Landmark Healthplan of California, Inc.
2629 Townsgate Road, Suite 235
Westlake Village, CA 91361
Phone: (800) 298-4875, Option 2
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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: $ _____

ENROLLMENT SUMMARY *(Enrolled members must have a major medical plan in place to be eligible)*

Total # of employees	Total # of employees eligible for medical benefits	Employees to be enrolled in Landmark Healthplan

CURRENT MEDICAL CARRIER(S) *(Enrolled members must have a major medical plan in place to be eligible)*

Carrier(s)	# Employees enrolled	Will Landmark coverage be provided to these employees?
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No

NEW EMPLOYEE WAITING PERIOD

Options – select one:

❑ 1st of the month following_____days/months *(circle one)* from the date of hire
❑ Date of hire
❑ Other *(please be specific)* _____

TERMINATED EMPLOYEE COVERAGE

Options – select one:

❑ Covered through the last day in the month of termination
❑ Date of termination
❑ Other *(please be specific)* _____

COBRA

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.

DEPENDENT ELIGIBILITY

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.

PREMIUM PAYMENT

Employer agrees to pay premiums to Landmark Healthplan when invoiced.

BROKER INFORMATION

Broker Name_____ Agency Name _____

Commissions to be paid to ❑ Individual ❑ 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)_____

PAYMENT FOR FIRST MONTH'S COVERAGE *(Please make checks payable to Landmark Healthplan)*

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, 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.**

Signature of Responsible Party _____

Print Name and Title _____