EMPLOYER GROUP HEALTH APPLICATION

Employer Information

Employer Name ____________________ Requested Effective Date ______________

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other Years in Business ______________

Employer Tax ID # ______________________ E-mail ____________________________ Primary PPO Network ________________________

Street Address ____
Street County City State Zip Code

Mailing Address (if different) ____
Street County City State Zip Code

Contact ____________________________ Title ________________ Phone (include area code) ___________________ Fax _________________

Nature of Business _________________________ **SIC Code** ___________ Are affiliates/subsidiaries to be included? ☐ Yes ☐ No

If yes, name of affil./sub. ________________________________ City ______________ State ________ # of Employees __________

Waiting period for initial Employees _______________________
Waiting period for subsequent Employees ___________________

Employer Contribution Percentage For:
Medical Employee _____% Dependent _____%
Life Employee _____% Dependent _____%

Current group medical insurance? ☐ Yes ☐ No
Carrier ________________________ Account # ______________

Do you offer another medical plan? (i.e. HMO) ☐ Yes ☐ No
Carrier ________________________ Account # __________________________

Please indicate the carrier(s) you have been insured with in the last 5 years:
Carrier ______________________ Effective ________________ Terminated ___________
Carrier ______________________ Effective ________________ Terminated ___________
Carrier ______________________ Effective ________________ Terminated ___________
Carrier ______________________ Effective ________________ Terminated ___________

Workers Compensation Coverage:

Carrier ________________________
Account # ______________________

Schedule of Benefits

Please circle requested benefit level

Deductible $250 $500 $1,000 $1,500 $2,000 $5,000

Co-Insurance 90% 80% 70% 50%

Stop Loss $5,000 $10,000 $15,000 $20,000 $30,000

$20 PCP Co-Pay ☐ YES ☐ NO

$30 Specialist Co-Pay ☐ YES ☐ NO

Maternity ☐ YES ☐ NO
(Not Available For Groups with less than 5 covered employees)

Supplemental Accident ☐ YES ☐ NO

RX Card ☐ YES ☐ NO

If Yes, Please Check One Below

___ Plan B Generic Only (Name Brand drugs covered under medical, subject to annual deductible) ☐ YES ☐ NO
___ Plan H (10/25/50) or 20% Greater of
___ Plan D (10/50/100) or 20% Greater of
___ Plan E (10/25/50, $150 Annual Deductible) or 20% Greater of

If no RX Card: Drugs covered under medical coverage, subject to annual medical deductible?
☐ YES ☐ NO

Life Volume Selected
☐ Flat Amount For All Employees $_______________
($15,000 minimum) Maximum Life Amount ($50,000)

+ Life amounts will reduce to 65% at age 65, 42% at age 70, 27% at age 75, 18% at age 80, 12% at age 85, terminate at retirement.

Employer Information:

1. Total number of employees (including active Partners, Proprietors, and Corporate Officers) ___________________________
2. Number of eligible full time employees working 30 or more hours per week _____________________________
3. Number of employees ineligible because they are: Part-time ______ Seasonal _____ Covered under another group plan ________
   Other ________________________________ Explain ______________________________
4. Number of former employees / dependents on COBRA ______________________
5. Has the company employed 20 or more full-time and part-time employees for 20 or more weeks during the prior calendar year? ☐ Yes ☐ No

The Administrator is Advanced Insurance Brokerage and Administration, Inc. The Insurer of medical and life coverage applied for is _____________________________________. I, the undersigned employer, wish to become a participating employer. I am acquainted with the rules of eligibility and understand that the effective date of the insurance for which I am applying shall be subject to the written approval of the Administrator, acting on behalf of the Insurer. I understand that the benefits provided shall be subject to the terms of the group insurance policy(ies) as amended from time to time, and that these group insurance policies may be terminated by the Insurer following due notice. I agree to remit to the Administrator regularly, in advance, the required monthly premium contributions for insurance, and I understand that failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the 31-day grace period. I agree to offer the insurance to all present and future new employees who work for remuneration on a full-time basis. I also agree to maintain the participation requirements of the plan with respect to eligible employees and their eligible dependents in order to procure and continue the requested insurance and agree that any insurance issued as a result of this request may be cancelled as of any monthly premium due date if participation requirements are not maintained.

Dated at ____ on ____
City State Month Day Year

Employer's Legal Business Name ____

Employer's Signature ____ Title ___________________________________

Writing Agent

Name ____
Please Print

____
Street City State Zip

Telephone (Please include area code) _________________________________ Fax (please include area code)______________________

Agent's Statement

To the best of my knowledge all statements in the Employer Group Health Application, Group Insurance Enrollment Cards, and Health Statements are complete and true. My client has been advised by me not to terminate any existing coverage until receiving notice that the coverage being applied for is accepted. I agree that I have no right to bind this coverage, alter terms of the insurance contract or Employer Group Health Application, or adjust any claim for benefits under the insurance contract.

____
Agent's Signature Date

Check one: ☐ Social Security # ________________________________ ☐ Tax ID #___________________________________

Where would you like for us to send the PD's and ID Cards? ☐ Agent Address ____

Service Fees Payable to: ☐ Group Address ____

Advanced Insurance Administration, Inc.
1525 Merrill Drive, Suite 2000 Little Rock, AR 72211
Telephone: (501) 224-8269 Fax: (501) 312-4666

To be Completed by Administrator				
Underwriter	Effective Date	Policy #	Approval Date	Decline Date

Check Amount Received _________________ Check # __________

Agent Check List

Have you included:

- ☐ A copy of the quote for the plan applied for?
- ☐ Employer Group Health Application?
- ☐ Employee Enrollment forms? (No Faxed Copies)
- ☐ Current Insurance Bill plus original effective dates?
- ☐ Deductible Report if applicable?
- ☐ Quarterly Tax & Wage Report?
- ☐ E-Doc Services Agreement?
- ☐ TPA Agreement?
- ☐ Business check payable to Advanced Insurance Administration?