



3310 Fields South Drive
Champaign, IL 61822

LARGE GROUP EMPLOYER APPLICATION

(for 51+ full-time-equivalent employees)

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|--|-------------|-----------|
| Group Name as shown on Tax and Wage Statement: | | |
| Employer Federal Tax ID Number (TIN): | | |
| Group Contact: | | |
| Industry Type: | | |
| Email Address: | | |
| Physical Address: | | |
| Billing Address: | | |
| City: | State: | Zip Code: |
| Phone Number: | Fax Number: | |

SECTION 1: ADDITIONAL GROUP INFORMATION

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| 1. Total number of employees including full-time, part-time, seasonal, owners, etc.? |
| 2. Requested Health Alliance effective date: |
| 3. Name of current carrier: |
| 4. Is Health Alliance the sole source of health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, identify other carriers: |
| 5. Date business started: |
| 6. Is your organization a: <input type="checkbox"/> State Government <input type="checkbox"/> Local Government <input type="checkbox"/> Publicly Traded Corporation <input type="checkbox"/> Non-Profit <input type="checkbox"/> Controlled Group <input type="checkbox"/> Privately Held Corporation <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Church Group <input type="checkbox"/> Other |
| 7. Is the group subject to ERISA? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. SIC Code: |

SECTION 2: CREDITS

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| 1. Does group wish to have In-Network Deductible Credit? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Deductible Credit is defined as the amount Health Alliance will credit for payments made toward the in-network deductible under the previous health insurance. If the new deductible is higher than the previous deductible, the additional amount needs to be met before benefits will be paid. Explanation of Benefits and/or a Deductible Credit Report from your previous carrier must be submitted for Deductible Credit to be applicable. <i>NO CREDIT WILL BE GIVEN FOR OUT-OF-POCKET MAXIMUM.</i> |

SECTION 3: MEDICARE SERVICES

Please contact your Broker and/or Sales Account Executive for plan options, rates and details.

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| 1. Please check the plan(s) that interest you: <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Medicare Stand-Alone PDP Which plan(s)?: |
| 2. Effective date of Medicare plan: <i>(please note applications for Medicare Services cannot be retroactive)</i> |
| 3. Approximately how many Medicare-Eligible (primary) employees does your group have?: |
| 4. Approximately how many Medicare-Eligible retirees does your group have?: |
| 5. Medicare billing type: <i>(choose one)</i> <input type="checkbox"/> Group Level <input type="checkbox"/> Individual |
| 6. Medicare plan contact information. Medicare Group Contact: Email Address: Physical Address: City: State: Zip Code: Billing Address: Phone Number: Fax Number: |
| 7. Sponsor type: <input type="checkbox"/> Employer <input type="checkbox"/> Union <input type="checkbox"/> Trustees of a Fund |
| 8. Who will the plan(s) be offered to? <input type="checkbox"/> Future Retirees <input type="checkbox"/> Past Retirees <input type="checkbox"/> Both |
| 9. Will the plan be offered to spouses? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Will the group allow non-Medicare eligible spouses to stay on the active plan if the spouse moves to the group Medicare plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Same for dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Can retirees leave the plan and come back? <input type="checkbox"/> Yes <input type="checkbox"/> No |

SECTION 4: THIRD PARTY ADMINISTRATIVE SERVICES

1. Do you have a Health Savings Account (HSA)? Yes No

2. Do you have an HRA? Yes No

3. Are you currently using BPC to administer third party services such as COBRA, HRA, FLEX or HSA?: Yes No
If Yes, please list services:

SECTION 5: BROKER INFORMATION (IF APPLICABLE)

I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by this application and the eligibility and enrollment information is accepted. I understand I have no right to bind this coverage, to alter terms of the Coverage Contract or Application in any manner or to adjust any claim for benefits under the Coverage Contract.

Print Broker Full Name: _____ Agency: _____

Signature: _____ Date: _____

I agree that the typed name above shall be treated as a valid signature for all purposes of this form.

SECTION 6: GROUP INFORMATION

I have read this application and attest to the accuracy of the above information.

Group Contact: _____

Signature: _____ Date: _____

I agree that the typed name above shall be treated as a valid signature for all purposes of this form.