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

EMPLOYER NEW BUSINESS CHECKLIST

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

- ❑ Employer Group Application for Small Group
- ❑ For Employers: a copy of the most recent Quarterly Contribution Return and Report of Wages (Continuation) (DE 9C); a copy of the prior carrier premium statement may be submitted in lieu of the DE9C
- ❑ Owners who are not listed on the DE 9C or payroll report will need to sign the WHA Owner Statement
- ❑ Enrollment/Change Form for each enrollee
- ❑ HealthEquity HSA Authorization Form, if applicable
- ❑ Declination of Coverage Form for each eligible employee who declines group health coverage for themselves and/or their dependents
- ❑ Copy of rate quote
- ❑ A payment for the first month's premium on company check stock or via e-check (electronic funds 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.

Type of Industry_____Website_____

Are all employees eligible for this plan covered by Worker's Compensation? ❑ Yes ❑ No – Explain_____

Are your benefits subject to ERISA regulation? ❑ Yes ❑ No

Employer Form 5500: Plan Name_____ Plan Number (3 digit code)_____

GROUP ACCOUNT CONTACTS

CEO or other Company Officer_____

BENEFITS ADMINISTRATOR

Name_____
Phone_____
Title_____
Email_____

BILLING CONTACT

Name_____
Phone_____
Title_____
Email_____

FEDERAL COBRA ADMINISTRATOR

TPA_____
Phone_____
Contact Name_____
Email_____

COBRA billing statement to be sent to:

- ❑ Group Administrator
- ❑ COBRA Administrator
  (complete Group Structure Form)

MEDICAL CARRIER(S) OFFERED

List additional medical carrier(s) to be offered:

Carrier_____ ❑ HMO ❑ PPO
Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

Carrier_____ ❑ HMO ❑ PPO
Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

❑ **WHA will be sole carrier**

PREVIOUS MEDICAL CARRIER(S)

List any medical carrier(s) previously offered:

Carrier_____ ❑ HMO ❑ PPO
Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

Carrier_____ ❑ HMO ❑ PPO
Plans offered: ❑ Platinum ❑ Gold ❑ Silver ❑ Bronze

OR ❑ No Prior Coverage

MEDICAL PLANS

Groups with one to two enrolled employees: Choose one plan

Groups with three or more enrolled employees: May choose multiple plans to offer; one HSA-compatible high-deductible plan per metal tier

TRADITIONAL	GATEWAY SERIES	CAPITAL SERIES
	❑ Gateway 20 Platinum 90 HMO	❑ Capital 20 Platinum 90 HMO
	❑ Gateway 30 Platinum 90 HMO	
	❑ Gateway 70 Platinum 90 HMO	
	❑ Gateway 40 Platinum 90 HMO	
DEDUCTIBLE	**GATEWAY SERIES**	**CAPITAL SERIES**
	❑ Gateway 4010 Gold 80 HMO	❑ Capital 250 Gold 80 HMO
	❑ Gateway 4020 Gold 80 HMO	❑ Capital 2500 Silver 70 HMO
	❑ Gateway 5020 Silver 70 HMO	❑ Capital 6300 Bronze 60 HMO
HSA-COMPATIBLE* HIGH-DEDUCTIBLE	**GATEWAY SERIES**	**CAPITAL SERIES**
	❑ Gateway 2600 Gold 80 HDHP HMO	❑ Capital 2850 Silver 70 HDHP HMO
	❑ Gateway 1600 Gold 80 HDHP HMO	
	❑ Gateway 7050 Bronze 60 HDHP HMO	

❑ HealthEquity HSA — a complimentary health savings account (HSA) as an added benefit to an HDHP with WHA

OPTIONAL RIDER PLANS

❑ INFERTILITY — available to all groups with 20 or more eligible employees

❑ ADULT DENTAL — available to all groups

indicate plan choice: ❑ Delta Dental PPO℠ ❑ DeltaCare® USA (DHMO plan)

Enrollment / Payment Provisions

EMPLOYEE COUNTS

_____ Total number of full-time and full-time equivalent employees*

_____ 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 determined by the employer consistent with California Health & Safety Code Section 1357.500 et seq., 45 CFR 155.20, and all other applicable statutes and regulations.

CONTINUATION COVERAGE

Employer is responsible for contacting current carrier to obtain name(s) and address(es) of current COBRA participants.

Please indicate number of current COBRA participants _____ (attach list)

Is employer required to offer: ❑ Cal-COBRA ❑ Federal COBRA

ELIGIBILITY REQUIREMENTS

A bona fide employee/employer relationship must be maintained; that is, the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona fide employer/employee relationship.

Eligible employees shall be active employees who work at least:

❑ 20 hours or more per week ❑ 30 hours or more per week ❑ Other_____

CATEGORIES OF ELIGIBILITY

❑ Dependents (spouse, CA registered domestic partner, child(ren) up to age 26)

❑ Domestic Partners (expanded eligibility class for non-registered domestic partner: attach Declaration of Domestic Partner Form with enrollment form)

❑ Retired Beneficiaries (subject to approval, attach retiree policy)

COMMENCEMENT OF COVERAGE

❑ 1st month following Date of Hire

❑ 1st month following 30 days from Date of Hire

❑ 1st of the month following 60 days from Date of Hire

❑ Other (attach description)

Note: All terminations are effective the last day of the month in which employee ceases to be eligible under group eligibility provisions.

EMPLOYER CONTRIBUTION

❑ Employee Only $_____ or _____% of Rate

❑ Dependents $_____ or _____% of Rate

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.

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

Enrollment / Payment Provisions

BROKER INFORMATION

❑ Existing Broker

❑ New Broker (must complete Agent Agreement)

Broker name:_____ Phone:_____

Agency:_____ Email:_____

WHA Broker #:_____ 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

Monthly prepayment fees are due and payable in full on the first day of each calendar month for which services are provided. If payment is not received from the employer, coverage for enrollees will be terminated on the last day of the month for which prepayment fees were received. Any other payment arrangements require prior approval.

EMPLOYER STATEMENT

We wish to enroll our organization as an employer group with Western Health Advantage. We understand the eligibility rules, employee counting rules and prepayment fee requirements. Employer contribution and employee participation requirements have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Service Agreement and shall become a part thereof. WHA reserves the right to terminate group coverage or the coverage for any individual member if the employer or individual member has made any material misrepresentation.

Signature:_____ Date:_____

Print Name:_____ Title:_____

BROKER STATEMENT

I certify that: all the information contained in this application is correct to the best of my knowledge; the applicant is a bona fide business establishment; participation requirements have been met; and all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

Broker Signature:_____ Date:_____

WHA APPROVAL (office use)

Group Approval:_____ Date:_____

Sales Team Assignment:_____ Date:_____