AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094
(800) 991-2642 (734) 591-9000 (734) 591-4628 Fax
www.american-community.com

Large Group Employer Application

For 51+ Eligible Employees

Employer_______________________ Tax ID# _______________________

SIC _______________________ Worker's Comp Carrier_______________________

Street _______________________

City_______________________ County_____________ State_____ZIP________

Billing Address (if different) Street _______________________

City_______________________ County_____________ State_____ZIP________

Telephone Number (   )_______________________

Nature of Business_______________________

President/CEO Telephone Number (   ) _______________________

Contact Person _______________________ Title _______________________

Telephone Number (   )_____________ Fax Number (   )_____________ Email _____________

Employer Contributes ☐ % of Premium or ☐ Dollar Amount as follows:

	Life	Dependent Life	WI	Health/Rx	Dental	Vision
Single						
Parent & Child						
Couple						
Family						

Premium Submitted $_____________

Other Affiliates or Subsidiaries Included or Excluded

Name and Address | Include or Exclude

1. _______________________ _______________________
2. _______________________ _______________________
3. _______________________ _______________________

Previous Insurance Carrier _______________________

Health Deductible_________ Co-Insurance_________ Effective Date_________ Paid to Date _________

Dental Deductible_________ Co-Insurance_________ Effective Date_________ Paid to Date _________

Proposed Effective Date: ______ / ______ / ______
Mo Day Yr

Waiting Period for New Employees

30, 60, or 90 days_______________

Other_______________

Effective Date for New Employees

1st day after waiting period_______________

1st of month after waiting period_______________

Number of Employees	Number of Employees Insured for	Number of Employees Waiving Coverage	Number of Employees on Continuation of Coverage
Full Time ______	Life/AD&D ______	Life/AD&D ______	COBRA ______
Part Time ______	Dependent Life ______	Dependent Life ______	State ______
Retired ______	Health ______	Health ______	USERRA ______
Are retirees covered under this plan? ☐ Yes ☐ No	Dental ______	Dental ______	
	Vision ______	Vision ______	
Contract or leased ______	WI ______	WI ______	
Total ______			

In addition to this health plan, will your company provide supplemental health coverage, that is, either a self-funded or insurance program that helps cover all or part of the employee's deductible under the primary health coverage? ☐ Yes ☐ No

The Employer understands and agrees that:

1. No insurance will become effective without the written approval of American Community.
2. The eligibility, participation requirements, pre-existing conditions provision and cost-containment/PPO requirements have been discussed with and explained by an American Community representative or the agent.
3. This application shall become a part of the contract issued by American Community.
4. All known ongoing serious illnesses and/or large claims (exceeding $10,000) in the last 2 years have been disclosed to the agent and American Community.
5. Any incomplete, incorrect, or misleading answers may void the insurance contract at American Community's option.
6. The employer will be required to sign the final acceptance of benefit selection, rates and effective date of coverage.

______________________________ Dated at

______________________________ Date

______________________________ Employer's Authorized Signature

______________________________ Witness (Licensed Resident Agent's Signature)

______________________________ Agent's Number

______________________________ Agent's Name (Print)

______________________________ Agent's Phone Number

______________________________ Agent's Fax Number

Legal Notice

Returned Check Fee: For groups issued in all states, **except** Nebraska, if any premium payment made directly by check is returned for nonsufficient funds, a $20 nonrefundable service fee will be applied. This fee will be due with your next premium payment.

Ohio residents: Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania residents: We are required by Pennsylvania law to inform you of the following: "Any person who, knowingly and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."