

# OH Small Group Employer Application

**For 2-50 eligible employees. To avoid delays in processing, all areas must be completed.**

**REQUESTED EFFECTIVE DATE:** \_\_\_\_\_

**PRODUCT:**  American's Choice Options       Latitude™       Triple Tier™  
 APEP Choices™       Next Generation HSA™       Life Insurance

Employer (Full Legal Company Name) \_\_\_\_\_

Employer (DBA Name) \_\_\_\_\_

Located at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Billing Address (if different) \_\_\_\_\_

Address of Other Locations Being Covered \_\_\_\_\_

Business Legal Status:     Corporation     Sole Proprietorship     Partnership     Other \_\_\_\_\_

Telephone Number (        ) \_\_\_\_\_ Fax Number (        ) \_\_\_\_\_

Tax ID Number \_\_\_\_\_ County \_\_\_\_\_

Contact Person \_\_\_\_\_ Title \_\_\_\_\_

Names of Owner/Sole Proprietor/Partners/Corporate Officers \_\_\_\_\_

Nature of Business \_\_\_\_\_ SIC \_\_\_\_\_

Worker's Compensation \_\_\_\_\_ Policy # \_\_\_\_\_

**Prior Health Carrier** \_\_\_\_\_ Policy # \_\_\_\_\_

Telephone Number (        ) \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Coinsurance \_\_\_\_\_ Effective Date \_\_\_\_\_ Paid to Date \_\_\_\_\_

**Prior Dental Carrier** \_\_\_\_\_ Policy # \_\_\_\_\_

Telephone Number (        ) \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Coinsurance \_\_\_\_\_ Effective Date \_\_\_\_\_ Paid to Date \_\_\_\_\_

Prior Orthodontia Coverage?     Yes     No

**Legal Notice**

**Returned Check Fee:** 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.

**Fraud Notice:** 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 Employer understands and agrees that:** 1) No insurance will become effective without the written approval of American Community; 2) The eligibility, participation requirements, waiting periods (see page 3), pre-existing conditions limitation, and utilization review requirements, if any, have been discussed with and explained by the agent; 3) This application shall form a part of the employer's contract or certificate issued by American Community; and 4) Any incomplete, incorrect, or misleading answers may void the insurance at American Community's option. **The employer will be required to sign the final acceptance of benefit selection, rates, and effective date of coverage.**

Signature of Employer or Authorized Representative \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_ City and State \_\_\_\_\_

# Eligibility and Participation

## To be completed by the employer

- An eligible employee is an employee who works a *minimum* of 25 hours per week on a permanent basis. Owners, sole proprietors and partners are considered eligible.
- Affiliated companies are companies that qualify as parent/subsidiary and/or brother/sister controlled groups as defined in IRC section 414, or are eligible to file a combined tax form.

1. Do you have any affiliated companies?  Yes  No

If yes, list all affiliated companies (attach additional sheet if more space required)

Company Name \_\_\_\_\_ Company Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Nature of Business \_\_\_\_\_ Nature of Business \_\_\_\_\_

Include Company in Plan  Yes  No Include Company in Plan  Yes  No

Number of Eligible Employees \_\_\_\_\_ Number of Eligible Employees \_\_\_\_\_

Tax ID Number \_\_\_\_\_ Tax ID Number \_\_\_\_\_

2. Identify the number of employees in the following categories (if not applicable, indicate N/A):

Employee Status:	Currently Covered by:	Number Enrolling in:
Full-time _____	COBRA Continuation _____	Life/AD&D _____
Part-time _____	State Continuation _____	Health _____
Temp or Contract _____	Medicare _____	Weekly Income _____
In Waiting Period _____	USERRA _____	Dental _____
		Vision _____

**A Group may be non-renewed if it falls below 2 employees, or the participation requirements are not maintained.**

3. COBRA Eligibility: All employers who had 20 or more employees on 50% of their typical business days, during the previous calendar year, must comply with COBRA. Part-time employees are counted as a fraction of a full-time employee.

Identify the number of employees in the following categories (if not applicable, indicate N/A):

Full-time \_\_\_\_\_ Part-time \_\_\_\_\_

Combined total hours worked per year \_\_\_\_\_ Number of hours per week considered full-time \_\_\_\_\_

4. Indicate the percent of premium or dollar amount paid by employer below:

	Life	Weekly Income	Health	Dental	Vision
Employee					
Dependent(s)					

5. Waiting Period for New Employees

30 days     60 days     90 days     Other\* \_\_\_\_\_

Waive waiting period on original employees

*\*Cannot exceed 90 days.*

**Effective and Termination Dates**

**Immediately.** Coverage begins immediately following the waiting period and ends immediately following termination of employment or change in status from eligible to non-eligible employee or dependent.

**1st of month following.** Coverage begins on the first of the month following the waiting period and ends on the last day of the month in which employment terminates or status changes from eligible to non-eligible employee or dependent.

6. 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 employees' deductible under the primary health coverage?

7. Special Requests (please list any special requests here for underwriting considerations):

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# Agent Information

Employer Name \_\_\_\_\_

## New Case Submission Checklist (required to complete the Underwriting process):

- Employer Group Application OH SGERA 6/09 REV 7/09
- Employer Trust Request to Participate Form  
ATRTP 7/05 REV 3/08 for American's Choice Options  
AT5RTP 4/06 for APEP Choices, Latitude, Next Generation HSA or Triple Tier
- HealthEquity HSA Authorization Form (required for NGHSA plan if HealthEquity chosen as fund administrator)
- HealthEquity HRA Employer Application (required for APEP Choices or Latitude plan if HealthEquity chosen as fund administrator)
- Group employee application for all employees and new hires who will be eligible to apply for insurance within 60 days of the effective date. Employees waiving coverage must provide reason for waiving.
- Husband and wife groups need copy of ownership papers
- The **final** proposal (or list the final proposal ID number) indicating the employer's selected benefits, final census and effective date
- Employer's current premium statement from the prior carrier
- Employer's most recent quarterly state wage and tax statement. For owners not listed on wage and tax statement, we need a copy of ownership papers. For employees not listed on wage and tax statement, we need a copy of current pay stubs.
- Employer's check for the first month's premium made payable to American Community Mutual Insurance

Does this group qualify for JET Issuance?  Yes  No

### All of the above items are required for JET issuance of a group, and:

- No missing information on forms  No significant medical conditions
- All of the above received by American Community at least 2 weeks prior to the requested effective date

American Community will contact the agent with a reference number when the new case is received in the Home Office.

Premium submitted \$ _____	Proposal I.D. _____
Requested effective date _____ subject to Home Office approval	
Where proposal created:	<input type="checkbox"/> Agent Office <input type="checkbox"/> National Sales Office <input type="checkbox"/> Home Office
Mail new case certificates and ID cards to:	<input type="checkbox"/> Agent <input type="checkbox"/> Employer
Has this group been pre-reviewed by American Community prior to this submission?	

### AGENT #1

### AGENT #2

Name _____	Name _____
Agent # _____	Agent # _____
Phone # _____	Phone # _____
Fax # _____	Fax # _____
Email _____	Email _____
Split Commission% _____	Split Commission% _____

All agents sharing commissions on this application must sign. Example: 50% Agent #1 and 50% Agent #2.

**Agent's Statement:** I certify that all of the information contained in the Employer Group Application, the employee applications and any attached papers is correct to the best of my knowledge. I have fully explained the provisions of the Group Application and the plan of benefits selected by the employer as described by American Community in its brochure. I have notified the group that their employees may be contacted by an American Community underwriter to verify information on their application.

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_