# **Employer Group Application**

FOR SMALL GROUP [1 TO 100 EMPLOYEES]



#### **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

EMPI (	OVER	NFW F	RIICINIFCC	CHECKLIST

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

<ul><li>Employer Group Application for Small Group</li></ul>	HealthEquity HSA Authorization Form, if applicable				
☐ For Employers: a copy of the most recent Quarterly Contribution Return and Report of Wages (Continuation) (DE 9C); a copy of the prior carrier	<ul> <li>Declination of Coverage Form for each eligible employee who declines group health coverage for themselves and/or their dependents</li> </ul>				
premium statement may be submitted in lieu of the	Copy of rate quote				
DE9C	A payment for the first month's premium on				
<ul> <li>Owners who are not listed on the DE 9C or payroll report will need to sign the WHA Owner Statement</li> </ul>	company check stock or via e-check (electronic funds				
☐ Enrollment/Change Form for each enrollee	transfer 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	٦.				
Type of Industry	Website				
Are all employees eligible for this plan covered by Worker's Comp	ensation? 🗆 Yes 🚨 No – Explain				
Are your benefits subject to ERISA regulation? ☐ Yes ☐ No					
•	Plan Number (3 digit code)				
GROUP ACCOUNT CONTACTS					
CEO or other Company Officer					
BENEFITS ADMINISTRATOR	FEDERAL COBRA ADMINISTRATOR				
Name	TPA				
Phone	Phone				
Title	Contact Name				
Email	Email				
BILLING CONTACT	COBRA billing statement to be sent to:				
Name	☐ Group Administrator				
Phone Fitle	·				
ı ilic	□ COBRA Administrator				

(complete Group Structure Form)

MEDICAL CARRIER(S) OFFERED		PREVIOUS MEDICAL CARRIER(S)			
List additional medical carrier(s) to be offered	:	List any medical carrier(s) previously offered:			
Carrier	_ □ HMO □ PPO	Carrier	□ HMO □ PPO		
Plans offered: 🗆 Platinum 🖵 Gold 🗖 S	ilver 🖵 Bronze	Plans offere	d: 🗖 Platinum 🗖 Gold 🗖 Silver 🗖 Bronze		
Carrier	_ □ HMO □ PPO		□ HMO □ PPO		
Plans offered: ☐ Platinum ☐ Gold ☐ S	ilver 🗖 Bronze	Plans offere	d: 🗖 Platinum 🗖 Gold 🗖 Silver 🗖 Bronze		
☐ WHA will be sole carrier		OR ☐ No Prior Coverage			
MATERIAL DI ANG					
MEDICAL PLANS					
Groups with one to two enrolled employees	•				
metal tier	ees: May choose mult	tiple plans to offer; or	e HSA-compatible high-deductible plan per		
TRADITIONAL	GATEWAY SERIES		CAPITAL SERIES		
	☐ Gateway 20 Platinu	um 90 HMO	☐ Capital 20 Platinum 90 HMO		
	☐ Gateway 30 Platinum 90 HMO☐ Gateway 70 Platinum 90 HMO☐				
	☐ Gateway 40 Platinu	um 90 HMO			
DEDUCTIBLE	GATEWAY SERIES		CAPITAL SERIES		
	☐ Gateway 4010 Gol	d 80 HMO	☐ Capital 250 Gold 80 HMO		
	☐ Gateway 4020 Gol	d 80 HMO	☐ Capital 2500 Silver 70 HMO		
	☐ Gateway 5020 Silv	er 70 HMO	☐ Capital 6300 Bronze 60 HMO		
HSA-COMPATIBLE* HIGH-DEDUCTIBLE	GATEWAY SERIES		CAPITAL SERIES		
	☐ Gateway 2600 Gol	d 80 HDHP HMO	☐ Capital 2850 Silver 70 HDHP HMO		
	☐ Gateway 1600 Gol	d 80 HDHP HMO			
	☐ Gateway 7050 Bro	nze 60 HDHP HMO			
☐ HealthEquity HSA — a complimentary he	alth savings account (I	HSA) as an added ber	nefit to an HDHP with WHA		
OPTIONAL RIDER PLANS					
□ INFERTILITY	available to all groups with 20 or more eligible		ible employees		
☐ ADULT DENTAL	available to all group	_			
	☐ Delta Dental PPOs		JSA (DHMO plan)		

## **Enrollment / Payment Provisions**

EMPLOYEE COUNTS						
	Total number	r of full-time and full-t	ime equivalent emp	loyees*		
	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 dete 45 CFR 155.20, and all other ap			with California Health	n & Safety Cod	de Section 1	357.500 et seq.,
CONTINUATION COVERA	GE					
Employer is responsible for con	tacting current o	carrier to obtain name	e(s) and address(es) o	of current COE	RA participa	ants.
Please indicate number of curre	ent COBRA parti	icipants	(attach list)			
Is employer required to offer:	☐ Cal-COBRA	☐ Federal COBRA				
ELIGIBILITY REQUIREMEN	ITS					
A bona fide employee/employe the form of annual, monthly, we pursuant to which the employee bona fide employer/employee	eekly or hourly w r pays those pay	age. Further, the em	ployer and employee	e must maintai	in an employ	yment relationship
Eligible employees shall be acti	ive employees w	vho work at least:				
☐ 20 hours or more per week	□ 30 hours o	r more per week	☐ Other			
CATEGORIES OF ELIGIBILI	TY					
☐ Dependents (spouse, CA reg	istered domesti	c partner, child(ren) u	p to age 26)			
☐ Domestic Partners (expanded enrollment form)	d eligibility class	for non-registered do	omestic partner: atta	ch Declaration	ı of Domesti	ic Partner Form with
☐ Retired Beneficiaries (subject	to approval, att	ach retiree policy)				
COMMENCEMENT OF CO	VERAGE		EMPLOYER COI	NTRIBUTION	J	
☐ 1st month following Date of I	Hire		☐ Employee Only	\$	or	% of Rate
☐ 1st month following 30 days	from Date of Hir	re	■ Dependents	\$	_ or	% of Rate
☐ 1st of the month following 60	days from Date	e of Hire	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.		of 50% of the	
☐ Other (attach description)						
Note: All terminations are effect in which employee ceases to be					ect to WHA	

(office use) Region: □ 1 □ 2 □ 3 □ OOA

provisions.

# **Enrollment / Payment Provisions**

### **BROKER INFORMATION**

<ul><li>□ Existing Broker</li><li>□ New Broker (must complete Agent Agreement)</li></ul>	
,	Phone:
	Email:
	Use broker-specific ID number if producer is to be listed on account
Account manager or service team contact:	Email:
General Agent:	WHA Agency Number for General Agent:
COMMENTS	
PREPAYMENT REQUIREMENTS	
	ne first day of each calendar month for which services are provided.  r enrollees will be terminated on the last day of the month for which gements require prior approval.
EMPLOYER STATEMENT	
employee counting rules and prepayment fee requirement	with Western Health Advantage. We understand the eligibility rules, is. Employer contribution and employee participation requirements have intained in order for the account to remain eligible for coverage.
issuance of coverage under the Group Service Agreement	atements are true and complete. This application shall be the basis for the and shall become a part thereof. WHA reserves the right to terminate group employer or individual member has made any material misrepresentation.
Signature:	Date:
Print Name:	Title:
BROKER STATEMENT	
business establishment; participation requirements have be	on is correct to the best of my knowledge; the applicant is a bona fide een met; and all coverages, enrollment provisions, eligibility requirements, plained to the employer. I recommend that such coverage be offered and
Broker Signature:	Date:
WHA APPROVAL (office use)	
Group Approval:	Date:
Sales Team Assignment:	Date: