any balance necessary to constitute the full initial Payment for the group benefits herein identified. **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.** I (we) hereby Authorize Landmark Healthplan of California to initiate debits for monthly premiums from our ☐ Checking Account or ☐ Savings Account indicated below.

Financial Institution: Branch:
 City: State: Zip Code: -
 Routing Number: Account Number:
 Signature: Print Name:
 Date: / / Effective Date: / / Title: