EMPLOYER GROUP APPLICATION

(Becomes part of the Group Policy)

Underwritten by: NATIONAL HEALTH INSURANCE COMPANY
DALLAS, TEXAS
Third Party Administrator: Meritain
1405 Xenium Lane North, Suite 140, Minneapolis, MN 55441

COMPANY NAME			GROUP NUMBER (office use)	
STREET ADDRESS (physical address only)			DIVISION NAME AND NUMBER (office use)	
CITY	STATE	ZIP	REQUESTED EFFECTIVE DATE – First of the Month	
BILLING/MAILING ADDRESS			COUNTY	FEDERAL EMPLOYER I.D. NUMBER
CITY	STATE	ZIP	TYPE OF INDUSTRY	
CHIEF EXECUTIVE OFFICER OR PROPRIETOR			YEARS IN BUSINESS	
BENEFITS ADMINISTRATOR / TITLE			PHONE	FAX
E-MAIL AND WEBSITE ADDRESS			OTHER LANGUAGE CONSIDERATIONS	

Are all employees eligible for this plan covered by Worker's Compensation? ☑ YES ☐ NO

If NO, please explain: _____

Are your benefits subject to ERISA regulation? ☐ Yes ☐ No

TYPE OF ORGANIZATION:

☐ Sole Proprietorship ☐ Corporation ☐ Partnership Other_____

ELIGIBLE EMPLOYEES:

1. Total number of employees _____
2. Total number of employees covered under another employer sponsored plan _____
3. Number of part-time, seasonal and temporary employees _____
4. Number of eligible employees (subtract line 2 & 3 from line 1) _____
5. Number of employees declining (complete waiver) or covered elsewhere _____
6. Total employees enrolling with National Health Insurance Company (subtract line 5 from line 4) _____

CONTINUATION COVERAGE:

Employer is responsible to contact current carrier to obtain name(s) and address(es) of current COBRA participants.

Please indicate number of current COBRA participants _____ (attach list)

Is employer required to offer: ☐ Federal COBRA

BENEFITS:

☐ Sexual Dysfunction

Preferred Provider Choices
State _____
PPO Network _____
PPO Network _____
PPO Network _____
PPO Network _____

RATES (office use):	**MEDICAL**	**EMPLOYEE**	**EE + SP/1**	**EE + CH(REN)**	**EE + SP + CH(REN)**
Option	_____	_____	_____	_____	_____
Option	_____	_____	_____	_____	_____
Option	_____	_____	_____	_____	_____
Option	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

EFFECTIVE/RENEWAL DATE _____ RAF: _____ OPEN ENROLLMENT: _____ TO:_____

Enrollment / Premium Provisions

GROUP NAME	GROUP NUMBER (office use)

SELECTED ELIGIBILITY REQUIREMENTS: A bona-fide employee/employer relationship is required to be maintained; that is the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona-fide employer/employee relationship.

Eligible employees shall be active, full-time employees who usually work at least __30___ hours per week.

CATEGORIES OF ELIGIBILITY:

☐ **Dependents** spouse, children ☐ Domestic Partner

☐ **Retired Beneficiaries** ☐ **Early Retirees (under age 65)** ☐ **Other – provided detailed description** (subject to approval)

COMMENCEMENT OF COVERAGE:

☐ 1st month following Date of Hire ☐ Date of Hire

☐ 1st month following ☐30 ☐60 _____ days from Date of Hire

☐ Any day within 90 days from Date of Hire _____

Note: All terminations are effective the day of the month in which Employee ceases to be eligible under group eligibility provisions.

EMPLOYER CONTRIBUTION REQUIREMENTS:

(Employer must contribute a minimum of 50% of Employee only premium)

☐ **Employee Only $ _____ or _____ % of Rate**

☐ **Dependents $ _____ or _____ % of Rate**

BROKER INFORMATION:

☐ Existing Broker

☐ New Broker (must complete Carrier Appointment & Commission Agreement/s)

Broker Name: _____ Phone: _____

Agency: _____ Fax: _____

Broker Number: _____ E-mail: _____

Commission: ☐ Standard Scale ☐ Flat _____% ☐ Other: _____ License Number:_____

COMMENTS:

EMPLOYER STATEMENT

We wish to enroll our organization as an employer account with National Health Insurance Company. We understand the eligibility rules applicable to enrollment and understand the premium requirements.
Employee participation requirements and employer contribution have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

PREMIUM REQUIREMENTS: Monthly premiums are due and payable in full on the first day or the fifteenth (to coincide with original effective date) of each calendar month. If premiums are not received from the employer, coverage for enrollees will be terminated on the last day or the fifteen (to coincide with original effective date) of the month for which premium was received. Any other premium payment arrangements require prior approval.

To the best of our knowledge and belief, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Policy and shall become a part thereof. National Health Insurance Company reserves the right to terminate the Group Policy or the coverage of any individual Certificateholder who has made any intentional misrepresentation of a material fact.

_____ _____

Signature Date

_____

Print Name and Title

BROKER STATEMENT

I certify that: All the information contained in this application is correct to the best of my knowledge; the applicant is a bona-fide business establishment; all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

_____ _____

Broker Signature Date

_____ _____

Sales Approval Date Account Executive Date

National Health Insurance Company