Group Application

Pennsylvania in-area PPO products are underwritten by HealthAssurance Pennsylvania, Inc., d.b.a. Coventry HealthAmerica. Pennsylvania out-of-area products, are underwritten by Coventry Health and Life Insurance Company, d.b.a. Coventry HealthAmerica. Pennsylvania HMO products are underwritten by HealthAmerica Pennsylvania, Inc. d.b.a. HealthAmerica HMO.

Company Name

Street Address	City	State	Zip
Billing Address (if different than street address)	City	State	Zip

Telephone Number	Fax Number	Email Address

Nature of Business	SIC Code	Company Tax ID Number
		Date Company Established

Business ☐ Proprietorship ☐ Corporation ☐ Partnership ☐ Municipality ☐ Limited Partnership ☐ Non-profit ☐ Union Group ☐ Other ____________

Current Medical Carrier

Worker's Comp Carrier

Decision Maker	Title	Telephone Number	Fax Number

Average Number of Employees

Please provide the average number of employees at your company during the preceding calendar year (i.e. 2014). This average must include all individuals employed by your company, whether an employee was full-time, part-time, and/or seasonal. **Important**: the government requires the total average number, regardless of whether employees were eligible to enroll, and/or participated in the group insurance coverage. Only include temporary employees if they worked for your company (i.e., employees to whom you issue a W-2).

Example:

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average
FT Emp.	20	22	23	24	25	27	25	22	23	21	20	18	270	
PT Emp.	2	2	2	2	3	3	2	2	1	3	3	3	28	
Seasonal	1	1	1	0	0	0	0	0	0	30	40	40	113	
Total	**23**	**25**	**26**	**26**	**28**	**30**	**27**	**24**	**24**	**54**	**63**	**61**	**411**	**34**

Average = Total Number of Employees for 2014 ÷ 12 months (e.g., 411 ÷ 12 = 34).

Please share with us the average number of employees at your company: __________ (required)

Total Eligible for Medical

Qualified Beneficiaries under COBRA

of COBRA Enrollees on Group Policy

# of Employees Out-of-Area

# of Hours Worked Per Week To Be Considered Eligible To Enroll

Effective Date

Dual Option* ☐ Yes ☐ No * A minimum of eight 8 employees must enroll. A rate adjustment may apply.

Plan Requested: (If Dual Option indicate both plans)

☐ In-area PPO ______________________________

☐ Out-of-area PPO ___________________________

☐ HMO _____________

Employer Medical Contributions ______ % of single premium toward the cost of each tier –OR– ______ % of premium rates for each coverage tier **Domestic Partners** ☐ Yes ☐ No	**Terminated employees are covered through:** ☐ end of month –OR– ☐ last date of employment **Provide adult dependent coverage through age 29?** ☐ Yes ☐ No If "Yes" please have the adult dep complete a separate Employee Enrollment/Change form.

Eligibility ☐ date of hire ☐ first of month after date of hire ☐ (check one) first of month after ☐30 ☐60 days of employment ☐ (check one) ☐30 ☐60 ☐90 days after date of hire Does this apply to all classes of employee? ☐ Yes ☐ No If no, please explain. ______________________________	**Medical loss ratio (MLR) classification. Check the appropriate box below. More information about MLR can be found at www.hhs.gov.** ☐ ERISA ☐ Government Group – Non Federal (A non-Federal governmental plan is a plan that is established or maintained by the government of any State or political subdivision thereof for its employees, or by any agency or instrumentality of any government of any State or political subdivision for its employees) ☐ Non-ERISA and not a Government Group (if you choose this option you must complete the Coventry non-ERISA addendum that will be provided AND check one of the boxes below) ☐ Agree to the terms in the Coventry non-ERISA addendum ☐ Don't agree to the terms in the Coventry non-ERISA addendum

Employer Funding - If enrolling in a C3 HRA/HSA product only:

Please list the amount that the employer is funding toward the employee's single / family deductible.
I certify that I am funding $_________ (single) / _________ (family) of my employee's _______________ medical plan (Please see the C3 product selection worksheet for general product guidelines and selection).

Execution of Group Application

The terms and conditions contained in this Group Application (Application) are hereby made an integral part of the Group Contract between HealthAmerica and the Group named below. These terms and conditions will remain in effect until the Group Contract is non-renewed or terminated in accordance with its termination provisions.

Group Information & Applicant Group Signature

Application should only be signed once rates and benefits have been finalized.

Group Name ________________________ Group Number ________________________ Effective Date of Coverage ____________________

Authorized Signature – REQUIRED ____

Print Name __________________________________ Title _____________________________ Date of Signature _______________

Fraud Warning

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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.

Agent Agreement (***applicable for employer groups with under 50 total average employees only***)

If you wish to recognize a broker to represent your Coventry HealthAmerica plan, please provide the following information.

To be completed by the broker:

Writing Agent Name: ______________________________ (**required**)

Social Security Number: ____________________ (required)

Agency Name: ______________________________ (if applicable)

Commission Payable To: ______________________________ (**required - -must mirror HAPA appointment**)

Tax ID Number: ____________________ (required)

Telephone Number: ____________________

WHOLESALER INFORMATION if applicable. Commissions will be paid to wholesale agency.

Wholesaler: ______________________________

Tax ID Number: ____________________ (required, when applicable)

To be completed by the employer's authorized company representative:

Authorized Company Representative Signature: ____________________

Authorized Company Representative Title: ____________________ Date: ____________

Group Name: ____________________ Group Number: ____________________ Effective Date: ____________

Your signature above as the ***authorized company representative*** allows the individual listed above to act as an agent of HealthAmerica and to receive compensation in the form of monthly commission payments for his/her services. ***You further understand and agree*** that the broker does not have the authority to approve your coverage and/or effective date and may not accept premiums on our behalf. The broker of record listed above will remain in force until HealthAmerica receives formal written notice of cancellation from your company.

Authorized company representative signature is required to execute agent agreement.

Attach Final Medical Plan Premium Rates and Contingency