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**GROUP MARKET - LARGE AND SMALL
EMPLOYER APPLICATION**

New Group Amendment Other

Section I – Employer Information

Employer name: (Full legal name)		Phone number:	
Contact name:		Fax:	
Street address:	City:	State:	ZIP:
Mailing address: (if different from above)			
Nature of business:		How long in business:	
Employer Identification No. (EIN):		S.I.C.#: (if known)	
Legal structure: <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Non-profit corporation			
State of incorporation:			
Are any affiliated companies to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" provide name(s), address(es), and relationship(s) below:			
Name of Affiliate		Address	Relationship
Effective date:		Waiting period:	
Total number of employees (including owners):		Number of hours per week considered full time: <small>(A min. of 25 hours is required in Ohio)</small>	
Number of full-time employees (including owners):		Are any full-time employees excluded? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes," why?			
Attach recent State Quarterly Compensation Report (contains employee name, Social Security Number and wages).			

Section II – Health Plan Information

Will coverage replace any current group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes," complete the information below and attach copies of the prior carrier's latest billing.					
Name of current carrier:		Effective date:		Policy number:	
Are present coverages being voluntarily terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes," when and why?			
If "No," please explain:					
Does your company have a policy for continuation of coverage for disabled employees or employees on leave of absence? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes": <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days or <input type="checkbox"/> Other:				Attach a copy of the policy.	
Does your company provide health benefits for laid-off employees? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes": <input type="checkbox"/> 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 days					
Are all employees covered by Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," provide the following information:					
Name of insurer:		Effective date:		Policy number:	
List all individuals covered under COBRA and their effective dates:					
Name	Eff. Date	Name	Eff. Date	Name	Eff. Date

Section III – Amendment(s) to Existing Health Plans

<input type="checkbox"/> Plan design	From plan	To plan
Other: Specify changes on appropriate form or officer-signed letter and attach to this application		

Section IV – Plan Design Options

PPO Plans	QHDH Plans
<input type="checkbox"/> PPO 500 Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)	<input type="checkbox"/> QHDHP 1100 Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)
<input type="checkbox"/> PPO 750 Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)	<input type="checkbox"/> QHDHP 1500 Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)
<input type="checkbox"/> PPO 1000 Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)	<input type="checkbox"/> QHDHP 2500 Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)
<input type="checkbox"/> PPO 2500 Coinsurance Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)	Prescription Drug Options <i>available only with QHDH plans</i> <input type="checkbox"/> Option E - Discount Card: 80% coinsurance after deductible
<input type="checkbox"/> PPO 5000 Coinsurance _____% Preferred (in network) _____% Non-Preferred (out of network)	PPO Network Selected <input type="checkbox"/> _____ (insert PO name here) <input type="checkbox"/> _____ (insert PO name here)
Prescription Drug Options <i>available only with PPO plans</i> <input type="checkbox"/> Option A - 3-tier copay; Retail: \$10/\$30/\$50 Mail: \$20/\$70/\$150 <input type="checkbox"/> Option B - 3-tier copay; Retail: \$10/\$40/\$80 Mail: \$20/\$100/\$180 <input type="checkbox"/> Option C - 3-tier copay; Retail: \$15/\$50/\$90 Mail: \$30/\$130/\$210 <input type="checkbox"/> Option D - \$150 deductible and 50% coinsurance	
	<input type="checkbox"/> Calendar year <input type="checkbox"/> Plan year

Section V – Employer Contribution Information

Employer understands and agrees to contribute _____% of the employee's cost and _____% of the dependent's cost.

Note: All non-contributory plans require 100% participation. All contributory plans require application by at least 75% of those eligible, or coverage will not become effective.

Section VI – Employer Contribution Information

You (the employer) understand and agree that the coverage, if issued, will include the costs and administrative provisions that apply. Such provisions are binding upon you and us (Significa Insurance Group, Inc.) subject to policy terms and conditions. The coverages you are applying for will not become effective until: 1) this Application is approved by us; and 2) the number of persons covered is not less than the minimum required by law. You understand that pre-existing conditions may be excluded from coverage according to policy provisions.

You further understand and agree that the agent/broker does not have authority to: 1) approve effective dates; or, 2) change or modify coverages or conditions relating to the insurance.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The person signing below, as one of your authorized and active officers: 1) represents that all the information included is true, complete and correct; and, 2) understands the proposed coverage(s) will not become effective until approved by us. **Important: An eligible employee must be actively at work before benefits can begin. If the employee is not actively at work when coverage would otherwise have started, coverage will be deferred until the first day that he or she returns to active work and all other requirements are satisfied. This does not include days missed due to health factors (as defined by HIPAA) and/or regularly scheduled non-working days, if the employee was actively at work on the last day preceding a regular work day.**

(Date)

(Full legal name of employer)

(Signature of authorized officer)

(Print or type officer's name and title)

Section VII – Agent/Broker Information

(Name of brokerage)

(Brokerage address)

(Printed Name of agent)

(Signature of agent)