CLEAR Entire Form | CLEAR All Except Broker Information | SAVE Form | PRINT Form

Landmark Healthplan of California, Inc.
2629 Townsgate Road, Suite 235
Westlake Village, CA 91361
Phone: (800) 298-4875, option 5
Fax: (916) 307-5250
E-Mail: sales@LHP-CA.com

Group Application

PLEASE PRINT or TYPE

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 *(Offer one or two plans to your group, check ASO OOS Plan to cover employees outside of California.)*

Plan 1: ☐ MP Access (Internal Use)

Co-Pay Visits

☑ Insured Plan *(Fully-Insured CA only)*
☐ ASO OOS Plan *(Out-of-State Plan)*
☐ ASO CA Plan

Check both ASO plans for a National ASO plan.

Benefit Type:

☐ Chiropractic Only
☐ Acupuncture Only
☑ Combined – Chiropractic & Acupuncture

Herbal Rider: (Available only on Acupuncture plans.)

☐ $5 Co-pay/$500 Annual Max. Herbal Rider Benefit
☑ No Herbal Rider Benefit

Plan 2: ☐ MP Access (Internal Use)

Co-Pay Visits

☐ Insured Plan *(Fully-Insured CA only)*
☐ ASO OOS Plan *(Out-of-State Plan)*
☐ ASO CA Plan

Check both ASO plans for a National ASO plan.

Benefit Type:

☐ Chiropractic Only
☐ Acupuncture Only
☐ Combined – Chiropractic & Acupuncture

Herbal Rider: (Available only on Acupuncture plans.)

☐ $5 Co-pay/$500 Annual Max. Herbal Rider Benefit
☑ No Herbal Rider Benefit

RATES

Plan 1:	**CA Monthly Plan Rates**	**ASO OOS Fee**
Employee Only:	$_____	$_____ PEPM
Employee + One:	$_____	**ASO CA Fee**
Employee + Child(ren):	$_____	$_____ PEPM
Employee + Family:	$_____	

Plan 2:	**CA Monthly Plan Rates**	**ASO OOS Fee**
Employee Only:	$_____	$_____ PEPM
Employee + One:	$_____	**ASO CA Fee**
Employee + Child(ren):	$_____	$_____ PEPM
Employee + Family:	$_____	

ENROLLMENT SUMMARY *(All employees/dependents on group's medical plan must enroll in the Landmark plan)*

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

CURRENT MEDICAL CARRIER(S) *(Landmark enrollment must match medical enrollment)*

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

NEW EMPLOYEE WAITING PERIOD *(Must match medical plan waiting period)*

Options – select one:

☑ 1st of the month following ___30___ ___ days from the date of hire
☐ Date of hire
☐ Other *(please be specific)* _____

TERMINATED EMPLOYEE COVERAGE *(Must match medical plans)*

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? ___0___ Your Group is: ☐ 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/Employer Contribution *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.*

Employer Contribution toward Landmark Healthplan Premium for Employees _____%; Dependents_____% *(50% Employee Only Minimum)*

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) Word & Brown General Agency _____

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 _____

Intended Effective Date of Coverage _____ (Date Format: MM/DD/YYYY) Today's Date _____